Addressing alcohol and other drug use among young people from migrant and ethnic minority backgrounds: Perspectives of service providers in Melbourne, Australia

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Authorship

CD conceptualised and designed the study, conducted the interviews, analysed the data and led the writing of the manuscript. DH, KB, MH and ML assisted with study conceptualisation and design, provided feedback on data analysis, reviewed drafts of the manuscript and approved the final version.

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Abstract

Young people from migrant and ethnic minority backgrounds are recognized as emerging priority populations for reducing alcohol and other drug (AOD)-related harms in Australia. Limited research has investigated how service providers address AOD challenges in migrant communities. In this qualitative study, we interviewed 15 service providers from AOD, migrant support, community and other health services in a diverse region of Melbourne. Interviews explored the challenges that service providers faced and the strategies they implemented to engage with young migrants in relation to AOD use. Thematic analysis was used to generate four themes: stigma as a barrier to service delivery, intergenerational differences between young people and parents, the need for outreach and establishing trust and understanding over time. Service providers believed that stigma prevented many young people from migrant backgrounds having open conversations about their AOD use with family members and professionals. Participants perceived that some parents had less AOD-related knowledge and lower English language proficiency than their children creating challenges for effective communication. Service providers recognised the importance of engaging with young people in settings where they felt comfortable rather than expecting them to approach their service. Participants also acknowledged the need to invest time in establishing trust and understanding with young migrants so they could facilitate conversations about AOD use as relationships evolved. Although service providers had a strong understanding of young people's needs, they found it challenging to build relationships in the context of funding and time constraints. Our results indicate the need for long-term funding and timelines that enable service providers to build strong relationships with young migrants, their families and their broader cultural communities to facilitate access to AOD support.

Key words
Young people, alcohol, drug use, migrants, service provision, qualitative research

What is known about this topic

- People from migrant backgrounds face barriers to accessing alcohol and other drug (AOD) services
- Australia's national drug and alcohol policies recognise young people from migrant backgrounds as a priority population for reducing AOD-related harms
- Research is needed to understand how service providers can meet the needs of young migrants

What this paper adds

- Addressing AOD use among young people from migrant backgrounds can be challenging in the context of stigma and intergenerational differences between young people and parents
- Programmes need adequate funding and long-term timeframes to enable service providers to develop trust and understanding with young people, their families and communities to facilitate access to AOD information and support

Main text

Introduction

Alcohol consumption and illicit drug use make a substantial contribution to the global burden of disease (Gore et al., 2011). Alcohol is a risk factor for injury, cancer, neuropsychiatric disorders and liver, cardio-vascular, gastrointestinal and infectious diseases (Rehm et al., 2017). Regular cannabis use increases the risk of injury, cognitive impairment and psychoses (Hall, 2015) and injecting drug use increases the risk of HIV and viral hepatitis (Larney, Peacock, Mathers, Hickman, & Degenhardt, 2017). Other impacts of alcohol and other drug (AOD) use include hospitalisations (Roxburgh, Ritter, Slade, & Burns, 2013), contact with the criminal justice system, violence and financial costs (Australian Institute of Health and Welfare, 2018).

Evidence suggests that adults from migrant backgrounds are less likely to consume AOD than the broader population (Donato-Hunt, Munot, & Copeland, 2012; Rowe, Gavriel Ansara, Jaworski, Higgs, & Clare, 2018). In the Australian National Drug Strategy Household survey, adults who were born in Anglo-dominated countries who spoke English-only at home reported a higher prevalence of AOD use than participants classified as culturally and linguistically diverse (Rowe et al., 2018). However, large surveillance surveys typically have an under-representation of people from migrant and ethnic minority backgrounds thus our

understanding of AOD use among these groups remains limited. Despite lower prevalence, Australia's recent national drug (Department of Health Australia, 2017) and alcohol (Department of Health Australia, 2019) strategies consider people from culturally and linguistically diverse communities as an emerging priority population because they face barriers to obtaining appropriate support (Department of Health Australia, 2019). Major barriers compromising access to AOD treatment include stigma, limited health literacy and concerns about the cultural responsiveness of services (McCann & Lubman, 2018; McCann, Renzaho, Mugavin, & Lubman, 2017).

Within migrant communities, young people experience additional challenges related to AOD use. In Australia, experimenting with AOD use is generally considered a normal part of young people's social worlds, however use may be highly stigmatized by their families and cultural communities. This dichotomy means that young people may face difficulties in balancing their identity as a young person and upholding traditional cultural values (Renzaho, Dhingra, & Georgeou, 2017). Evidence suggests that a minority of young migrants may be vulnerable to harmful AOD use due to traumatic experiences, mental health conditions, low socio-economic status, unemployment and insecure living arrangements (Victorian Alcohol and Drug Association, 2016). Research has highlighted that young men from East Africa and Sudan in Melbourne who engaged in heavy alcohol consumption experienced significant harms including injuries, violence, family conflict and police contact (Horyniak, Higgs, Cogger, Dietze, & Bofu, 2016). Local services must adapt to meet the needs of their population including young people with a range of cultural backgrounds, preferred languages and experiences (Davern et al., 2016).

In Australia, many different services including social, welfare, education, harm reduction, health promotion and treatment providers play important roles in Australia's AOD response (Department of Health Australia, 2017). For example, treatment providers can offer counselling, withdrawal programmes, care and recovery coordination, rehabilitation and pharmacotherapy (Lubman, Manning, & Cheetham, 2017) while social services and community groups can provide support for housing, education and employment. Despite this well-developed sector, relatively little attention has been given to how service providers address the AOD needs of young people from migrant and ethnic minority backgrounds. This study aimed to explore the perceptions and experiences of service providers who addressed AOD use among young migrants. In this manuscript, we defined young people from migrant backgrounds as 16-25 year olds who were born overseas or had at least one parent born overseas, with a focus on ethnic minority groups. We explored the challenges service providers faced and the strategies they implemented to engage with young migrants in the context of AOD use.

Methods

Setting

This study took place in the City of Wyndham which is located in the outer south-western suburbs of Melbourne and has the highest population growth in Victoria (Wyndham City Council, 2017). Wyndham was selected as the study setting because the local council identified a need to improve AOD services for their culturally and linguistically diverse communities. An estimated 42% of Wyndham residents were born overseas and 41% speak a language other than English at home compared to 34% and 33% of Greater Melbourne residents respectively (.id Consulting, 2020). Compared with Greater Melbourne, Wyndham has a higher percentage of people with Indian, Filipino, Burmese, Maori, Samoan, Bengali and Sudanese ancestry (.id Consulting, 2020). Wyndham also has a high proportion of people with refugee backgrounds including people born in Burma (Republic of Myanmar), Thailand, Sudan, Kenya, South Sudan and Ethiopia (Davern et al., 2016).

Study procedures

Between December 2018 and August 2019, we conducted 15 semi-structured in-depth interviews with service providers. Participants were eligible for inclusion if they worked with young people from migrant backgrounds or addressed AOD use in Wyndham. Participants were excluded if they did not respond to researchers after three contact attempts or if an interview time could not be arranged. Participants were purposively sampled through existing networks of the study team and the local council, with additional participants identified through snowball sampling. Author CD contacted potential participants by phone or email and invited them to undertake a one-hour interview in person or over the phone to discuss their experiences providing AOD and related services to young migrants. CD did not know the participants prior to the interviews. Participants provided written informed consent for face-to-face interviews and verbal consent for phone interviews. All interviews and study materials were in English. Participants responded to open-ended questions focused on their observations of AOD use among young migrants. Specific interview questions included: What is your current role? Which groups do you currently work with? What challenges do you face in this role? What lessons have you learnt from working with migrant communities in Wyndham? How could service access be improved for the groups you work with? Transcripts were not returned to participants for comment however, they were encouraged to contact the interviewer by email if they wished to provide additional information. Most participants completed the interviews during their work hours and were not reimbursed for participation. The study was approved by the Alfred Hospital Ethics Committee (Project 428/18).

Participants

Author CD invited 21 service providers to participate; six did not respond to email correspondence. Overall 15 service providers from 12 different organisations were interviewed (nine males, six females). Most interviews were conducted at the participant's workplace or local cafes. Participants' were employed by different services including community and other health services (n=6), migrant support services (n=4), AOD services (n=4) and law enforcement (n=1). Participants had various roles including managers, team leaders, nurses, outreach workers, youth workers and community engagement workers (defined as employees who worked directly with migrant communities to assess their needs and develop community-based solutions). Eight participants self-identified they were from a migrant background. Most participants worked with young people from many different cultural backgrounds including young people with refugee experiences and migrants from first- and second-generation backgrounds. Some participants worked with specific groups including Sudanese, South Sudanese, Māori, Pacific Islander and Burmese (including the Karen community, an ethnic group who face persecution in Myanmar). Most participants worked with young people who experienced challenges including mental health conditions, financial difficulties and barriers to accessing education and employment.

Data analysis

Author CD audio-recorded and transcribed interviews verbatim and kept field notes throughout data collection. Identifiable information was removed from transcripts. Data were analysed in NVivo using reflexive thematic analysis (Braun, Clarke, Hayfield, & Terry, 2019). This process involved becoming familiar with the data, coding, generating initial themes, reviewing themes, defining and naming themes and writing a narrative. In practice, this process involved re-reading transcripts, writing reflections on each interview, manually coding transcripts on paper, coding in NVivo, creating mind maps and re-thinking initial ideas to identify underlying meaning. We adopted an inductive approach to coding meaning we generated codes inherent in the raw data rather than using a pre-determined coding framework. Author CD led the analysis and met regularly with co-authors to discuss codes and themes throughout the process. Reflexive thematic analysis recognises the active role and experiences of the researcher in generating knowledge. This analysis was influenced by the positionality of the first author as an Australian-born, white, cisgender, female PhD student with a background in public health research and volunteering with young people from migrant backgrounds.

Findings

From the interviews, we generated four themes that illustrated the participant's perspectives of providing AOD and related services to young people from migrant and ethnic minority backgrounds. Themes included stigma as a barrier to service delivery, intergenerational differences between young people and their parents, the need for outreach and establishing trust and understanding over time.

Stigma as a barrier to service delivery

Most of the participants believed that AOD-related stigma experienced by young migrants and families was a barrier for providing AOD information and support. Some participants worked with young people from Muslim backgrounds where intoxication is considered haram (forbidden) in their religion. This belief made sharing AOD-related information difficult because the topic can be considered inappropriate and irrelevant for the community and AOD workers can be perceived as *"outrageous".* Participants who were from migrant backgrounds reflected on the negative labels associated with AOD use in their communities. A community engagement worker described how South Sudanese young people who consumed AOD were generally perceived as failures within their communities:

> *"When kids go into drinking a lot of alcohol and taking drugs, they see you know they've failed, you know people who have no use at all in the society or within their family"* (Participant 3, community engagement worker)

Participants also described the stereotypes experienced by families whereby community members assumed young people's AOD use was enabled through "*bad parenting"*. Service providers believed the negative labels associated with AOD consumption prevented young migrants from having open conversations with workers. The reluctance to discuss AOD use made it difficult for service providers to assess the scale of AOD problems among the communities they worked with. One outreach worker highlighted how some young people would avoid workers if they had been drinking alcohol:

> *"Most of the kid, they know me…when you find them drunk, sometimes they run away from you, they just don't want to see your face, they don't want to talk to you, just like embarrassment"* (Participant 15, outreach worker)

Participants who worked in AOD treatment believed they obtained better outcomes such as treatment uptake and completion when a young person was supported by their family. However, young migrants were often unwilling for workers to approach their family in fear of being ostracised from their families and cultural communities. One youth worker discussed how

most clients preferred to keep both their AOD use and any engagement with services hidden from their relatives however, were open to attending with peers:

> *"The young people I work with, they don't want to involve their families cus of the stigma behind using AOD or having a worker for AOD, it's kind of shameful so they don't want to involve their parents…that's like in the community seen as alcoholic or a druggo. Sometimes they have friends who might also be using or having issues and they might come together…but I've struggled to get them to agree to let me work with their families"* (Participant 11, youth worker)

Service providers believed stigma delayed help-seeking among young people from migrant backgrounds, with some of their clients only presenting to services in response to a crisis or contact with the criminal justice system. In other examples, participants described how young migrants and family members attempted to cope with AOD problems on their own rather than seek professional support:

> *"I've had someone in the Karen community tell me rather than trying to get help, a parent will try to lock up their child and stop them going out you know doing whatever…but these are parents doing it without the knowledge because they just don't understand that there are services out there that can help with this"* (Participant 6, AOD team leader)

Participants also acknowledged the intersection between AOD-related stigma and race. Participants described how their clients from migrant backgrounds were perceived by the public as more deviant than their white peers for similar behaviours. Participants recalled past incidents where local residents would contact police when South Sudanese young males were socialising in the park fearing they were a "*gang*". Service providers believed when young people were labelled as gangs, there were implications for the settings of AOD consumption. A community engagement worker described how young people would consume alcohol with peers in public places or private dwellings and deliberately avoid licensed venues:

> *"Most of them drink in public places…they don't go to those clubs because you know they tend to be - you know labelled in the wrong way because they find if you know 10 South Sudanese were in the pub, which would mean there would be a problem…to other people"* (Participant 3, community engagement worker)

Intergenerational differences between young people and their parents

Service providers observed significant disparities in AOD-related knowledge and experiences between young people from migrant backgrounds and their parents. They described how their young clients had often spent most of their lives in Australia

whereas their parents were raised in countries with stricter attitudes towards AOD use. These different upbringings resulted in young people having greater exposure to AOD through their social networks and higher levels of knowledge than their parents. Participants described how parents would sometimes approach professional services with limited knowledge about AOD use, the types of support available or how to initiate conversations with young people without creating conflict. Workers often needed to manage parent's expectations of AOD treatment and explain harm reduction principles and the long-term nature of recovery. Multiple participants described how parents wanted AOD services to "*fix*" their child rather than reduce harmful consumption:

> *"What we are finding is that the families of people in the migrant community, their understanding is that if he stopped using or she stopped using things will be fine, abstinence is the end goal. If they're still using occasionally there's an ongoing guilt that's put on them even though they might have reduced substance use significantly"* (Participant 7, AOD team leader)

Service providers also acknowledged the desire to seek professional support could differ between young people and parents. Some participants described how parents from migrant backgrounds would request support for their child or relative. While parents believed their child's AOD use was problematic, young people perceived their use as a social activity. These differences created barriers where young people were reluctant to speak with service providers, as highlighted by a community engagement worker:

> *"Most parents they come to me, they have a family member user, they explain to me "Oh I got my son, this very heavy user, I need someone's support" but what happens is I engage with the client's son and he says "I will be fine, I don't need it"* (Participant 14, community engagement worker)

Service providers observed differences in English language proficiency between young people and parents. Although most young migrants had a high level of English language proficiency, sometimes interpreters were required if parents attended appointments and English was their additional language. When service providers used accredited interpreters they found it difficult to convey emotion and meaning. Some participants described challenges in finding an interpreter for people from smaller cultural communities. Two participants described examples where appointments had to be terminated because the clients knew the interpreter or were connected to them through close contacts. In other cases, young people would interpret for their parents in their preferred language, making it difficult for service providers to determine what messages

were communicated. A team leader described the challenges that occurred when working with young people and their families:

> *"It's very, very hard and we can have translators but still it's not flowing and the empathy or whatever you're feeling might not show up in the actual language itself so that's hard to get past that point too. A lot of times, it's a bit like you're the expert, you fix it. My son's on drugs, I just want him to stop. It's very hard to tell them that these things take a long time"* (Participant 10, AOD team leader)

The need for outreach

Service providers recognised there were numerous barriers which made it difficult for young people from migrant backgrounds to access AOD services. They emphasized the importance of actively reaching out and meeting young people where they already spent time to promote AOD information and support services. Participants advocated for youth drop-in spaces with a "*chilled laid-back vibe*" where young people could go to "*hang-out*", connect with others, use computers, and participate in recreational activities. These spaces provided opportunities for workers to reach young people and promote their services in non-threatening and non-clinical environments:

> *"A lot of them are the kids that don't engage your more clinical settings where they have to agree to become part of something or there's fees or there's appointments, so the kids come in, they hang out and then they just chat to the services and ultimately they get service provision, just because they're familiar with the faces and conversations happen"* (Participant 6, AOD team leader)

Reaching out to young people through other recreational activities, faith-based settings and community events was also viewed as a positive way for initiating conversations about AOD. For some participants, this meant regularly hosting and attending events with the local community. One community engagement worker found it particularly useful to connect with young people and provide AOD information through sporting clubs:

> *"How do you get young people to come in? Find out what activities they normally do…probably soccer or dancing group…you have to go in when they're doing those activities and ask for some permission to be able to talk them…but just having a stand-alone alcohol and drugs [session] they're not likely to come (laughs)"*
> (Participant 1, community engagement worker)

Service providers recognised the need to reach young migrants in public places because not all people were involved with youth spaces, recreational activities, or sporting clubs. In these

circumstances, offering and sharing food was seen as essential when approaching young people to facilitate conversations. An outreach worker described the importance of connecting with South Sudanese young people through food:

> *"Some of the kids when they take alcohol or drug, they don't have food, it affects them a lot. I just explain myself if you need help from me, I can help you. Especially the food, if you need to come where we cook, you can come, but most of them they don't like to come. We need to provide food for them and we can deliver the food. When we deliver food they take it, they don't have issue"* (Participant 15, outreach worker)

Establishing trust and understanding over time

Participants explained it can take a long time for young people from migrant backgrounds to disclose their AOD use to service providers, therefore it was important for workers to have ongoing engagement to establish trust and understanding with individuals. Both participants from migrant and non-migrant backgrounds acknowledged the benefits of having employees who shared a cultural background with their clients or patients; namely that they often had existing relationships and shared experiences with the community and possessed a deeper understanding of the cultural context that people were embedded within. However, participants also highlighted that not all young migrants were comfortable speaking about AOD use with a worker who shared their cultural background, particularly when there were high levels of shame in their community. Nevertheless, service providers from migrant backgrounds felt able to integrate their nuanced understanding of migration challenges and cultural perceptions of AOD into their roles. Participants who addressed AOD in their own cultural communities believed their positionality helped them to connect and build trust with young people and deliver information in culturally appropriate ways:

> *"For me I feel like...being from the community myself I already have that comfortability with the kids ...like there's a certain...amount of trust before we even start speaking"* (Participant 11, youth worker)

Service providers who did not share a cultural background with their clients or patients were still able to establish trust and understanding however they acknowledged the importance of connecting with the broader migrant communities with which their clients identified. Without dedicating time to connect with people in the community, it was not feasible to have conversations about stigmatised topics. To build these relationships, participants believed it was important to connect with community leaders, listen to their needs and work in collaboration to solve complex challenges. One

participant described how working with religious leaders had been invaluable for connecting with community members and developing a sense of trust. This relationship also enabled the participant to develop skills to communicate AOD information in culturally appropriate ways:

> *"A lot of the Karen community have engaged with the church, that's where they meet and have that sense of community. We can't work with them until they [the ministers] know who we are…We need to stand up in a church and talk about this stuff for them to accept that it's being condoned by the church so it means there's no shame. This is where they trust, this is how we believe we might be able to help them to address alcohol and substance use issues"* (Participant 6, AOD team leader,)

Participants commented that most AOD services were based on western models of treatment thus often unfamiliar to people from newly-arrived communities. One participant reflected on how some recently arrived communities in Australia had limited knowledge of counselling and relied on service providers to explain the process before they attended appointments:

> *"Counselling is important but I know my culture, we never seen counselling before so I have to keep promote to them what the counselling look[s] like, what it is, how it will help you"* (Participant 14, community engagement worker)

While service providers viewed long-term engagement to establish trust and understanding as rewarding and beneficial, they also commented it was challenging and time-consuming to do within programmes that were "*generally short-term or precariously funded*" (Participant 4, team manager). Some participants highlighted that their funding was dependent on meeting targets which were usually measured by the number of people receiving treatment:

> *"When you're working with new and emerging communities, the work is potentially much more complex and time consuming. If you get focused on meeting targets, you risk moving away from quality engagement"* (Participant 8, team manager)

Processes like long-term engagement and developing trust and understanding were generally not well captured or considered a measure of success. One team leader articulated how funding limitations influenced the level of trust between service providers and migrant community members:

"Programs closing…all those different connections I've made sort of die off so they [the community] lose trust. It makes it really hard to get involved with a lot of groups" (Participant 10, AOD team leader)

Discussion

This study highlighted the challenges and strategies for service providers who address AOD use among young people from migrant backgrounds in a diverse region of Melbourne. The key themes generated from in-depth interviews included stigma as a barrier to service delivery, intergenerational differences between young people and parents, the need for outreach and establishing trust and understanding over time. Although service providers had a strong understanding of the challenges faced by their clients and implemented relevant strategies, they felt constrained by system issues such as limited funding and short-term programmes.

Our participants perceived stigma directed towards AOD use as a major barrier to sharing information and having open discussions with young people from migrant backgrounds. Stigma refers to a social process in which a person or group's attribute is identified as different and associated with negative characteristics (Link & Phelan, 2001). Research demonstrates how people who use AOD are stereotyped as criminal, deviant and immoral leading to social exclusion, internal shame, decreased quality of care and poor health outcomes (Room, 2005; Wilson, 2020). Previous research indicates that stigma can prevent individuals from seeking AOD support (McCann et al., 2017), impede counselling, and may be associated with relapse and treatment attrition (Gray, 2010). Other studies have suggested an intersection between stigma and racism whereby Latino people who injected drugs were perceived as more deserving of punishment compared to white people who injected drugs (Kulesza et al., 2016). This intersection was noted by our participants when they described negative community perceptions of young South Sudanese males. There is a need to reduce stigma towards AOD within migrant communities and address the negative attitudes towards young migrants from the broader community. Theoretical frameworks suggest that social structures and power dynamics enable stigma and discrimination to occur thus interventions must address the drivers of stigma and minimize harms for people who experience stigma (Stangl et al., 2019). Some interventions have successfully reduced self-stigma through therapeutic interventions and social stigma through sharing positive stories of people with substance use disorders (Livingston, Milne, Fang, & Amari, 2012). However, few interventions have targeted or been developed with people from migrant communities. Previous research suggests that language can reinforce negative stereotypes (Lancaster, Seear, & Ritter, 2018). For example, when people who use drugs are described as addicts, immoral or lazy, this reinforces the belief that people are undeserving of care (Tindal, Cook, & Foster, 2010). Campaigns promoting the use of person-

centered terminology (Wilson, 2020), inclusive language and anti-stigma messages created with cultural leaders and community members may be a way forward. Additionally, campaigns should be informed by people with lived experiences of AOD use and migration to ensure the content and delivery of messages is relevant and appropriate for cultural communities (Lancaster et al., 2018).

Participants acknowledged the impact of intergenerational differences between young people and their parents, which can be intensified in migrant families. Existing research suggests that when families migrate to Australia, parental authority can be threatened as young people experience increased freedom (Renzaho et al., 2017). Power dynamics can shift, particularly when young people have higher English language proficiency than their parents (Renzaho et al., 2017). Consequently, young migrants may find it difficult to strike a balance between upholding traditional cultural beliefs that their parents subscribe to and belonging with their peer groups. While experimenting with AOD use is considered a normal part of Australian youth culture, parents from migrant backgrounds may be more fearful and concerned about their children engaging in these behaviours.

Importantly, participants acknowledged that AOD services are generally based on western ideals which typically focus on supporting the individual. This approach may not reflect the needs of migrants who are from collectivist cultures where there is an emphasis on group goals and family and cultural support (Du et al., 2014). Parents and other family members play a crucial role in supporting young people in AOD treatment and often require assistance to navigate services, manage stigma and seek personal support (McCann & Lubman, 2018). Evidence suggests that family-based interventions can improve engagement and retention in AOD treatment, reduce harmful use and improve family functioning compared to individual-focused treatment (Cassidy & Poon, 2019). Our participants acknowledged the value of including family members in treatment however found it challenging to manage beliefs that young people who used AOD were problematic and required fixing. Some evidence supports the involvement of migrant families in AOD treatment and suggests there is a need for education around the complexity of recovery and support (Reid, Crofts, & Beyer, 2001). When service providers work with families there can be language barriers and large gaps in health-related beliefs thus treatment plans and the information shared are not always appropriate (Kaufert & Putsch, 1997). Using professional interpreters can help to bridge language barriers, improve a clients' experience, reduce communication errors and raise the quality of clinical care (Karliner, Jacobs, Chen, & Mutha, 2007; Kaufert & Putsch, 1997). Studies indicate that professional interpreters have a stronger impact on positive patient outcomes than ad hoc interpreters (e.g. family members) (Karliner et al., 2007). However, using professional interpreters can also

present challenges if the client is from a small community and has concerns about their confidentiality. It is important for service providers to receive adequate training so they are able to work effectively with young people and their families across different cultural contexts.

Participants in this study emphasised the importance of service providers undertaking outreach with young people, and developing trust and understanding over time. Service providers recognised sustained engagement is needed to build relationships and facilitate conversations about AOD use with young people and their broader communities. A previous program that targeted young men from African backgrounds who were disengaged from education and employment, identified that short-term programmes do not enable adequate time for building relationships and addressing complex challenges (Turnbull & Stokes, 2011). The Victorian Alcohol and Drug Association recommend that AOD services should receive support to partner with multicultural and settlement services and community groups to improve service delivery for individuals and families from migrant backgrounds experiencing AOD-related harms (Victorian Alcohol and Drug Association, 2016). Other services (such as the Alcohol and Drug Foundation) have partnered with local communities to produce culturally-specific AOD resources (Alcohol and Drug Foundation, 2020). Participants in our study believed that workers from migrant backgrounds may be better positioned to establish trust and understanding around AOD use with their own communities. For example, the Muslim Youth, Adults and Family Programme was a partnership between the Islamic Council of Victoria and AOD treatment providers including Odyssey House Victoria, The Salvation Army, Self Help Addiction Resource Centre and Youth Support and Advocacy Service. The programme employed staff members (majority who were from Muslim backgrounds) to develop relationships with individuals and families from Islamic communities to facilitate access to drug treatment and other support services. While our participants recognised the need for outreach and long-term engagement, they felt constrained by funding and the need to demonstrate outcomes. These constraints reflect challenges in the broader AOD sector with short-term and irregular funding recognized as barriers to service delivery (van de Ven, Ritter, Berends, Chalmers, & Lancaster, 2020). Additionally, demonstrating progress towards outcomes can be challenging when greater value is placed on abstinence or reduced consumption as opposed to improvements in health and quality of life (Savic & Fomiatti, 2016). Future research must evaluate AOD programs targeting people from migrant backgrounds and identify important outcomes to monitor.

This study has several limitations. We used purposive and snowball sampling to recruit participants in diverse service provision roles who worked with a broad variety of client groups and were well positioned to reflect on the issues of interest. It is likely our participants had higher levels of cultural competency than those who did not take part or workers from less

culturally diverse areas. Although we took some steps to confirm our understandings of participants' key concerns during the interview process, due to time limitations in conducting the research we did not conduct member checking to confirm the final themes. It is possible that the final themes may be influenced by our own personal experiences and viewpoints. We acknowledge that while there are some common experiences for people from migrant backgrounds, not all migrant communities are the same and there are also differences within and between ethnic groups. This study was based in one region of Victoria and service providers in other locations may have different experiences. However, barriers to accessing AOD services for migrants discussed in this study are consistent with previous studies in Australia (Posselt, McDonald, Procter, de Crespigny, & Galletly, 2017) and internationally (Satinsky, Fuhr, Woodward, Sondorp, & Roberts, 2019) thus findings may be applicable to other culturally diverse locations in high-income countries. Further research with young people from migrant backgrounds is needed to understand their experiences with AOD services. Despite the limitations, this study raises important considerations for future AOD programmes and services working with young people from migrant and ethnic minority backgrounds.

Conclusion

This qualitative study provides an insight into the challenges and strategies for service providers who address AOD use among young migrants. The results highlighted how stigma associated with AOD use and intergenerational differences between young people and parents create barriers to service delivery. Although outreach and long-term engagement with young people and their communities was seen as important, these activities were constrained by funding, short-term programmes and pressure to demonstrate outcomes. Moving forward, programmes targeting AOD use among migrant communities must have adequate funding and long-term timeframes to allow service providers to build relationships with young people, their families and wider communities to address this stigmatised and complex issue.

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