Brotherhood of St Laurence
Working for an Australia free of poverty

Submission re Whole of Government Victorian Alcohol and Drug Strategy

Brotherhood of St Laurence

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Summary

The Brotherhood of St Laurence welcomes the opportunity to provide feedback and recommendations to the Victorian Government on its Whole of Government Alcohol and Other Drug (AOD) Strategy. Through research, services and advocacy, the Brotherhood helps people experiencing disadvantage at all stages of life, empowering them to build a better future. The Brotherhood has taken a leading role in trialling innovative approaches to assisting disadvantaged groups to address their diverse and complex range of needs.

The problem

This submission largely focuses upon the impact of AOD-related issues on disadvantaged populations. The Brotherhood provides a number of services for disadvantaged groups who often confront interrelated challenges such as the lack of affordable housing, transport, poor health or disability, and financial insecurity, which may be due to unemployment, underemployment or low-paid work. As stated in the National Preventative Health Strategy, there is an imperative to 'address the unequal distribution of health and risk in Australia' by focusing upon the structural determinants of health including the allocation of resources, money, and power' (NPHT 2009, p. 32). The Brotherhood's research emphasises the interrelationship of multiple elements of social exclusion (see, for example, the Social Exclusion Monitor <http://www.bsl.org.au/Social-exclusion-monitor>). For some people who experience disadvantage, AOD use may serve as a form of self-medication in response to stress, poverty and trauma. In addition, antisocial behaviours associated with AOD may have broader effects on vulnerable communities—and vulnerable community members—which may increase their sense of insecurity and distress.

The Brotherhood's research and experience in delivering services to disadvantaged populations provides insight that can usefully inform the development of a whole-of-government AOD strategy. These are:

- AOD-related issues need to be understood in context. They are one of many interconnected factors associated with entrenched disadvantage. Geographical and cultural isolation, racism, stigmatisation, homelessness and mental health issues may interact to exacerbate AOD-related harms, and vice versa.
- AOD-related harms can impact on other people who themselves are not using alcohol or other substances. This is evident among disadvantaged groups who may be affected by the AOD use of others in their communities.
- The complexity of issues that many AOD users experience requires a coordinated approach at a policy and service delivery level.
- Integrated service hubs that seek to address a range of needs can be effective within a whole-of-government approach if they are adequately resourced, effectively coordinated, embedded within the community and, where appropriate, focused on long-term case management.
- Holistic approaches to prevention often depend upon the mediating role of parents and families. A life-course approach ensures that diverse family structures and parent–child relationships become a resource rather than a barrier when addressing AOD issues.

An integrated, whole-of-government approach should enable the development of integrated policy approaches as well as the implementation of 'joined-up', person-centred approaches to service

delivery. The Brotherhood therefore welcomes the Victorian Government's stated intention to address AOD harms in a more holistic manner.

Recommendations

- The Victorian Government has a role in establishing wellbeing and health as key indicators of an inclusive society alongside economic participation. The status of alcohol as 'no ordinary commodity' must be reflected in Victorian Government policy through harm minimisation and risk-based principles that take account of its social harms and costs alongside its economic benefits to the night-time economy (see p. 12).

- Developing options for socialising that do not involve alcohol requires funding and planning. In particular, young people's social and cultural needs should feature in urban and social planning at local council and state levels. Dedicated places for community activities, youth hubs, shared public space, recreation and sporting space, and improved transport must be provided in new developments, especially in outer-suburban and regional areas (see p. 7).

- Increased regulation of on-licence and off-licence businesses is needed so that economic gains are balanced against social harms and costs to health. Recent evidence pertaining to the harms associated with alcohol outlet density should be used to inform Victorian Government policy around these issues (see p. 12).

- The Victorian Government should develop and promote culturally appropriate educational material for parents to aid their understanding of AOD use among young people and of the most effective strategies for preventing AOD-related harms. Community and health services, along with the education sector, could lead this work supported by government funding (see p. 8).

- The Victorian Government should conduct a community consultation to examine harm minimisation approaches to AOD use in public housing, to increase the safety and security of the residents while supporting those who may have AOD issues (see p. 10).

- As a priority, increased funding to mental health services is required for timely access to support, especially for young people with co-morbidity issues and young people in rural and regional settings (see p. 11). The Brotherhood supports the Victorian Government's four-year $108.55m mental health plan and calls for continued funding to improve access to mental health services.

- Greater access to multi-service support for issues including AOD use, unemployment, housing, health and wellbeing requires funding and administrative arrangements that enable joined-up services (see p.13). This requires a commitment at state and federal levels to ensure that competing compliance arrangements do not work against effective collaboration and case management. The Victorian Government should work with the federal government to review administrative arrangements that compromise the implementation of joined-up approaches.

The Brotherhood of St Laurence

The Brotherhood is an independent, non-government organisation with strong community links that has been working to reduce poverty in Australia since the 1930s. Based in Melbourne, but with a national profile, the Brotherhood continues to fight for an Australia free of poverty. We undertake research, service development and delivery, and advocacy with the objective of addressing unmet needs and translating the understandings gained into new policies, new programs and practices for implementation by government and others

1 Introduction

This submission largely focuses upon the impact of AOD-related issues on disadvantaged populations. The Brotherhood provides a number of services for disadvantaged groups who often have a range of interrelated needs, including affordable housing, financial security and decent, sustainable employment. The health and wellbeing of disadvantaged individuals is shaped by these unmet needs. As stated in the National Preventative Health Strategy, there is an imperative to 'address the unequal distribution of health and risk in Australia' by focusing upon the structural determinants of health including the allocation of resources, money, and power (NPHT 2009, p. 32). The Brotherhood's research emphasises the interrelationship of multiple elements of social exclusion (see, for example, the Social Exclusion Monitor <http://www.bsl.org.au/Social-exclusion-monitor>). Indeed, for some people who experience disadvantage, AOD use may serve as a form of self-medication in response to trauma, stress and poverty. Antisocial behaviours associated with AOD may have broader effects on vulnerable communities—and vulnerable members of communities—with an increased perception of insecurity.

There is significant public concern over the damage done by alcohol in the community. The Whole of Government Consultation Paper identifies young people as a priority group that are disproportionately affected by AOD use. Research suggests that this focus is justified, particularly in relation to alcohol. For example, a national survey of 50,000 young people found heightened personal concern about alcohol among at-risk groups (Mission Australia 2011). Other research suggests that more young people are presenting at hospitals because of acute harms caused by alcohol (Livingston 2008). At the same time, alcohol is widely celebrated in Australian culture. Its consumption is normalised; and as a driver for the hospitality and hotel industries it is viewed as a key part of the state's economy. Whatever its economic benefits, the consumption of alcohol has significant personal and social costs and may exacerbate the complex issues related to economic disadvantage and poor health.

The use of illicit substances among Victorians is also a cause for concern. The National Drug Strategy and the Victorian Drug Strategy both support a harm minimisation approach; however, this is not always borne out in public policy. Specifically, the 'three pillars' shared by these strategies (reduction of supply, demand and harm) are not equally weighted, as policy places heavier emphasis on demand and supply reduction than on the more contentious area of harm reduction. Among disadvantaged groups, drug use may only be one factor interacting with other forms of social exclusion to negatively affect a person's health and wellbeing. Alcohol and other drug use may be associated with homelessness, unstable or unsafe accommodation, unemployment, disengagement from education, stigmatisation, racism, violence and poor mental health to further entrench disadvantage. The complexity of issues that many AOD users experience requires a coordinated approach at a policy and service delivery level.

A whole-of-government approach should enable integrated policy approaches as well as the implementation of joined-up, person-centred approaches to service delivery. The Brotherhood therefore welcomes the Victorian Government's stated intention to address AOD harms in a more holistic manner.

2 Interconnected AOD-related issues and disadvantaged populations

AOD use has a disproportionately negative impact upon disadvantaged populations. Some research suggests an association between low socioeconomic status and riskier drinking behaviours such as heavy drinking episodes (Giskes et al. 2011). However, in the broader context, AOD use is just one of many factors associated with disadvantage. Other factors include homelessness; geographical isolation; refugee status and ethnicity; mental health; unemployment, underemployment or low-paid, insecure work; and exclusion from formal learning opportunities. Importantly, research demonstrates that these factors do not operate in isolation, but are interrelated (Sen 1999). AOD-related issues in disadvantaged populations persist for a complex, interconnected set of reasons. To address AOD-related issues, policy must look beyond the individual to determine how it can change AOD use within the community. Our research and experience suggest that the following issues mediate the effect of AOD use on disadvantaged populations. These highlight the broader parameters to which a whole-of-government AOD strategy must attend.

Geographical and cultural isolation

Young people in rural, regional and outer-suburban areas which are not well served by transport or alcohol-free community activities are at particular risk of harmful AOD use. Victorian data demonstrates that indicates that young people aged 0–24 years from rural areas were more likely than their metropolitan counterparts to be involved in an 'alcohol-related family incident' (Laslett, Matthews & Dietze 2006). A lack of leisure options and ensuing boredom have been found to be associated with alcohol consumption and substance use (Bot et al. 2007; Caetano 2007; Coleman & Cater 2005). Indeed, the Brotherhood's experience working with young people in the Frankston and Mornington Peninsula area suggests that for some young people drug use has become routine as a precursor to the school day.

In Victoria there has been considerable focus on urban growth corridors, following the extension of the urban growth boundary in June 2010. The then Labor government added 43,600 hectares in the growth corridors of Cardinia and Casey in the south-east; Whittlesea, Mitchell and Hume in the north; and Melton and Wyndham in the west (*The Age*, 12 February 2011). Local councils and the state government face challenges including the provision of basic infrastructure such as water, sewerage, power, roads, transport, community facilities and schools. Often overlooked in these developments is the need for adequate cultural and social amenities for young people.

Place-based disadvantage may shape young people's AOD use. A previous Brotherhood submission on the liveability of outer suburban Melbourne (BSL 2011) indicated a 'lack of existing social and cultural activities and services' for burgeoning populations of families and young people. Compared with young people in urban areas, those from regional, rural and urban fringe areas are more likely to have fewer transport options open to them. Limited access to suitable public transport is likely to further constrain youth activities, resulting in 'less involvement in recreational and leisure pursuits' (Currie, Stanley & Stanley 2007, p. 161). A 19-year-old interviewee from the Mornington Peninsula cited a 'lack of things to do' as a causal factor of drug

use among her peers (Hancock & Morabito 2003, p. 47). On the other hand, research suggests that 'individuals involved in youth groups and sporting activities are less likely to exhibit risky drinking behaviours' (Bellis et al. 2007). However, developing options for socialising that do not involve alcohol requires funding and planning. In particular, young people's social and cultural needs should feature in urban and social planning at local council and state levels. Dedicated places for community activities, youth hubs, shared public space, recreation and sporting space, and improved transport must be provided in new developments, especially in outer suburban and regional areas.

Parents, families and communities

The role of parents and families needs to be considered within a more holistic approach. The research is clear that parental support in the form of nurture, affection and acceptance can act as a protective factor against young people's use of alcohol and other substances (Barnes et al. 2006). Similarly, the effectiveness of health professionals working with the positive qualities already inherent within families demonstrates the importance of a strengths-based approach (Usher, Jackson & O'Brien 2005). However, these approaches often assume that strategies will be applied within the idealised, stable, nuclear family. In doing so, they fail to take account of the impact of racism, discrimination and stigma experienced by disadvantaged and culturally and linguistically diverse (CALD) communities that may limit the effectiveness of strategies centred upon the family unit. Other factors such as poverty of income and time, as well as geographical isolation, lack of housing, mental health issues and lack of transport, have also been demonstrated to impact greatly upon social exclusion, thus weakening the impact of prevention approaches that focus on individual causes of alcohol and other drug use.

The potential positive role of parents in preventing AOD use among young people can also be undermined when parents model risky AOD use. The Brotherhood's study related to the Frankston and Mornington Peninsula Youth Connections program demonstrates that the effect of this kind of modelling may or may not be recognised within disadvantaged populations (Bond, forthcoming):

> Substance use was also identified as a significant barrier that created an unpredictable home environment. For example, some young people were described as having to deal with 'three parents in one day', i.e. 'scattered' and disorganised in the morning, in more control by midday when they had started drinking, and drunk by the evening. Both parental drinking and drug use was modelled to young people who also assumed these habits. One worker observed that with intoxication, violent and antisocial behaviour became an issue, along with other crime such as theft. While some parents sought help for their children's substance use issues, others were observed to be 'in denial' and difficult to engage.

One community professional said that communication and parenting difficulties were exacerbated among parents who had themselves not experienced an authoritative parenting style, and among those with mental health, drug and alcohol issues. She also noted that these young clients had been 'exposed to a lot' and tended to be 'more independent and out of control' (Bond, forthcoming). The same worker added that AOD issues were also difficult to address because students had to disclose the problem and voluntarily seek help to be referred to drug and alcohol agencies, where they faced long detoxification waiting lists. In other examples, students caught dealing drugs within school were dealt with in a punitive rather than rehabilitative manner. Moreover, cannabis use was not perceived by some young people to be illegal, as growing and dealing was a 'survival thing' to support individual habits and contribute to family finances (Bond, forthcoming).

These examples demonstrate that services do not always follow a 'no wrong door' policy, and show the inconsistent approach to AOD use, which includes its demonisation as a criminal issue. They also

highlight that a holistic approach must attend to the whole life course, including the backgrounds of parents and caregivers. The young 'client' at the centre of any service is not just an individual but also part of a broader family unit that is situated within a community. What is needed are services supporting family units that utilise the families' inherent strengths and qualities.

Refugee groups and the CALD community

Through the Ecumenical Migration Centre, the Brotherhood has been assisting new arrivals since 1962. Currently, its services focus upon family, youth, employment and settlement in Australia. Its work is supported by Brotherhood research that investigates social inclusion, employment participation, community capacity building and culturally responsive support. Since February 2008, refugees have received priority access to community health services under the Victorian Government's Demand Management Framework. Refugees have multifaceted needs and require long-term support. Joint research by Deakin University and the Brotherhood outlined the myriad difficulties faced by refugees settling into a new country: 'Economic and political hardship, torture and trauma, the social status of individuals and families in country of origin, together with the response of the new host society following resettlement, all contribute to the psychosocial adjustment and resettlement' (Gartrell, Edwards & Graffam 2006, p. 11).

Generally speaking, CALD communities are underrepresented in AOD client services. Research conducted in Victoria and Tasmania demonstrates that this is due to a lack of awareness of services, language barriers, lack of understanding of substance dependence issues, and lack of trust in AOD services (Mario-Ring et al. 2005; Reid, Crofts & Beyer 2001). In terms of prevention programs, CALD communities are similarly excluded. For example, 'universal' or mainstream prevention messages are typically culturally inappropriate for CALD communities. They may be particularly challenging for some refugee communities, in which drug use is stigmatised as shameful and consequently remains hidden. Our work also reveals concerns among refugee groups about the level of AOD use among their young people. Risk factors that may contribute to AOD use for this group include low neighbourhood attachment and belonging, geographical and cultural isolation, balancing peer and public pressures to assimilate or to conform with parental (ethnic) expectations or national values, and trauma associated with a sense of loss or separation of family members. The disruption to refugee family life has been found to heighten risk of drug use and dependency (DrugInfo Clearinghouse 2006). AOD use among refugee communities is therefore multifaceted and is driven by a range of interrelated factors. Indeed, Dr Ahmad Al-Mousa of the Brotherhood's Ecumenical Migration Centre observes: 'All these factors can lead to self-harm and alcohol/drug misuse among youth from refugee backgrounds, especially those living in areas with limited access to settlement support'.

The multiple factors associated with AOD issues are also compounded by the entrenched racism experienced by refugee groups. For example, high-profile cases of violence among young Sudanese Australians are played out in the media and public discourse as a failure of integration. In heightening stigma, there is real potential for refugee groups to experience exclusion and persecution. Overlooked alongside such stories is the more immediate role of alcohol that impacts upon all Australian young people, as well as the multiple barriers that limit refugees' social, cultural and economic participation. The stigmatisation of refugee groups therefore masks debate on the broader factors that contribute to alcohol and substance use.

While all families face challenges in addressing AOD issues, the challenge for those from refugee or CALD backgrounds can be especially difficult to overcome without the appropriate support. There is a need for culturally appropriate educational material to be developed and widely

disseminated for parents from refugee and CALD communities. By outlining evidence-based, effective strategies for preventing AOD-related harms, this material could aid understanding of AOD use, de-stigmatise AOD-related issues and correct existing myths.

Homelessness / poor housing options

In 2006, the homeless population in Victoria was estimated as 20,511 (Chamberlain & MacKenzie 2009). There are numerous pathways to homelessness. For some people, alcohol and other drugs may lead directly to homelessness, while others may develop AOD issues after becoming homeless (Chamberlain & MacKenzie 2009). In spite of this complexity, the role of AOD use in contributing to and exacerbating homelessness should not be underestimated. A key theme of interviews of youth workers and school staff for the Peninsula Youth Connections evaluation was that unstable housing and homelessness represented one of the major issues that led to young people disengaging from school. With few housing options available, they couch-surfed at the homes of friends and acquaintances, with some opting to sleep on the beach. According to youth workers, this transience was often accompanied by substance abuse (Bond, forthcoming):

> For example, one 22-year-old accessing a health service for the last six years had been on the public housing waiting list much of this time. Describing the young man's experience of family rejection and homelessness, a community worker said school was one of the first things to go, as 'daily survival' became the greater priority. The young man slept on the beach, his health deteriorating over time. The worker described his drug habit as a 'coping mechanism'. Being 'bombed out' meant he didn't have to deal with the reality of his situation.

In the following case study, the complex association between homelessness and drug use is also highlighted (Bond, forthcoming):

> Eddie stopped attending school at the beginning of Year 8 and was referred to [a case management program]. He also had a support professional to address his substance abuse issues. His case manager said that his mother felt unable to deal with the situation and was 'on the verge of kicking him out of home'. It was around this time that Eddie left home and 'went missing' until midway through the year. A frequent cannabis user until this point, he met with his case manager and said he wanted to return to school, and he stopped using.
>
> His former school willingly agreed to a trial period but then a misunderstanding led to the school asking him to take a week off to defuse a complex situation. While this was not a suspension or expulsion, Eddie interpreted it that way and, 'feeling let down', he 'went missing' for another week and returned to drug use.
>
> After this, the case-manager referred him to another AOD worker and he stayed clean for several months. Eddie said he wanted to become a pastry chef but there were no courses starting at that time of year. However, the Brotherhood was able to offer Certificate II in Hospitality. After completing this course, Eddie was enrolled in the Community VCAL program. His worker said he still had unresolved issues, and transport difficulties meant he sometimes called asking for a lift to school. Nonetheless he had attended every day of classes and was committed to graduating.

This example demonstrates how insecure housing and disengagement from school may combine to pull a young person back into substance use. At the same time, however, it also illustrates how broader social supports can be changed to reengage young people and thus protect them from substance use issues.

While AOD use can increase the risk of homelessness (Clapham 2003, cited in Hulse & Saugeres 2008), Brotherhood research (Myconos 2011, p. 15) has shown that AOD issues can also adversely impact upon the quality of housing for disadvantaged groups. In the following example, a study conducted in a high-rise public housing setting reveals how AOD harms impact upon *other* people's housing options, as noted by the community worker:

> The laundries have a water supply. They're discreet, so we do get a lot of drug users using the laundries which [are] very close physically to the drying rooms. I would say that has an impact on some people. I know some people would rather use a laundromat than use the communal laundries on each floor because people get their clothes stolen, find syringes in their washing, all that kind of irresponsible stuff.

Similarly, subsequent Brotherhood research (Bond 2010b) highlights how stigma associated with drug use can impact upon disadvantaged groups with poor dental health, limiting their ability to obtain housing. For example, some people have been rejected when applying for accommodation at caravan parks on the assumption that they are 'junkies'.

In other Brotherhood research, drugs were found to impact upon housing options (Bodsworth 2010, p. 54) for those already disadvantaged in the private rental market, with an interviewee arguing that:

> The only places I can really stay without affecting my housing application are hostels, which my housing worker has admitted to me, and I've spoken to her about the fact that people getting directly out of jail don't go to these hostels because they're bad places and they dislike them. They've literally said they prefer Port Phillip prison than staying at one of these hostels. That's my options: I've got to sleep under a bridge, up a tree, in a hedge, empty building, bin, anywhere but there. It's violent, drugs, I can't be around it, it just gets too much to me. I realise it, but I still can't control it. I have self-control issues, I don't hurt other people, I generally just hurt myself.

In the same report, a middle-aged man was forced to move back with his elderly parents. He had avoided share accommodation due to the cost and the risk of a group setting leading him to drinking alcohol and derailing his recovery from alcoholism. In both these examples, the individual's determination to avoid AOD use was made more difficult by the paucity of safe and affordable housing.

These examples demonstrate the interaction of housing needs and AOD-related issues. It is vital for those with complex needs to be able to access safe, secure and affordable housing without being stigmatised as AOD 'users'. To achieve this, greater recognition is needed of the impact of AOD-related issues on those seeking housing as well as those in public housing. This could take the form of a community consultation that examines harm minimisation approaches to AOD use in public housing. Additionally, improved access for people with complex needs to the housing system could be better supported through the simplification of the administrative processes of the housing and homelessness service system, as called for by the Council to Homeless Persons (CHP).

Mental health and substance use

AOD use can often lead to, or co-exist with, mental health issues. Anecdotal evidence from health and wellbeing workers in the Brotherhood's youth services reveals that several students would fit the criteria of co-morbidity of mental illness and substance abuse. For example, anxiety and depression are prevalent among the young people who are using substances. This is supported by research that finds that 'the primary causal direction leads from mental disorder to cannabis use among adolescents and the reverse in early adulthood' (McGee et al. 2000, p. 491). It should be

noted that the young people we serve may have some experience of childhood trauma; indeed their substance use may be a coping mechanism. AOD and mental health services in the outer fringe areas of Melbourne are typically underresourced, while regional and rural services are few. For existing services, the lack of resources means that it can take weeks to see a young person, even if that young person is in severe crisis. This gap in services can lead to young people using substances in an effort to self-medicate for ongoing mental health issues.

Brotherhood research (Bowman & Lawlor, unpublished) also highlights the need for ongoing personalised support that recognises the interrelationship of AOD and mental health issues for disadvantaged jobseekers. For example:

> R2: … most of the time I'm just drugged out, basically … too tired, you know, always late to appointments, always rocking up late—he still saw me and that.
>
> R1: And he'd [IPS worker] be pretty forthright too, if you were off your guts, he'd say 'You look a bit rank today, can we leave it to another day?'
>
> R3: And yeah, you know, 'Next time, don't come in that state …'
>
> R1: Yeah, 'cos you're getting nowhere like that. You know, you think you're on top of the world when you're like that, but you forget the whole interview the next day. It's grey, you know, it's all very grey! You remember [the IPS worker] was there, you remember you were there, but you could have spoken about anything all day and you wouldn't have remembered. So, yeah, [IPS worker]'s good like that.

In such situations, the interaction between mental health and substance use has the potential to be a barrier to disadvantaged groups seeking work. However, the understanding of the IPS worker ensured that the relationship with the jobseekers was maintained. This demonstrates the importance of services that respond to the complex overlay of needs in a way that does not stigmatise their clients.

The above examples demonstrate the need for mental health services sensitised to the co-existence of AOD issues. Just as importantly, the severity of co-morbidity issues requires services that can be accessed in a timely manner. For young people with co-morbidity issues and young people in rural and regional settings, these services are sometimes non-existent or inaccessible; so improved resourcing is required.

3 'Whole of government' and integrated approaches

As discussed in section one of this paper, the interconnected factors related to AOD use are sometimes expressed as a complex set of needs among disadvantaged populations. These needs may be addressed within different policy portfolios which may lead to unintended contradictions, gaps or duplication. As a multidimensional issue, policies related to AOD use require a joined-up approach that involves a range of government departments that deal with matters of employment, housing, education, settlement and mental health. Therefore, the emphasis on a 'whole of government' approach to addressing AOD-related issues is appropriate.

However, there are difficulties in working in a joined-up way. Funding, regulatory and administrative issues as well as professional and sectoral boundaries can impede integration. Policy, regulations, and services are shaped at different levels of government and add another layer

of complexity. A whole-of-government approach must acknowledge these issues so that collaboration can be developed.

The Victorian Government has a role in establishing wellbeing and health as key indicators of an inclusive society alongside economic participation. The status of alcohol as 'no ordinary commodity' must be reflected in Victorian Government policy through harm minimisation and risk-based principles that take account of its social harms and costs alongside its economic benefits to the 'night-time economy' (Zajdow 2011). For example, increased regulation of on-licence and off-licence businesses is required so that economic gains are balanced against social harms and costs to health. Recent evidence pertaining to the associated harms with alcohol outlet density (Livingston 2011) should be used to inform Victorian Government policy around these issues.

One potential whole-of-government model is the community hub which seeks to deliver services in an integrated—often co-located—manner. It is important to note, however, that multi-service hubs are not the entire solution to multidimensional AOD issues and that their effectiveness depends upon cohesive, cross-governmental collaboration and consistent policy.

Multi-service community hubs have been operated by the Brotherhood to address the complex and multiple needs of various disadvantaged populations. These centres are targeted, place-based, citizen-centred interventions which seek to put social inclusion principles into practice. Experience gained from these centres provides important lessons for similar services in the AOD sector. By tailoring community and health services to the needs of individual clients, the take-up of services can be strengthened. As importantly, continued to engagement with these services can also be improved by taking a life-course perspective. Though often associated with prevention, this approach can also benefit treatment by ensuring appropriate services to clients.

Also critical to the success of place-based community hubs is that they respond to community priorities, identified through ongoing consultation (BSL 2010). By being embedded within the community, such centres are more adept at responding to the specific needs brought about by local disadvantage. This has important implications for a whole-of-government AOD strategy, as local communities can be supported to take on a proactive role in preventing AOD-related problems. This is evident in a variety of forms, from community partners working with licensees in liquor accords through to efforts to address more structural measures. Similarly, a joined-up approach to social planning and urban planning could address the lack of leisure options that can have negative effects on AOD use. Joined-up approaches are also evident when multi-service community hubs apply effective collaboration and case management. By addressing a range of complex needs within this context, changes to AOD-related behaviour are much more likely. It is important that such integrated services have adequate funding and administrative support to enable joined-up services that are coordinated rather than just co-located.

The Brotherhood's contribution in this area includes integrated service centres such as the Frankston High Street Centre and the Centre for Work and Learning, Yarra. Our work indicates that effective integrated services must satisfy a number of requirements. These include: clear principles and measures, consistency of access to support; and age-appropriate services that address a range of issues beyond AOD use, including health, housing, education and meaningful work.

Client-centred approaches must acknowledge the complex and interconnected needs of disadvantaged groups. In order to address AOD issues, wide-ranging support in a number of domains is necessary. However, on the ground delivery of multiple services can lead to fractured, disjointed and inconsistent client experiences. The success of a holistic approach is therefore

contingent upon coordination; and resources must be dedicated to the specific task of supporting clients to navigate the myriad service providers. To some extent this constitutes an extended case management approach, but with a stronger emphasis on a coordinator's role that ensures adequate follow-up. Brotherhood service experience also suggests that modest case loads of between 10 and 15 clients is optimum for this approach to be effective.

Other research has found similar best practice elements in multiple service sites. For example, the following issues are important:

- long-term case management
- a stable 'home' for the program and residents
- planned achievements across several life domains with a sustained focus on education, employment and training
- flexible, long-term resourcing to enable a holistic approach
- partnership with multiple service providers (DHS 2010).

However, this kind of integrated approach, in which multi-service hubs address a range of complex client needs, is not without its challenges.

Challenges

Typically, integrated centres are more resource-intensive. Bringing together disparate service specialists can also lead to increased complexity in managing multiple funding streams and increased administrative burden in reporting requirements. Another major obstacle is the level of coordination required within these centres, as co-location does not necessarily equal coordinated service. Brotherhood research suggests that without a clear purpose and dedicated coordinator roles, co-located hubs can be as disjointed as a referral-based system of specialist services (Bond 2010a). However, well-integrated services can be effective (Bond, forthcoming), as a Brotherhood community youth worker observed:

> One of the reasons young people like coming here is that it can be a one-stop-shop. They can see their doctor here, they see a counsellor here, they see a drug and alcohol worker, we have a Centrelink person that comes in sometimes to see them. So I think the one-stop-shop concept is actually quite useful for young people, they get used to going to one place and they don't like going from one to another.

Greater access to multi-service support for issues including AOD use, unemployment, housing, health, wellbeing, and co-morbidity requires a commitment to developing funding and administrative arrangements that enable joined-up services. This requires a commitment at state and federal levels to ensure that competing compliance arrangements do not work against effective collaboration and case-management. The Victorian Government should work with the federal government to review administrative arrangements that compromise the implementation of joined-up approaches.

4 Conclusion

The Brotherhood's research and experience in delivering services to disadvantaged populations provides insight that can usefully inform the development of a whole of government AOD strategy. These are:

- AOD-related issues need to be understood in context. They are one of many interconnected factors associated with entrenched disadvantage. Geographical and cultural isolation, racism, stigmatisation, homelessness and mental health issues may interact to exacerbate AOD-related harms, and vice versa.
- AOD-related harms can impact on other people who are not themselves using alcohol or other substances. This is evident among disadvantaged groups who may be affected by the AOD use of others in their communities.
- The complexity of issues that many AOD users experience requires a coordinated approach at a policy and service delivery level.
- Integrated service hubs that seek to address a range of needs can be effective within a whole-of-government approach if they are adequately resourced, effectively coordinated, embedded within the community and, where appropriate, focused on long-term case management.
- Holistic approaches to prevention often depend upon the mediating role of parents and families. A life-course approach ensures that diverse family structures and parent–child relationships become a resource rather than a barrier when addressing AOD issues.

5 References

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