THE UNIVERSITY OF SYDNEY

EXPLORING THE NEEDS OF ABORIGINAL WOMEN WITH CO-MORBID DRUG AND ALCOHOL AND MENTAL HEALTH PROBLEMS

Theme analysis of interview transcripts

University of Sydney (Addiction Medicine)

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Dr Kylie Lee and A/Prof Kate Conigrave

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Background

This report summarises findings from interviews conducted with Aboriginal women, their families and staff employed within health services on the South Coast and Far South Coast of NSW. The study is part of the *Koori Women's Healing Research Project (KWHRP)* and was coordinated by the South Coast Medical Service Aboriginal Corporation (SCMSAC)**.**

The project sought to understand the service needs of Aboriginal women suffering from mental health and drug and alcohol abuse problems. The project also explores the experiences of families and carers of these women, and of the mental health and drug and alcohol staff currently working in the area.

Introduction

A project officer was employed on a full-time basis for a period of two years for the duration of the study. The role of the project officer was to work effectively with local services and conduct interviews and/or focus groups where appropriate with local women suffering from mental health and drug and alcohol abuse problems. In order to successfully analyse findings of the study it was necessary for the project officer to transcribe the interviews conducted.

Kerry Reed-Gilbert from Kuracca Consultancy also provided support and research training including assisting development of research tools, cultural protocols and presentation of the final report.

Funding for this study was provided by the Mental Health Coordinating Council's (MHCC) and the National Drug Strategy (Department of Health and Ageing).

Methodology

Thirty-eight interviews were conducted face-to-face with three different groups of respondents (women, their families/carers and Aboriginal Health Workers) in the South Coast and Far South Coast area, comprising 44 interviewees in total. Interviews were conducted by the project officer from June to November 2009, either individually or in small groups, depending on the preference of interviewees. Interviews were then transcribed by Project Officer and sent to ARTD for analysis.

Key findings

The women's stories

The women were aged between 20 and 61 years and had experienced different mental health conditions, ranging from mild anxiety to severe psychoses. The women's use of alcohol and other drugs also varied, including alcohol, cannabis and heroin. Some women suffered from more than one mental health problem and/or were poly-drug users.

The women commonly attributed their mental health and drug and alcohol problems to traumatic experiences in their life, such as physical or sexual abuse, domestic violence or the death of a loved one. They also pointed to other influencing factors that may have led to substance misuse, such as peer or family's drug use, low self-esteem, experimentation and boredom.

They stated that the impact of living with co-morbidity was considerable and personally devastating. Co-morbidity often led to a loss of social networks, ill health, unemployment and financial instability. Some women had their children removed and taken from their care, which led to feelings of shame, guilt, withdrawal and depression. Others were estranged from their families, or had difficulty maintaining relationships with people other than fellow users.

The women reported using a number of strategies to cope with their co-morbidity. Women who were actively seeking help or who said they were in remission tended to cope by relaxing and keeping busy (such as reading and further study). Other women used alcohol or other drugs to

help cope with their mental health problems. Being able to find a way to relax and feel normal was important to all participants.

The family's stories

Families and carers often supported the women over long periods of time and were often the most important source of informal support. Family members reported significant stress, including a constant fear for the women's health and wellbeing. The women's behaviour often led to families feeling embarrassment within the community or 'shaming'. Families who often cared for the children of these women reported financial strain and at times, feelings of resentment.

The children's stories

Family members reported that in some instances the children of these women also suffered, due to their mothers health problems. They believed that the children commonly experienced sub-standard care and disruptive childhoods, going hungry, missing out on school, lacking affection and witnessing domestic violence. In some cases, these children had grown immune to their parent's drug use, seeing this as 'normal'.

The use of informal supports

Family support was particularly important, with family members providing unconditional support when relationships with friends and colleagues had collapsed. Over time, the stresses of caring for the women meant some families struggled to maintain this support. The families' capacity to effectively support the women was affected by their lack of knowledge on support services in the area and the family member's own substance misuse.

Seeking help

The women generally sought help when in crisis due to health problems, but in some instances personal fears and feelings of shame stopped them from using the services. The majority of women involved in the study stated that there is a lack of knowledge about what services are available. When women sought help for their drug and alcohol use, they felt that having a mental health disorder sometimes impeded their access to these services.

Access to health services

The women used a variety of health services such as Aboriginal Medical Services (AMS), drug and alcohol rehabilitation and mental health services. General Practitioners, AMS, the police and the Department of Community Services (DoCS) were often the first point of contact for women when in crisis. Transportation to access these services was seen as a major barrier in relation to the women being able to successfully access services.

Aboriginal service providers

The majority of participants interviewed stated that they preferred to attend an Aboriginal Medical Service for their mental health and/or medical needs rather than a non-Aboriginal service provider. The women listed a variety of reasons for their preference while most stated they felt more comfortable at, and preferred using Aboriginal-run services.

A few of the women, however, had concerns about their privacy being maintained when using these services and some reported instances where their confidentiality had been breached. Some workers agreed that confidentiality policies were not adequately enforced.

Non-Aboriginal service providers

When relating their experiences of dealing with non-Aboriginal services the women felt that the staff were sometimes critical of the women's experiences of health services and whether they were willing to keep using a service. Unfortunately, some women reported bad experiences, for example workers who were 'judgemental', 'rude' and 'condescending'. The women also reported that negative attitudes of staff and a lack of ongoing support were particular problems in acute mental health settings. Staff encountered significant challenges in treating this user group and it appears that there is a need for better professional supervision for staff.

Some women told of long waiting times and difficulties accessing services when in crisis, which caused considerable distress. Some of the issues raised include services not open outside normal business hours, lack of staff, lack of same day appointments and difficulties with access to transportation to attend doctor and therapist appointments. In some instances the women

involved in the project talked of not being accepted into rehabilitation treatment services because of their mental health condition/problems.

What makes a good service?
Many women spoke of the importance of keeping busy and valued support services that provided recreational activities and opportunities to socialise. They also valued services that are responsive to their needs. Health workers reported that coordination of services, where it occurs, has benefited women.

Family members valued being able to go to family support groups and to share their experiences about living with a person with serious mental health and drug and alcohol problem. Families and carers felt that services should be promoted better as currently they believed they were uninformed about what was available.

Suggested service improvements
Women, family members and staff suggested ways to improve services:

- *Improve the coordination of services.* Mental health and drug and alcohol services should improve joint working in the delivery of their services. Efforts should also be made to increase collaboration with other services such as housing, education, prisons and community services.

- *Better promotion of services.* Suggested avenues are working with Koori groups and advertising in local town centres, schools and universities.

- *More education for families and carers about co-morbidity.* Families and carers require more information on what they can do to support family members with mental health and drug and alcohol problems, and to improve their understanding of the symptoms associated with mental health and drug and alcohol problems.

- *Better professional supervision for health workers.* Health workers should better be provided with opportunities for professional supervision. Adequate training in the care of clients experiencing mental health and drug and alcohol problems is also required.

- *More group-based support options for women in recovery.* The women would like more opportunities to be part of a group and to reduce their social isolation. For example, chances to participate in support groups and share their experiences with Aboriginal women in similar situations. They also enjoyed and wanted more chances to be part of groups that included recreational activities.

- *Improve support for families/carers.* For example, to establish and help run family support groups and offer more of these programs.

- *Provide childcare during treatment.* Women want to ensure their children are receiving proper care when they are using in-patient services and are unwilling to use in-patient services when childcare is not available.

- *More local treatment options and outreach services.* There was a call for more localised services, particularly local rehabilitation and acute mental health services and outreach.

- *Make it simpler to get appointments.* Women, health workers and families want services to address factors that make it hard to get appointments, like inflexible appointment times and helping with transport to and from appointments.

Recommendations:
Overall the findings of the study confirmed the need for a specific Aboriginal Women and Children's Healing Centre. Recommendations by the women, families and staff including non-Aboriginal service providers involved in the project include:

- An Aboriginal women and Children's Healing Centre be established within the South Coast and Far South Coast region.

- The centre should employ Aboriginal staff e.g.: Aboriginal health workers
- The centre should involve family members, including the children and their partners, in the rehabilitation of the women themselves.
- Educational programs are conducted for children and family during the rehabilitation process.
- Aboriginal and non-Aboriginal service providers working in partnership to address the social and emotional needs of the women during their time at the centre.

1 Introduction and methodology

This chapter provides a summary of the Koori Women's Healing Research Project, which is a project to improve services for Aboriginal women with mental health and drug and alcohol problems.

1.1 The Koori Women's Healing Research Project

The *Koori Women's Healing Research Project* was instigated and implemented by the South Coast Medical Service Aboriginal Corporation (SCMSAC).

The project aimed to find out how to improve existing services for Aboriginal women experiencing both drug and alcohol and mental health problems in the South Coast and Far South Coast, New South Wales. Specifically, the research will answer the following questions:

1. What is the experience of Aboriginal women with co-morbid drug and alcohol and mental health problems in the study communities?

2. What are the women's experiences of help seeking, both informal and service based? What has been successful and what has failed?

3. What has been the impact on the families and children of women with drug and alcohol and mental health problems? What additional family support is required?

4. What do local service providers think of the services delivered in the area? What is the current delivery issues from their perspective and how could these be overcome?

5. What can this research contribute to the evidence-base on effective interventions for Aboriginal women with concurrent drug and alcohol and mental health issues in rural and regional areas?

To answer these questions, interviews were conducted face-to-face with three different groups:

a) Aboriginal women living in the study area. The women had experienced drug and alcohol and mental health issues from 2 months – 18 years prior to interview (n=21)

b) Family members and carers of these women (n=12)

c) Employees of drug and alcohol and mental health services currently operating in the study area (n=11)

Some interviews were conducted with individual respondents and some in small groups. This varied according to the preference of the interviewees. The interviews were conducted, recorded and transcribed by the project officer based at SCMSAC, from June to November 2009.

Towards the conclusion of the project the University of Sydney was approached by SCMSAC to coordinate analysis and report writing. ARTD Consultants (ARTD) was commissioned by the University of Sydney to code and analyse all interview transcripts and to prepare a final report.

SCMSAC and its key stakeholders will use this data to identify current gaps in the provision of mental health and drug and alcohol services in the South Coast and Far South Coast. The research may also be published in academic journals to contribute to the evidence base on effective mental health and drug and alcohol services.

1.2 Data analysis

Qualitative analysis of the interview transcripts was conducted using NUDIST (software package).

Initially, three transcripts each were reviewed, representing interviews with service women, their families and carers. After reviewing a total of nine transcripts, the team met in a half-day workshop to discuss emerging themes. The result of this workshop was the development of a preliminary coding framework, based on these emerging themes and the key research questions.

This preliminary framework was tested on three more interview transcripts, to ascertain its useability and its ability to capture key interview themes. Two consultants to explore inter-rater reliability then coded three transcripts separately. After this exercise, the framework underwent minor revisions to improve flexibility, ease of analysis and thematic coverage. Consultants were then assigned all remaining transcripts for coding.

Data was analysed using reports generated by the NUDIST software, which allowed for cross-referencing of data as appropriate. This was the limitations what they did how they reached their conclusion

1.3 Limitations of the data

Challenges in interview transcription led to some difficulties in data interpretation. Also, interview data tended to focus on the experiences of Aboriginal women and their families in dealing with mental health and drug and alcohol problems, with less data on possible service improvements. However, there is sufficient data to conduct thematic analyses and contribute to the evidence base.

1.4 This report

This report summarises the key findings from the research. The report starts with an exploration of the experiences of the women, their families and carers in dealing with co-morbid drug and alcohol and mental health issues. It then looks at the informal supports available to the women to cope with their issues, as well as the barriers they face in accessing more formal (i.e. service-based) support. The report then focuses on the women's, families' and staff's experiences of mental health and drug and alcohol services in the South Coast and Far South Coast area, with the final chapter dedicated to suggestions on how these services could be improved. Each chapter closes with a summary of its key findings.

Throughout the report, vignettes are displayed in text boxes to support a particular point or theme. The vignettes are based on the experiences of interviewees; however, where names are used these have been changed to protect the interviewee's identity.

2 The women's stories

In this chapter we show the impact of suffering from mental health problems whilst also misusing drug and alcohol, has on women and their families.

2.1 The women and their health

Twenty-one Aboriginal women, aged between 20 and 61 years old, took part in this research.

Substance misuse and early indicators of mental health problems (i.e. melancholia, mild anxiety) were often present at an early age, and almost always by adolescence. In some instances, women were poly-drug users and/or diagnosed with more than one mental health disorder.

The extremity of substance addiction and mental health issues across the group appeared to vary considerably; for example ranging from melancholia to severe depression disorder. Similarly, drug use ranged from marijuana use, to poly-drug use, including "harder" drugs such as heroin. Women and their families said they were more likely to relapse if they used harder drugs.

A large proportion of service women reported negative experiences and adversity in early life, with experiences of sexual abuse, physical abuse and domestic violence.

2.2 Life experiences and other influences

The women commonly attributed their mental health problems and drug and alcohol use to traumatic life experiences, but they also acknowledged other factors that might have played a role. Whilst drugs were often used to self-medicate mental health disorders, substance misuse was also linked to the onset or exacerbation of mental health conditions (e.g. speed and psychosis).

Findings of the interviews indicate that traumatic life events, ranging from sexual abuse, physical abuse, domestic violence, relationship breakdown and death were extremely common in this group of Aboriginal women. The women said the stress caused by these life events played a significant role in the onset of depression and anxiety disorders. To escape from the pain of these life events, the women often turned to drugs or alcohol.

In most cases, the women also described a normalised alcohol or drug culture in childhood or adolescence, most frequently within their immediate family. Many women, and their families, felt that this had lead to an ongoing cycle of substance misuse across generations. They also talked about the widespread misuse of alcohol and its acceptance within Aboriginal communities.

Sometimes, study participants said they starting using drugs because of pressure from their friends or acquaintances. Staff and family speculated that women had been bullied into using by their friends or partners, and some women expressed a desire to 'fit in'. But, the women also said that seeing their friends or acquaintances take drugs helped them realise that drugs are used to alleviate emotional distress.

For other women, the issue was not so much the wrong crowd, but the wrong relationship. When women had a relationship with a man who used alcohol or other drugs, they often expressed a fear of losing their man if they did not use too. Women in this situation said that their partners did little to support them to stop using or to seek help.

> *'If the husband drinks the woman's gonna drink too'*.

A few women said they had a **desire to experiment** with drugs, they stated that seeing others use drugs made them want to find out 'what the thrill was'. These women described having large social networks, and saw themselves as the type of person who would try anything once.

> *'I wanted something more exciting, it was too mundane, too ordinary and I wanted to up the ante'.*

A few women also talked about a **sense of boredom** they could not overcome, instigated by lack of work and a lack of things to do in the community.

Many women reported **feeling shy, lacking confidence, low self-esteem** and feeling "uncomfortable in [their] own skin". One woman emphasised feelings of confusion in relation to her sexuality, which made her feel isolated and like an outsider. These feelings led to women were seeking comfort, escapism or confidence from substances.

Enjoyment of drug use was also a key contributor to the continuation and exacerbation of drug use. However, for some of these women, enjoyment was very rarely associated with the "high" experienced, but more often the escapism the substance afforded.

2.3 Relationship matters

The most common impact of co-morbidity for the women was the breakdown of close relationships with families and friends. The women often sought to hide the challenges they were facing from those who cared about them, making contact less and less frequently as their drug or mental health problems escalated. There were also instances whereby some study participants said they deliberately sabotaged their relationships, out of fear of being hurt or hurting others. In one such instance, a woman had such a low opinion of herself and her ability to care for others that she cut herself off from her daughter.

> *'I wanted her to think I was dead because I wasn't worth her'.*

Many of the women had low self-esteem and related feelings of self-hatred, *'I am like contaminated waste'.* Some women said they live with a fear of judgement and condemnation from others and often feel a sense of failure to themselves and their families.

The women were also less inclined to build new positive relationships, due to their low self-esteem and the stigma attached to having mental health issues and misusing alcohol or other drugs. This often led to feelings of isolation, seclusion and loneliness.

> *'God, please tell me there is something more to life than sitting at home talking to four walls'.*

Conversely, the presence of multiple health problems supported the continuation and development of destructive relationships, particularly with life partners. There were many instances where partners were substance users, and one case where the partner was also living with co-morbid mental health and drug and alcohol issues. Within these relationships, domestic violence was common.

2.4 Caring for themselves or their family

The women involved in the study found their ability to care for themselves and others was deeply affected by their co-morbidity issues. Hospitalisation was common, and general ill health was a side effect for many, including a poor or reduced diet and unhealthy weight. A number of women stated that they often stopped looking after themselves, with hygiene issues being a common theme (particularly with hard drug use and/or depression). Many of the women had had their children taken from them, which had had a significant impact on their escalating depression and withdrawal.

Financial instability was a constant issue for this group, due to the high cost of their drug habit, and the difficulty in gaining and sustaining employment. In some instances the women had turned to theft or prostitution, often led to incarceration.

In summary, the lives of these women were characterised by a loss of 'normal' everyday life, including the loss of social networks, the inability to obtain employment and a loss of financial security. The importance of re-establishing this normality was felt to be critical to rehabilitation success.

2.5 Coping strategies

The women reported a number of strategies they used to deal with their mental health and drug and alcohol issues, other than accessing professional help.

For the majority of participants, coping strategies most commonly related to both relaxation and keeping busy. Relaxation would often be in the form of walking, listening to music, watching a movie, painting, reading or writing poetry. Keeping busy could include looking after a new pet, participating in a child's school activities, kickboxing, employment and further study. Self-talk, particularly positive affirmations, was another, less commonly used coping strategy. Interestingly, these activities were more common in those who had sought some initial help for their issues, and those who were currently in remission.

The women also reported investing more time in taking care of themselves during remission, with efforts to eat a healthy diet and taking pride in their hygiene and personal appearance. However, this was very rarely present in those who were still using drugs or suffering severe mental health issues.

A common coping mechanism for mental health issues was self-medication. This was often using illegal substances (i.e. marijuana use for depression), or non-prescribed painkillers. In the instances where prescribed drugs were used (i.e. anti-depressants), women frequently stopped taking these when their symptoms decreased, only to relapse.

2.6 Chapter summary

The psychological needs of Aboriginal women with co-morbid drug and mental health problems are significant and diverse. These women commonly experienced sexual abuse, physical abuse, domestic violence and low self-esteem, all of which require specialised treatment.

There are often a variety of other issues in their lives, including medical, family and social issues.

Drugs and alcohol were often used to mediate mental health problems. The women often stopped taking prescribed medications such as anti-depressants, only to suffer relapse.

The women also reported more efforts to stay well when the symptoms of their mental health problems were less acute or when in remission from their drug use.

3 Family and carer stories

This chapter describes the experiences of families and carers in supporting someone with co-morbid drug and alcohol and mental health issues. It also explores the experiences of the Aboriginal women's children in growing up in the care of someone with co-morbid mental health and drug and alcohol issues.

3.1 Family and Carer responsibilities

Families and carers were often the key support for Aboriginal women with co-morbid drug and alcohol and mental health problems. When relationships with others had failed, the women's families remained a constant support, providing understanding, counsel and care. The support provided by families is described in detail in chapter four.

Findings from the study indicate that supporting these women was not always easy. Families and carers faced constant anxiety as to their welfare, and the shame of the women's actions, especially when they had had interactions with DoCS and the justice system. Families and carers sometimes lived in fear of the women's erratic and aggressive behaviour.

In some instances family members do not always agree about how best to deal with the problematic behaviour of the women. Families and carers commonly reported emotional burnout, where they felt unable to continue providing support.

Due to the inability of co-morbid women to care for their dependents, the responsibility often fell to their families/carers. Child rearing by grandparents and other relations was extremely common, often involving multiple children and sustained over significant durations (as long as 12 years). Not surprisingly, this placed significant strain on these families, both financially and emotionally. In a few cases, this had lead to resentment over the loss of their older years, a time when the parent hoped to travel, spend time with their friends and enjoy their retirement.

Although at times families struggled with this child rearing, a deep love and attachment to these children was evident. A few families reported feeling fearful of losing the child if the mother was to get well: '*If [grandson] goes it's gonna kill everybody'*. This could have potential implications on the families' desire for their family member to get well, with one woman reporting that she believed this was the case in her family.

As described in Chapter two, familial substance misuse was extremely common. When family members had been a substance user themselves, supporting the women appeared to be accompanied by feelings of guilt and shame.

3.2 Children

The impact of being born to a woman experiencing co-morbidity issues is significant. In many instances, family members or a foster family are left to care for these children, making interaction with their mothers unstable and inconsistent. Where the child has remained in the care of their mother, the family and workers reported sub-standard levels of care, with children often going hungry, missing out on school and lacking affection. Education difficulties were also common, due to disruptive home environments, with children too tired or stressed to study. The emotional stress caused by this unstable childhood was substantial, with one child experiencing depression and another in therapy.

As previously described, domestic violence was common in many women's homes and the children often witnessed this.

> *'[The children] get scared, they know every time there's a beer that mum and dad are going to fight'*

In other cases, it would seem that children had grown immune to their parent's behaviour, and, like many of the women themselves, had become engaged in a normalised drug culture. Here, a woman speaks of how they became accustomed to their families' alcohol use.

> *'I liked sitting up late with my family and that, not really knowing they are all smashed .... you don't really know any different, you don't know that that's not what other families do*'

Families also said that these early life experiences have caused children to vacate the family home as soon as possible.

3.3 Chapter summary

Families and carers reported significant stress related to caring for a family member with co-morbid drug and alcohol and mental health issues, with families often caring for the children, causing financial and emotional strain. Nevertheless, the family is often the most important source of help for the woman.

Families and carers reported that children of women suffering mental health problems and substance misuse commonly experience disruptive and sub-standard care, which the women and their families believe has affected their emotional, physical and mental wellbeing.

4 The use of informal supports

This chapter shows that informal support from family members is important to women but that many family members struggle to maintain this support over a long time period.

4.1 Family/friends are important sources of support

The women talked about the importance of family contact whilst experiencing mental health problems and when using alcohol or other drugs.

Most women relied on a particular family member—often their mother—for refuge and support. A few women were estranged from their families or had troubled relationships with them.

Families provided support in a multitude of ways, but most commonly provided unconditional love and someone to talk to in a non-judgemental, non-confrontational atmosphere.

> *'He helps me just by loving me'*
>
> *'She's just there for me to talk to when I need her'*.

Because of their closeness to the women, families were able to notice the 'warning signs' for a substance or mental health episode. These warning signs may be the user acting a certain way, socialising with certain friends or frequenting risky places. Families also provided practical advice to women in regards to their use of alcohol or other drugs, for example recommending a 'shandy' as opposed to a beer, or advising a counselling session when the woman is feeling low.

In some instances, families sometimes took a "tough love" approach, by disowning the user as a way of getting her to change her behaviour. Where this was mentioned, no one said whether this approach had worked for his or her family member.

Very occasionally, friendships were made with others in recovery, and these helped the person to create social environments free from substance use. This was rare, and in most cases friendship networks had broken down, or had only been maintained with other women using alcohol or other drugs.

4.1.1 Providing long-term support

The continued support from families and carers was felt to be crucially important to the women's wellbeing. However, families, workers and the women themselves noted a number of factors that affected family members' capacity to provide effective and ongoing support.

Families felt significant emotional and financial strain as a result of caring for these women. Emotional burnout was particularly common, and often leads to feelings of estrangement from their family and losing this support network. Burnout was exacerbated by the need to support large families, including dependents of the woman (see chapter 3).

Furthermore, family members felt that their capacity to help was dependent on the women's readiness to change and accept their mental health or substance misuse problem. Carers said that women often attempted to hide their problems from their family, or blame the symptoms of their drug use on their mental health condition. Other times, it was felt that women were just not ready to listen to their family's advice, but may be more willing to take advice from a friend. In cases where there were issues of co-morbidity, families felt they did not have adequate knowledge to support the women, or awareness of the services available to support them. This was particularly the case for women with extreme mental health or drug and alcohol disorders, i.e. where suicide had been attempted or overdose had occurred.

It is worth remembering that some family and friends said they had issues of their own that they were struggling with, including substance misuse, domestic violence and, in one case, parole. In these instances, it was very difficult for family or friends to provide consistent or effective

support. Where relationships were maintained with families who were abusing drugs or alcohol, this had had a negative impact on rehabilitation success.

> *'I got Christmas leave from rehab and it was all my family around me and encouraging me to drink and stuff....watching them all drink made me do it, made me worse'*

4.2 Spiritual and/or cultural supports

Interviewees were asked about any spiritual or cultural supports they may have used. Participants, with some emphasising spiritual, religious or cultural supports, interpreted this question in different ways. A small number of the women reported actively pursuing this kind of spiritual, religious or cultural support.

Some women stated that a connection with those who had passed on was a common theme, as was a connection with nature and the land. Some in the form of bible reading or prayer experienced a religious connection. A handful of people mentioned the connection to their Aboriginal ancestry as providing spiritual support. Others participated in community activities such as basket weaving, Koori dancing and painting and found these helpful.

Although Elders were rarely contacted for support, the women involved in the study felt that more could be done on a community level to support people with co-morbidity, which may be facilitated by Elders in community centres. The women and service staff believed cultural activities should be integrated into mental health and drug and alcohol services.

4.3 Chapter summary

Family and carer support is very important to this user group and can promote help seeking.

A number of factors affected family and carers' capacity to provide support. These included a lack of knowledge on support services, their own addiction to substances, and severe emotional stress.

Only a few women actively pursued cultural, religious and spiritual supports, however women and staff felt that cultural activities could be better integrated into mental health and drug and alcohol services.

5 Seeking help

This chapter shows that the women generally seek help when in crisis as a result of one or other of their health problems, and that personal fears and feelings of shame often stop them from using services. Getting to services is also a major barrier to using services, as is a lack of knowledge about what is available.

When women seek help for their drug and alcohol use, having a mental health disorder can sometimes bar them from these services.

5.1 Seeking help

The women could often pinpoint a particular crisis or event that had lead them to seek help. These events came in various guises, including hospitalisations, overdoses, experiences of violence, losing the support of family members or losing custody of their children. Sometimes however, even severe crises had not been enough to make the women accept their problem and seek help (see vignette 1 below). As evidenced below for this woman, her drug addiction and/or mental health issues was so acute that she 'didn't have the headspace' to even think about getting help:

> *'I wasn't in the position physically or mentally to even know that there were services or workshops or counsellors available, 'cuz all I was doing was living to get the alcohol, get the pills, get the food, get home. And that's how small the world had shrunk'.*

In a number of instances, women reported being mandated by DoCS or the justice system to seek professional support. Workers generally felt that treatment outcomes were poorer for Aboriginal women with these problems, as they were reluctant clients who required a high level of dedication from service providers.

There were also examples of women accessing support for one dimension of their co-morbidity, but not the other. This was generally because their mental health disorder was unknown to them, or because they had not accepted that their drug use was contributing to their problems.

Vignette 1: Accepting the problem

Shelley*, service user

Shelley suffered from post-traumatic stress and anxiety, and was formerly addicted to heroin.

Shelley spoke of how even significant life stressors caused by her drug use were not enough for her to seek help. On one occasion, Shelley was hospitalised with a serious injury and despite warnings from doctors, she began using again within three weeks. On re-admission to hospital she was in a critical condition.

Despite this, Shelley reported never thinking that she should stop her heroin use: '*I honestly believed I would die an addict, that I would die at the end of the needle and that was never enough to scare me'.*

* Name has been changed.

5.2 Barriers to using services

5.2.1 Personal fears stop women from accessing services

A number of personal fears and concerns stopped the women from accessing timely support in relation to their mental health and drug and alcohol problems. The women stated they often tried to overcome their issues alone prior to accessing support, although this was rarely effective.

Stigmatisation was an enduring problem for women with mental health and substance misuse problems alike. In many instances, the women said they had been rejected by their community because of their behaviour, and expressed a dislike of their own drug use. As a result, a fear of judgement by service staff was exceedingly common. For some participants concerns were raised that some service providers wanted to help them for the wrong reasons – to mock their situation or to pry into their lives.

A number of women expressed concerns about confidentiality for various reasons. Due to the small size of some of the communities, the women often knew staff and other service users. The women feared being seen and that the nature of their issues could become known within the wider community.

The fear of intervention from other services, particularly DoCS, was also a significant barrier to service use, with mandatory reporting often being blamed. Many women had friends whose children had been taken into care, and felt that accessing these services might make them known to DoCS. Indeed, some women in the study had been reported to DoCS and did lose custody of their children.

Women were often fearful that their children might be taken from them whilst they underwent treatment, and would not access treatment if they had no one to care for their children. If contact with their children was maintained during treatment, this put significant strain on the child's carers, who had to travel with the children to visit their mother.

Attachment to other drug users was also a barrier to women accessing support. This was particularly the case where the woman's partner was a drug user, as their partners often prohibited them from seeking help. Given the high levels of domestic violence in these relationships, it is not surprising that women were frightened of accessing help. Previous negative service experiences were another common barrier to accessing services: '*if you don't feel comfortable you don't go back'* (see chapter 7).

5.2.2 Women not well informed about available services

There was a significant lack of awareness amongst the women and their families/carers concerning available services and routes of access. The women were not proactive in acquiring this information, with knowledge of services often acquired through word-of-mouth. It was felt that the services' commitment providing this information was low: 'they leave a flyer and then you never see them again'. Knowledge of childcare services was also low, with two women not aware of playgroups and day care centres in their area.

5.2.3 Transport: a common barrier to using services

Participants of the study stated that the lack of adequate transport was a common barrier to service use. Specialist services were often not available in the smaller towns, and accessing these services using public transport was expensive. Using public transport was also time consuming and unreliable, making women worry that they might miss their appointment.

Although transport was sometimes provided by services in the area, bookings need to be made in advance, which the women found frustrating as their decision to access services was generally based on a ''snap'' decision or an immediate crisis

5.3 Enablers to service access

Although the women faced many barriers to accessing support, they also noted the circumstances that made them more likely to ask for help. These included cutting ties with other users, and being able to talk to their children and families whilst in rehabilitation. Providing transport to services was also a key enabler, as knowing that a driver was there waiting for them encouraged them to keep appointments.

5.3.1 Positive experiences with health workers

Early positive experiences of services were important in the continuation of treatment. Positive relationships with doctors were particularly important, as contact with these was often established prior to treatment, and was a common entry point to other services. Even if the women were not ready to pursue help at first, building a non-threatening, supportive relationship with service providers gave them a clear point of contact for when they were ready. Support from family and friends were also important for the women in successfully accessing services.

5.4 Chapter summary

Women often access services only when in crisis – when 'they really need them'. It is important that drug and alcohol and mental health services, as well as general practitioners, consider the possibility of a dual diagnosis in initial assessments as findings indicate that some women sought support for one dimension of their co-morbidity, but not the other.

Barriers within the service system reduce Aboriginal women's access to mental health and drug and alcohol services. These include inflexibility, distance to key services, and a perceived lack of information on where to seek help.

There was evidence that health professionals treated drug and alcohol and mental health issues as separate issues. In some instances professionals refused treatment where a dual diagnosis was present.

Early positive interactions with health services, particularly doctors, were very important for the continuation of treatment.

6 Use of professional services

This chapter shows that women have used a variety of health services, both mainstream and Aboriginal. Women value services where staff are welcoming and professional, and therapies, which involve social and group activities.

6.1 Women used a range of health services

The women interviewed sought help from a vast range of services, including primary, acute, and specialist mental health and drug/ alcohol services. The specialist health services accessed by the women varied considerably, based on their individual needs and circumstances. Initial access to the health system was commonly via a general practitioner or Aboriginal Medical Service for health concerns unrelated to their co-morbidity. In some instances, practitioners were able to identify a substance issue or mental health problem and refer the patient to more specialist services. Unfortunately, this was not true in all cases, with one woman reporting that her doctor had never assessed her alcohol use.

Some women had accessed rehabilitation services to overcome their substance use issue. Support from mental health services was less common, and where they were sought, the problem was so severe that women were referred to acute services. Outpatient counselling was also commonly used to deal with trauma, and to develop alternative ways of coping with co-morbidity issues.

A few women received outreach support for their mental health problems, which was very well received. These women felt much more comfortable and relaxed in their own home, as they were able to make a cup of tea or take a break in the garden if they were feeling overwhelmed. Home treatment also removed the anxiety associated with attending appointments.

6.1.1 Women prefer using Aboriginal services

Aboriginal Medical Services (AMS) were also noted as a key source of support, including drug and alcohol counselling. The majority of the participants viewed the AMS' positively. Staff were observed to be non-judgemental and have a relaxed approach. It was felt that at times the AMS was also able to direct the women to other services.

Findings indicate that the women sought support from both mainstream and Aboriginal services and had experienced effective outcomes from both. However the women generally reported feeling more 'at home' in Aboriginal services as the environment was less 'sterile', more relaxed and less judgemental. For some women, however, interactions with members of their community made them more fearful that the information they shared would be passed on to people they know.

6.2 Approaches to service provision

6.2.1 Intergrated care more common but not for all

Health workers reported a shift towards more integrated care packages, with staff more likely to coordinate services across drug and alcohol and mental health teams, as well as services like DoCS and housing services. Where this was occurring, staff believed it provided fluidity in care and better outcomes for service.

In certain cases, women seeking rehabilitation for alcohol or other drugs use found that access was restricted by strict eligibility criteria. Rehabilitation centres would not always take on patients with mental health conditions, and counsellors and psychologists would not always accept clients who were currently drinking or using drugs. Women and health workers noted a number of other service restrictions.

- Rehabilitation centres often selected the type of drug and alcohol issue they would take on, with some centres not taking those who inject, or only taking alcoholics.

- There is a service that only supports women with children under three years of age.
- There is a rehabilitation program that, although targeted at Aboriginal women, restricted access for women with mental health problems because the treatment is not suitable (see Vignette 2).

As well as strict entry criteria, service provision itself was often seen as inflexible, with rigid appointment times and a need to book transport.

Vignette 2: Rehabilitation program that restrict access for those with mental health problems

One health worker spoke about a rehabilitation program that is targeted at Aboriginal women.

The rehabilitation program runs in two parts. The first is based around living skills and detox support. The second part involves more demanding group and role-play work. Although this intensive support was seen as a current gap in Aboriginal treatment by this worker, the person was not aware of any woman who had been deemed eligible for this second component of the treatment, as the women had to be 'psychologically fit' to do this intensive work.

6.2.2 Complementary therapies important

Many women spoke of the importance of staying busy when suffering from drug and mental health problems, and just having somewhere to go to take their mind of their problems was extremely helpful (see vignette 3). Women often reported being involved in complementary support packages, which focused on the development of life skills and involvement in new and free activities, such as pamper days, playing music, walking, painting and gardening.

The impacts of these activities were two-fold. Firstly, the learning of new things empowered the women and improved their self-esteem. Secondly, many women felt that such activities kept their minds active, which stopped them thinking about the life problems they were experiencing, and their addictions. Support days, where the women could network with other people experiencing similar problems were very well received. This often lead to improved social networks, which addressed the feelings of loneliness and isolation that women had as a result of their co-morbidity.

Vignette 3: The importance of keeping busy and establishing a 'normal' life

Keeping busy and having a daily structure was extremely important to these women. They reported a lack of everyday life skills, things that they would have otherwise learned if their mental health and drug and alcohol issues had not got in the way. They also lost any structure present in 'normal' everyday life, such as going to work, tending to loved ones and preparing the family meal. They had also lost social networks and their usual networking environments, i.e. pubs and clubs.

'We don't have our own life, we just walk down to the shops and back and sit on the veranda for half a day looking at the birds. We don't have a life, we don't have friends, we don't have other friends other than drinking friends who were in the wrong crowd, we would just be with drinking, drugs. But we don't have that social thing where we go to someone's house without drinking....we aren't like normal couples where you can go and have a barbecue and a few beers, you know, we couldn't sit there at a table and have a glass of wine or anything'.

6.2.3 Counselling has a place

As noted above, some women had accessed professional counselling to help them deal with their co-morbidity. In many cases, the counsellor provided a space for the women to tell their

story, and validated the horror of what they had been through. Women responded well to this approach, and noted that this process was essential to developing a rapport with their counsellor. Some reported that they experienced a more interactive and activity-based approach to counselling. This was less well received by the women who felt that activities such as writing journals or punching pillows were unhelpful, and often felt like homework.

6.3 Chapter summary

General Practitioners, AMS, the police and DoCS were often the first point of contact for people suffering dual disorders.

Rehabilitation services were often used by these women, as were acute mental health services, psychologists and counsellors.

Approaches to service provision were important, with positive experiences attributed to integrated care, a relaxed and welcoming environment, and services, which kept the women busy and established structure in their lives.

In general, Aboriginal services were preferred to mainstream however, both service types were linked to positive outcomes.

7 Experiences of health services

This chapter illustrates the importance of staff attitudes towards women using health services. Women's experiences of services are also influenced by waiting times and concerns around confidentiality. Health workers find the work rewarding but also challenging and need opportunities to debrief.

7.1.1 Attitudes of workers influences whether women continue to use services

It was clear that the quality of help provided by specific individuals within either mental health or drug and alcohol services was critical to the women's overall treatment experience, as well as their decision to continue treatment. Having the opportunity to talk to staff, be heard and to build meaningful relationships was extremely important to the women. The women often said that good service providers provided them with the time to discuss their challenges in a non-threatening and non-judgemental environment. They also had a strong commitment to the women, with ongoing and regular follow-up. The care provided was holistic, with providers advising and supporting them with a range of issues, including housing and financial needs[1].

Positive relationships with doctors were particularly important, and women were able to establish relationships with doctors who were friendly and approachable in manner, and were able to make the women feel relaxed and comfortable. A good doctor knew the client well enough to recognise changes in their behaviour, and acted on this appropriately (i.e. by referring them to a psychiatrist).

When ex-substance users or mental health sufferers formed part of the service this was generally viewed positively. The women felt that these people would be more able to relate to the problems they were experiencing and sometimes felt they were more responsive because of this. However, it was important that these workers did not let their own emotions and issues get in the way of treatment.

Unfortunately, negative experiences with service providers were also common, with a number of women feeling under-supported and disrespected by health workers. Staff were labelled as 'rude', 'condescending' and 'judgemental', and the women often felt overlooked by services that did not have enough time for them: 'you just feel like a number'.

The women were particularly critical of mental health staff in inpatient facilities, where the women spoke of a general lack of long-term or follow-on care following a crisis, and a lack of time dedicated to building a rapport with the women. One of the women reported *'they stitched me up at the hospital and sent me home but never really asked why I did it and it was never picked up on'*. Where women were given medication, it was felt that inadequate time was spent with them to explain the possible side effects. Women also highlighted a lack of specialist Aboriginal mental health services or Aboriginal workers in community health.

A number of women commented on the lack of consistency and continuity in service provider staff, which was particularly damaging when they had developed a good relationship with the provider concerned. One woman commented, 'Every time I go in and get to know people they always leave and I think I don't want to waste my time going over the same stuff with different people'. This was commonly linked to high staff turnover, which staff agreed affected the quality of care they could provide. More effective handover was suggested as a possible mitigation strategy.

7.1.2 Long waiting times cause anxiety for the women

Long waiting times were a particular concern. Waiting for services often alone and in a new and frightening environment, had a very negative effect on service use, and even lead to some women not accessing treatment (see vignette 4).

[1] In one case, a woman reported that her support worker had looked into further education courses for her, and helped her organise funeral arrangements for a relative.

Unfortunately, long waiting times were a common problem, especially in acute mental health settings. Clients reported waiting up to six hours for an appointment, and appointments were often 'booked out', leading to a severe lack of same day appointments. There was also reference to lack of staff cover during leave, and a six-week waiting list for rehabilitation services.

The impact of waiting times was particularly acute when the women were experiencing a 'crisis' and were in need of immediate help and support. With the lack of same day appointments, women often just wanted a quick telephone call with their counsellor or support worker. Support workers often didn't get back to the client for a few days, by which time the woman's crisis had passed or escalated. This lack of follow-up often lead the women to feel under supported: 'I'm not going to go back and see someone who doesn't even care enough about me to call me back'.

A lack of services outside normal business hours was also a problem, as relapse and life crises often occurred in the evening or on weekends. It also meant that staff often had to leave patients at a critical point in their treatment (see vignette 4).

Vignette 4: Waiting

Service user, Amanda*, was suffering from severe anxiety and stress. A drug and alcohol counsellor at her local AMS suggested she visit the Mental Health team at the local hospital.

Amanda was initially very reluctant to visit the team, and did not want to go to the hospital alone. The counsellor promised to accompany Amanda and to wait with her until she was seen.

Amanda and the counsellor waited together all day. At the end of the day, while Amanda continued to wait, her counsellor had to leave. This left Amanda in considerable distress. After waiting alone for many hours, and still having not been seen by the Mental Health team, Amanda walked home. Hospital staff would not call for a taxi until she had been seen by the team.

This was not the first time Amanda had to wait for care. Following a support group, which had left Amanda feeling upset, she called her AMS to arrange an appointment. However, staff were off sick and there was a general lack of appointments available. Amanda reported trying to make six appointments in this time.

* Name has been changed.

7.1.3 Lack of confidentiality was a concern

Services with clearly defined and strict confidentiality rules were highly valued. But confidentiality continued to be an issue for many of the women, with some concerned that confidentiality was not adequately enforced. Staff acknowledged that in some instances confidentiality breaches were a reality, with staff discussing client cases at home, and amongst each other in an uncontrolled setting. It was noted by the services providers that steps were being taken to overcome this problem.

7.2 Families/Carers' experiences of co-morbidity services

Families and carers spoke of a desire for increased information and support services in the South Coast and Far South Coast area. They also felt that the existing support services in the area should be better advertised, with many reporting uncertainty of where to go for additional support.

In most cases, families and carers simply wanted someone to talk to about the difficulties they were facing in caring for the co-morbid person, and the impact this was having on their own life.

> *'Even a couple of days ago, I was pretty stressed myself, and I could have done with someone to talk to, just for an hour or whatever, just to calm me down a bit'*

Where families had attended support or information sessions about mental health issues or drug and alcohol use, they had gained significant benefits from the insights of other families dealing with these issues. They also reported feeling at ease in sharing their problems, knowing that others in the room had also faced the shame and fear that they were experiencing.

7.3 Staff experience of delivering services

The consensus of staff was that working with the client group was extremely rewarding, and this is what kept their motivation strong. However, working with this group could be demanding and frustrating, given the group's challenging behaviours, their reluctance to change and low success rates. Vicarious trauma, where staff themselves became traumatised by the life events of these women, was cited. Emotional burnout was also common, leading to a lack of motivation, stress and melancholy.

Regular contact with someone within the service with which to share their experiences was seen as vital to reduce the distress associated with working with this group. But one interviewee felt that effective mechanisms for supervision were not always in place.

During the interviews, the health workers were asked about feedback mechanisms used within their service. They reported that there was a general lack of structured feedback mechanisms within their services, with most feedback gained opportunistically through conversations with service users. Formal feedback forms were rarely used, with services relying on suggestion boxes, which were more commonly used by staff than by service users.

7.4 Chapter summary

The attitude and approach of service staff was critical to how services were perceived. Staff encountered significant challenges in treating this user group and it appears that there is a need for better professional supervision for staff.

Long waiting times were common for this client group, as was a lack of follow-up and same day appointments. There was evidence that client confidentiality was not adequately enforced in some services.

Health workers and families feel that more could be done to address the wider needs of service women, including homelessness, unemployment and social inclusion.

There were limited support services available for families and carers and some family members are seeking more opportunities to attend such groups. Others want increased promotion of the relevant services as they felt uncertain about what services were available.

8 Summary of service limitations and suggested improvements

This chapter reviews the current inadequacies in the treatment of co-morbid mental health and drug and alcohol problems and summarises suggestions for improvements by women attending these services, their families /carers and service staff.

8.1 Better promotion of services

As discussed in chapter five, women and their families/carers struggled to find information on where to go for help, and many felt this was because services were under-advertised. It was felt that more systematic and proactive approaches to information sharing were required, with service providers adopting a hands-on approach to delivering information, through Aboriginal groups, local town centres, schools and universities. Services should explain what they do, why they work in a particular way and what services women should expect from their involvement.

8.2 Improved education on co-morbidity

As well as information on services, the research indicates a need for general education for communities on the nature of co-morbidity to reduce the stigma associated with it.

Children and adolescents were seen as an important target group for mental health and drug and alcohol education, given the onset of drug experimentation in adolescents and the cycle of mental health issues and drug misuse within families. Information sharing at schools, universities and youth groups was seen as a current missed opportunity, which could be very effective for early intervention and prevention.

Families and carers of service women often wanted more information on what they could do to support co-morbidity, and a better understanding of the symptoms associated with particular mental health and drug and alcohol problems. It was felt that this information would be best presented as a workshop with other families.

8.3 Better professional supervision for workers dealing with challenging behaviour

Staff attitudes were critical to how services were perceived, and one negative experience could lead to women stopping using a service.

The findings point to a need for more opportunities for staff to debrief using professional supervisors. In addition, drug and alcohol and mental health workers should receive more training in the care of Aboriginal women experiencing drug and alcohol and mental health problems. Those most in need are health workers providing initial access to care (GPs and acute mental health workers). The training should emphasise the importance of being non-judgemental and approachable.

8.4 More support for families and carers

The women, their families/carers and service providers indicated that support for families and carers was lacking in many respects.

Ways for families to be better supported were to:

- Fund a 24 hour hotline, run by other families affected by co-morbidity
- Establish local support groups for affected families in their area. Families said the support groups should be kept relaxed and fun, embracing opportunities for open interaction and relationships building, such as picnics or barbeques.

One provider noted the dearth of services for children of clients with co-morbid substance use and mental health problems. Given the impact of parental substance misuse and the increased susceptibility to mental health and drug and alcohol misuse amongst the children, this is a gap in services. Other service providers suggested that mental health and drug and alcohol services could do more to address the needs of children of those experiencing co-morbidity issues.

8.5 Provide childcare during treatment

Women want to ensure their children are receiving proper care when they are using in-patient services and are less willing to use services when it is not available. Some women suggested that more rehabilitation services could provide residential facilities.

Increased provision for child support was seen as critical to improving services in Aboriginal communities.

8.6 Support groups for Aboriginal women

Women suggested that support groups would be helpful, to bring other women in recovery together to discuss their illness and their coping mechanisms.

They said these should be relaxed, and encourage open communication between participants. The women also said there were few support groups for Aboriginal women with mental health problems and where the general groups did exist, these were seen as ‘a white person’s business’.

When in recovery, the women were keen to keep busy, and start living a normal life, but sometimes lacked the necessary life skills to do this. As such, there was a call for more holistic treatments methods, which focused on everyday life skills, and social, cultural and creative activities. These might include Aboriginal dancing or painting, cooking, sewing or organising barbeques.

8.7 Establish local rehabilitation, mental health services and outreach services

Separation from land, children and community was a common barrier to help, and the women, their families and health workers all wanted more local services, especially rehabilitation centres to reduce the number of women prematurely terminating treatment. The women who had used existing outreach services said they offer limited support, with one woman reporting home visits of just fifteen minutes per week.

There was also a call for improving the capacity of current rehabilitation services, as waiting lists were long, and service restrictions were high.

Specific services recommended by women or family members or health workers are:

- A local drug and alcohol rehabilitation service, with provision for childcare and/or residential facilities, with a female only unit preferred by some
- Withdrawal management services
- Local mental health services, particularly inpatient care
- Outreach services such as home visits, visiting clinics and telemedicine. A few women suggested that health services might consider setting up an outreach clinic in a local Koori group or community centre to simplify service access and make attending less intimidating for the women.

8.8 Make it simpler to get appointments

Easier access to treatment was desired by the women interviewed and also by their families and service staff. In rural locations, geography, poor transport links, inflexible appointment times and strict eligibility criteria all acted as barriers to timely access. Efforts must be made to reduce service inflexibility and ensure a ‘no wrong door’ policy is maintained.

8.9 Improve service coordination

Health workers generally felt that more could be done to address the wider needs of women with co-morbid health problems including homelessness, unemployment and social inclusion.

They also felt that links between drug and alcohol services and services in prisons could be improved to support those within the criminal justice system, and to continue support following release.

The findings indicate that mental health and drug and alcohol services should continue to work collaboratively in the delivery of these services and make more efforts to work with welfare services such as housing, education, prisons and community services.

9 Appendix 1: Final coding framework

1. LIFE EXPERIENCES	**1.1 LIFE HISTORY**	1.1.1 PERSONAL HISTORY (inc. experiences with MH & drug and alcohol)	
		1.1.2 FAMILY HISTORY (Inc. family history of MH & drug and alcohol)	
	1.2 DESCRIPTION OF PROBLEM	1.2.1 DEPRESSION	
		1.2.2 ANXIETY	
		1.2.3 OTHER MENTAL HEALTH	
		1.2.4 DRUG (inc. smoking)	
		1.2.5 ALCOHOL	
	1.3 FACTORS WHICH LEAD TO PROBLEM	1.3.1 TRAUMATIC LIFE EVENTS	1.3.1.1 VIOLENCE (DOMESTIC, FAMILY/ OTHER)
			1.3.1.2 SEXUAL ABUSE
			1.3.1.3 RELATIONSHIP PROBLEMS (FAMILY/ PARTNER/ FRIENDS)
			1.3.1.4 OTHER
		1.3.2 LOW SELF ESTEEM/ LOW CONFIDENCE/ NOT FITTING IN	
		1.3.3 DEPRESSION/ SADNESS/ MELANCHOLY/ BOREDOM/ ESCAPISM	
		1.3.4 PEER PRESSURES/ WRONG CROWD/ NEGATIVE RELATIONSHIPS	
		1.3.5 FAMILY DRINKING	
		1.3.6 ENJOYMENT OF DRUG-TAKING/ RELAXATION	
		1.3.7 EFFECTS OF OTHER DIAGNOSIS (i.e. MH or drug and alcohol)	
		1.3.8 OTHER	
	1.4 WAYS OF COPING	1.4.1 FAMILY/ FRIENDS SUPPORTS	1.4.1.1. ABILITY TO PROVIDE SUPPORT
		1.4.2 SELF-MEDICATING	
		1.4.4 OTHER	

		1.5.3 FOR THEIR CHILDREN	1.5.3.1 LOSING PRIMARY CARE-GIVER/ OR SUB-STANDARD CARE FROM MOTHER
			1.5.3.2 UNCERTAINTY/ INCONSISTENCY
			1.5.3.3 SHAME
			1.5.3.4 HEALTH ISSUES (i.e. addicted to drug at birth)
			1.5.3.5 OTHER
		1.5.4 FOR THE COMMUNITY	1.5.4.1 FEAR OF CRIME
			1.5.4.2 SHAME
			1.5.4.3 COMMUNITY BREAKDOWN
			1.5.4.4 OTHER
		1.5.5 FOR STAFF	
2. USE OF SERVICES	**2.1 REASONS FOR SEEKING/ NOT SEEKING SERVICES** *When do women seek services? Why do they* not *seek services?*	2.1.1 MANDATED	
		2.1.2 RECOGNITION OF PROBLEM (recognising or not recognising they had a problem, or recognising they needed help)	
		2.1.3 FAMILY/ FRIEND PRESSURE	
		2.1.4 LIFE PRESSUES/ PROBLEMS CAUSED BY CO-MORBIDITY (i.e. losing child, dental problems caused by alcohol/ heroin abuse etc)	
	2.2 SERVICES/ TREATMENT ACCESSED	2.2.1 AA/ NA/ D&A worker	
		2.2.2 GP/ DENTAL/ ABORIGINAL MEDICAL CENTRE	
		2.2.3 MENTAL HEALTH SERVICES	
		2.2.4 REHAB/ DETOX	
		2.2.5 PRESCRIBED DRUGS	
		2.2.6 REFUGE/ HOUSING	
		2.2.7 COUNSELLING/ PSYCHOLOGIST	
		2.2.8 EDUCATIONAL/ INFO SERVICES	
			1.5.2.6 OTHER

			2.6.1.4 SEPARATION FROM FAMILY/ CHILDREN/ FRIENDS/ COMMUNITY
			2.6.1.5 LACK OF KNOWLEDGE ON AVAILABLE SERVICES
			2.6.1.6 FEAR OF LACK OF CONFIDENTIALITY
			2.6.1.7 OTHER
		2.6.2 WITHIN THE SERVICE (infrastructure barriers)	2.6.2.1 ACCESSIBILTY OF SERVICES/ TRANSPORT
			2.6.2.2 AVAILABILITY OF SERVICES
			2.6.2.3 STAFF TURNOVER
			2.6.2.4 WAITING TIMES/ LACK OF STAFF
			2.6.2.5 LACK OF SERVICE FLEXIBILITY
			2.6.2.6 NOT ENOUGH TIME FOR CLIENTS
			2.6.2.7 DIFFICULTIES IN TREATING CO-MORBIDITY
			2.6.2.8 OTHER
	2.7 ENABLERS TO SERVICE USE	2.7.1 MOTIVATION/ CONFIDENCE/ READINESS TO CHANGE	
		2.7.2 PREVIOUS POSITIVE EXPERIENCES OF STAFF/ SERVICES	
		2.7.3 OTHER	
	2.8 IMPROVING SERVICES	2.8.1 MORE FAMILY SUPPORT	
		2.8.2 SUPPORT GROUPS	
		2.8.3 REHAB/ DETOX	
		2.8.4 OUTREACH	
		2.8.5 MORE LOCAL SERVICES	
		2.8.6 ENABLING WOMEN'S ACCESS TO CHILDREN/ FAMILIES DURING TREATMENT	

		2.8.7 SERVICES JUST FOR WOMEN	
		2.8.8 MENTAL HEALTH SERVICES	
		2.8.9 EDUCATION/ INFORMATION/ TRAINING (inc. Info about available services)	
		2.8.10 OUT OF PRISON SUPPORT	
		2.8.11 HOUSING/ RESIDENTIAL FACILITY	
		2 8 12 OTHER	
3. QUOTATIONS	Please record any quotations that you feel are particularly salient/or support a key theme		