

# Use and abuse

Understanding the  
intersections of childhood  
abuse, alcohol and drug  
use and mental health

Jan Breckenridge, Michael Salter and Elisabeth Shaw



**UNSW**  
THE UNIVERSITY OF NEW SOUTH WALES

Centre For Gender Related Violence Studies

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Report released January 2010

ISBN:

Recommended Citation: Breckenridge, J., Salter, M., and Shaw, E. (2010) 'Use and abuse': Understanding the intersections of child abuse, drug use and mental health, Adults Surviving Child Abuse and the Centre for Gender Related Violence Studies, University of New South Wales, Sydney.

## Acknowledgements

The research team would like to thank the Mental Health Coordinating Council for funding this project and in so doing acknowledging the importance of better understanding the intersections of child abuse, trauma and alcohol and drug use.

This research project could not have taken place without the willing participation of the women and men who agreed to share their life stories with us. It is testimony to their courage that they volunteered to participate in this project. Sharing their experiences and insights about childhood abuse and drug and alcohol abuse often involved retelling painful and sometimes traumatic aspects of their lives. Participants did this in the hope that their involvement would contribute to a better understanding of these issues. Their generosity in donating their time and energies to the research process is evidence of the capacity of individuals who have been abused to reclaim strength and agency in their lives.

We are also indebted to the workers who participated in this project. Some workers assisted the project by negotiating the participation of clients and others provided their own expert knowledge about their client group's particular needs and the ways existing services meet or fail to meet these needs. The workers interviewed demonstrated their commitment to striving for best practice and improving service provision.

We would also like to thank Adult Survivors of Child Abuse (ASCA) and the Centre for Gender-Related Violence Studies (CGRVS) at the University of New South Wales for their encouragement and support throughout the project. The partnership between these two organisations has proved to be productive and mutually beneficial.

Jan Breckenridge, Michael Salter and Elisabeth Shaw

January 2010

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# Section 1 — Introduction

In November 2008, researchers from the Centre for Gender-Related Violence Studies (CGRVS) at the University of New South Wales (UNSW) formed a research consortium with the non-government organisation, Adults Surviving Child Abuse (ASCA). This consortium successfully applied to the Mental Health Coordinating Council (MHCC), under the Non- Government Organisation Mental Health and Drug and Alcohol Research Grants Program to undertake a qualitative research project exploring the intersections of child abuse, adult trauma and alcohol and drugs from the perspective of both workers and clients. The research project aims to shed new light on the use of alcohol and drugs by adult survivors of child abuse and the challenges that this poses to professional practice in alcohol and drug (AOD) services.

This report describes the conduct, findings and implications of the research project. It is intended that the report will be valuable to practitioners within the AOD sector, as well as generic counselling services. The research findings also have implications for strategic planning and training of relevant workers and professionals in allied human services and health fields. As there is no available Australian research in the area, this project makes an important contribution to the Australian and international research field.

## 1.1 Background to the research

In the Australian media, alcohol or drug (AOD) use is a stigmatised activity frequently associated with physical and psychiatric illness, criminality and moral failure (Bright, Marsh et al. 2008). Nonetheless, many Australians report AOD use. A recent survey found that two out of five Australians reported using an illicit substance at some point in their lives, and one in seven reported using an illicit substance in the previous twelve months (Australian Institute of Health and Welfare 2008). It seems that AOD use is a part of the lives of many Australian adults and the research literature suggests that AOD use is not straightforward and that people use alcohol or drugs for complex reasons.

In a separate body of literature, child protection data and research findings confirm that emotional, physical and sexual abuse are common childhood experiences in Australia (Mazza, Dennerstein et al. 2001; AIHW 2006). The literature is unequivocal in asserting that a significant proportion of adults who are subjected to child abuse may, as a result, experience social, emotional and psychological problems of a serious and disruptive nature when they are adults. Both bodies of literature have identified strong links between childhood abuse, especially sexual abuse, and the development of AOD dependency and co-morbid psychiatric conditions in adulthood.

Recent research has consistently found that adult survivors of child abuse are over-represented amongst adults with alcohol and drug problems. It is acknowledged that workers often struggle to address the needs of clients with histories of child abuse within the context of alcohol and drug treatment. Select research studies and the ‘practice wisdom’ and experience of health and welfare workers suggest that it is common for an adult ‘survivor’ of child abuse to present at organisations such as AOD and/or mental health services with psycho-social problems associated with child abuse, however, these services are not tasked to address the traumatic basis of these symptoms. As their core needs are not being addressed, survivors may continue to seek help from a range of different AOD and mental health services making little or no progress in resolving their presenting difficulties.

## 1.2 Research aims and outcomes

Adult survivors of child abuse (many of whom will have experienced multiple forms of child abuse (see Finkelhor, Ormrod and Turner 2007)) fall between the gaps of service provision, since there are few government-funded counselling services that target the lifelong impacts of traumatic childhood experiences. The literature confirms that adult survivors as a group are also very likely to present with drug and alcohol problems, and that these problems are related, in complex ways, to their abusive experiences in childhood.

It is therefore important to understand the extent to which AOD services are currently addressing the range of mental health problems experienced by this group, including those problems that stem from their traumatic childhood experiences. It is also timely to explore the possibility of community-based support provided by NGOs for people with abuse-related mental health problems and alcohol and drug issues.

Accordingly the project aims are:

To explore the experiences of a small sample of adult survivors of child abuse who have accessed alcohol and drug services

1. To explore the experiences of a small sample of AOD service workers' perceptions of this group's needs.
2. To identify the complex issues involved in AOD service provision to adult survivors of child abuse and develop a range of recommendations for best practice.

This study provides the following outcomes:

- Valuable information about the experiences and needs of adult survivors of child abuse accessing alcohol and drug services
- The perceptions of service users and workers of the adequacy of AOD service provision to adult survivors of child abuse and the identification of possible shortfalls
- Recommendations re appropriate cross-referrals, workplace development and training, information sharing and service provision within the AOD sector.
- Recommendations regarding the possibility of community-based support provided by NGOs for people with abuse-related mental health problems and alcohol and drug issues.

## 1.3 Terminology

The research team is aware that language is not neutral and that the ways in which it is used convey interpretations and values, even if these are not conscious or explicit. With this in mind, the following notes on terminology are provided so that the terminology used in this report, and the thinking behind these choices, is transparent. It is important to note that, where we quote or paraphrase from a participant interviewee, or from research literature, the language used from these sources has not been changed.

***Childhood abuse:*** Covers a range of behaviours and relationships commonly referred to as physical, sexual, psychological and emotional abuse and neglect. Witnessing or 'living with' domestic violence is also seen as a form of childhood abuse. Individuals may be exposed to more than one type of abuse, 'one-off' events or ongoing experiences of childhood abuse. In this research all client participants self-identified as victims/survivors of child abuse.

**Victim/survivor:** The term *victim* has been commonly used in literature in the field as well as in the area of family and domestic violence. More recently, some people have felt that it can imply that an individual can never move on from this definition or representation, i.e. that they are fixed in their victim status. For this reason, the term *survivor* is preferred by some people and will be used throughout this Report.

**Drug 'use', drug 'abuse', drug problem':** In national and international surveys, individuals may nominate that they have 'used' alcohol or a drug within a specified time period. Drug 'abuse' or 'drug problem' usually refers to those individuals for whom there are drastic, life-altering effects from their use of drugs and alcohol. However the distinction between these terms is contentious and not always mutually agreed between researchers, service providers and individuals who use drugs and alcohol.

**Principal drug of concern:** refers to the main substance that the client stated led them to seek treatment from an AOD or generic counselling organisation

**Mental health concern:** Many of the client participants had been professionally diagnosed as having a mental illness as defined by a classification system such as DSMIV. All client participants reported ongoing struggles with well-being and happiness and others specifically identified experiencing on-going trauma in response to their childhood experiences.

## 1.4 The research team

To carry out this research a consortium of researchers offering specialist knowledge in the areas of gendered violence, alcohol and drug use and service provision formed a unique research partnership.

Researchers involved in the Consortium are:

Dr Jan Breckenridge— Senior Lecturer, School of Social Sciences and International Studies, Director of the Centre for Gender Related Violence Studies, the University of New South Wales (UNSW)

Ms Elisabeth Shaw— Psychologist and Research Associate of the Centre for Gender-Related Violence Studies, UNSW.

Mr Michael Salter— Director of ASCA and Research Associate of the Centre for Gender-Related Violence Studies, UNSW.

Organisations involved in this Consortium are:

**The Centre for Gender-Related Violence Studies (CGRVS)** is a UNSW Community Centre which aims to enhance the development of practice-informed research and projects which contribute to the body of knowledge addressing the causes, consequences and intervention strategies of gender-based violence.

**Adults Surviving Child Abuse (ASCA)** is a national organisation which works to improve the lives of adult survivors of child abuse throughout Australia, and to build the capacity of the Australian community to respond to their needs.

# Section 2 — Reviewing the literature

## 2.1 Summary of the literature

The research literature clearly identifies strong links between childhood abuse, especially sexual abuse, and the development of alcohol and other drug (AOD) dependence issues and psychiatric conditions in adulthood. This section provides an overview of the available empirical data on the complex linkages between child abuse and AOD use, and the mediation of this relationship by trauma-related mental health and psychosocial problems.

To summarize, this review of the literature suggests that:

- Abuse and neglect are common childhood experiences in Australia and overseas
- The health impacts of child abuse are felt across the lifespan, and they including a diverse syndrome of mental health problems such as:
  - The continuum of post-traumatic stress symptoms
  - Severe emotional distress
  - Depression and anxiety
  - Chronic suicidality and self-harm
  - A range of psychosocial problems including difficulties in sexual and social relationships
- There is a strong but complex relationship between child abuse, mental health problems and AOD use demonstrated by the following:
  - People with histories of child abuse are more likely to report AOD problems than people without histories of child abuse
  - AOD clients are more likely to report a history of child abuse than people in the community
  - Abuse-related mental health problems are a strong mediating factor in this relationship, since the mental health problems associated with child abuse are also associated with AOD use
  - The relationship between abuse, trauma and AOD use can persist into adulthood, since both a history of child abuse and AOD use independently predict increased risk of physical and sexual assault in adulthood.
- The linkages between abuse, mental health and AOD problems are particularly acute for women and require a gender-sensitive response from services. Women with histories of child abuse and current AOD problems can present with a number of pressing issues, including:
  - High rates of trauma linked to physical and sexual violence in adulthood as well as childhood
  - Acute trauma-related psychiatric problems
  - Issues pertaining to pregnancy and childcare, and interventions by child welfare agencies
  - Participation in sex work and transactional sex to fund AOD use
  - Experiences of multiple forms of stigma and discrimination (particularly for women with children)

- These multiple, intersecting factors constitute a complex clinical picture. AOD clients with histories of child abuse often present with:
  - heightened levels of depression, anxiety, somatisation, dissociation, phobias and eating disorders
  - increased risk of self-harm and suicide
  - increased levels of sexual and physical victimisation in adulthood
  - histories of high risk behaviors, including sex work and/or sharing needles
  - increased risk of relapse, since AOD treatment is complicated by the presence of other psychological problems and needs.

## 2.2 Issues in reviewing the literature

There are a range of relevant quantitative studies that provide data on the prevalence of child abuse, AOD use and the frequency of occasions of AOD service provision. However, little is recorded in either the Australian or the international literature about how adult survivors of child abuse with AOD problems experience treatment interventions in AOD contexts or the extent to which drug and alcohol services are addressing the mental health issues of clients with histories of child abuse. Consequently the ways in which the complex intersections of these issues are dealt with in practice remains under-researched and not well-understood. Even less is known about the perceptions and experiences of the professionals who are intervening with these clients, and how AOD treatment may be affected by having multiple and complex issues to work with.

The professional practice literature is to a certain extent 'siloed', in large part reflecting the different treatment or intervention contexts from where individuals may seek help. For example, mental health service providers prioritise treatment of the mental health issues/diagnosis presented to them. Similarly AOD professionals frequently conceptualise the alcohol or drug problem as the only focus of intervention. There is clear evidence in the research of the effects of childhood abuse on adult well-being and happiness. However it remains the case that the effects or 'symptoms' of abuse most often become the presenting problem for treatment or intervention rather than the childhood abuse itself. The ways in which these issues intersect is effectively obscured by the ways in which treatment in different settings is often focused primarily on one presenting issue.

What, then, does the literature tell us about the intersections of childhood trauma, adult substance use and mental illness and/or post-traumatic stress reactions? This review will address the literature on child abuse and alcohol and substance abuse separately in the first instance before looking at research examining the links between these issues and how these links may affect clinical treatments and interventions.

## 2.3 Child abuse and neglect

Over the three decades, Western countries such as Canada, the US and the UK have undertaken national prevalence or incidence studies to enable more accurate estimates of how much abuse and neglect occurs in each of their communities.

Australia, to this point, relies primarily on data collection by the Australian Institute of Health and Welfare (AIHW) and data collection from State and Territory statutory child welfare organisations. Child protection data only includes those cases of abuse and neglect that were disclosed, detected or reported and is therefore always likely to be an underestimation of the number of children abused

or neglected at any one time. Traditionally, child protection data have been perceived at best as a conservative estimate of the occurrence of child maltreatment (Bromfield & Higgins, 2004). Child abuse and neglect are frequently not reported or substantiated due to the private nature of the crime, the difficulties children experience in making disclosures and being believed (Breckenridge et. al. 2009), and lack of evidence to substantiate the crime (Irenyi, 2007).

The most recent national figures from the Australian Institute of Health and Welfare (AIHW) indicate that in Australia, during 2007–08, there were 317,526 reports of suspected child abuse and neglect made to State and Territory authorities. Following on from these reports there were 148,824 finalised investigations recorded across Australia (AIHW, 2009). Table 1 categorises the total number of substantiations (of notifications received in 2007–08) across Australia. The 55,120 notifications recorded during the financial year concerned 32,098 children.

**Table 1** Primary substantiated maltreatment types in Australian states and territories in 2007–08

	<b>NSW</b>	<b>Vic</b>	<b>Qld</b>	<b>WA</b>	<b>SA</b>	<b>Tas</b>	<b>ACT</b>	<b>NT</b>	<b>Australia</b>
Emotional abuse	13,106	2,814	2,955	304	1,106	429	382	214	21,310
Neglect	10,429	634	2,286	621	881	491	314	260	15,916
Physical abuse	6,725	2,507	2,182	280	249	212	86	162	12,403
Sexual abuse	3,875	410	605	259	95	82	45	120	5,491
<b>Total</b>	<b>34,135</b>	<b>6,365</b>	<b>8,028</b>	<b>1,464</b>	<b>2,331</b>	<b>1,214</b>	<b>827</b>	<b>756</b>	<b>55,120</b>

Source: AIHW (2009, p. 69)

These figures, although underestimates, confirm that childhood abuse in all of its various manifestations affects a large number of Australian children.

The most recent AIHW Report (2009) suggests that the high proportion of substantiations (as opposed to the incidence or prevalence) of emotional abuse is a relatively new phenomenon. Holzer & Bromfield (2008) hypothesize that the inclusion of children who have witnessed domestic violence in data collection is likely to be one of the key reasons for the high rates of substantiated emotional abuse. Australian researchers have argued that a significant percentage of children who are exposed to domestic violence are concurrently subjected to physical, sexual and emotional/psychological abuse themselves (Edleson 1999; Indermaur 2001; Gordon et al. 2002). Of further concern is the growing evidence that indicates that children exposed to violence in the home are at an increased risk of going on to commit or experience violence (UNICEF 2006, p. 7). This finding is particularly pertinent to this research as many of the participants indicated that they either grew up witnessing domestic violence and/or abuse or had experienced domestic violence in their adult relationships.

### 2.3.1 Child sexual abuse

The AOD literature contains a substantial body of work documenting that many AOD clients seeking treatment report a history of child sexual abuse (CSA). There is a corresponding argument in the sexual assault literature that substance use by abused children and adults may be an effect of and/or a response to abuse experiences and painful memories. In this context, AOD use by adults with histories of abuse and trauma is often referred to as ‘self-soothing’ or ‘self-medicating’. The reported strength of association between CSA and adult substance use in both literatures is striking. This section will therefore present a focused discussion of the extent, nature and effects of CSA in turn, to better understand how such a history may influence an adults’ use/abuse of drugs and alcohol.

Studies from Australia and overseas consistently report that CSA affects a significant number of

women and men, and that girls are disproportionately vulnerable to sexual abuse. Finkelhor (1990), in a random sample of 1,481 female and 1,145 male telephone users in all states of the USA, found that 8% of women and 1.7% of men disclosed incest and 27% of women and 16% of men disclosed child sexual abuse before the age of 18 years. In his summary of the available prevalence data, Briere (1992) found that sexual abuse prevalence rates are in the range of 20–30% for girls and 7–15% for boys.

Australian prevalence studies have smaller sample sizes than overseas studies however, they report similar findings. For example, in a random sample of 603 female and 388 male college students in Victoria, Goldman and Goldman (1988) found that 7% of women and 2% of men had experienced incest and 27% of women and 16% of men had experienced child sexual abuse before the age of 18 years. More recently, De Visser et al. (2003) undertook a study of experiences of sexual coercion among a representative sample of Australian adults. Computer assisted telephone interviews were completed by a sample of 10,173 men and 9,134 women aged 16–59 years. They found that 10.3% of women and 2.8% of men had been sexually coerced when aged 16 years or under.

It is often difficult to obtain incidence and prevalence rates for specific communities such as Indigenous and CALD communities, children living in Alternative Care and children and adults with disabilities because of the very particular difficulties involved in reporting violence for those groups. It is well recognized that some of these children are disproportionately vulnerable to sexual abuse, due to a variety of factors:

- *Indigenous children:* Lievore (2003:56) asserts that anecdotal evidence, case studies and submissions to inquiries support the assumption that sexual violence in Indigenous communities occurs at rates that far exceed those for non-Indigenous Australians. Wilson (1997), in the *Bringing them home* Report, documents the severe abuse that Indigenous children and adolescents suffered in care and servitude. Atkinson (1990) suggests that one particular consequence of colonisation has been that many Indigenous families are trapped in environments where deviance and atrocities have become accepted as normal behaviour and as such, form part of the children's socialisation.
- *Disabled children:* Briggs (1995) provides an excellent overview of the literature suggesting that children with disabilities are the children at greatest risk of sexual abuse and are less likely to receive intervention that may mediate the effects into adulthood. Tomison (1996) reported the incidence of intellectual disability as 11% in a sample of 293 cases of suspected abuse. This same study also classified the cases by type of abuse suspected, showing a different incidence for different types of abuse.

### 2.3.2 The health impacts of child abuse

A significant body of research links child abuse with a range of mental health issues, including adult substance use, poor life outcomes, and psychosocial problems in adulthood (Silverman, Reinherz et al. 1996; Thompson, Arias et al. 2002; Springer, Sheridan et al. 2003). It is well recognized that some victims of child sexual abuse develop mental health problems which may require on-going treatment and hospitalization (King 1998; Davidson and McNamara 1999).

The relationship between child sexual abuse and adult psychopathology can be conceptualised in terms of a chronic form of post traumatic stress disorder in some cases (see Herman 1992; Briere 1993 and Timmons-Mitchell, Chandler-Holtz and Semple 1997). Symptoms may include hyper-alertness, dissociation, disconnection from everyday life alongside feelings of guilt, responsibility and self-blame (Hayes and Tiggerman 1999). Other acute problems facing survivors of child abuse may include chronic suicidality, self-harm and distress (Creedy, Nizette and Henderson 1998; Fry 2001; Ystgaard et al 2004).

Health professionals are frequently unresponsive to the traumatic aetiology of the presentation of the abused client. Herman (1992) discusses the inappropriate pathologising of adult survivors of childhood sexual abuse and in particular the use of the diagnosis 'personality disorder'. It is nonetheless important not to be prescriptive about the effects of child abuse as many survivors can and do go on to lead lives relatively unaffected by their childhood experiences. However there are women and men who, as demonstrated in the previous discussion, are very affected by the trauma experienced in childhood and their health and well-being remains compromised in part due to the absence of appropriately targeted intervention.

## 2.4 Drug and alcohol use

The prevalence data on AOD use in Australia includes large community-based studies as well as studies of clinical populations, and it is therefore more substantive than the available Australian prevalence data on child abuse. Teeson, Hall et al. (2000) analysed the prevalence of co-morbid substance abuse from the findings of the 1997 Australian National Survey of Mental Health and Well Being (NSMHWB). The survey found:

- In the past 12 months 6.5% of Australian adults met criteria for an ICD-10 alcohol-use disorder and 2.2% had another ICD-10 drug-use disorder.
- There were high rates of co-morbidity between alcohol and other drug-use disorders and mental (and physical) disorders and low rates of treatment seeking.
- With the NSMHWB individuals who had an alcohol or drug-use disorder had higher rates of other mental health disorders. Among females, half of those with an alcohol-use disorder and 2/3 with a drug-use disorder met the criteria for another mental health disorder. For men, 1/3 with an alcohol-use disorder and 2/3 with a drug-use disorder met the criteria for another mental health disorder.

The most recent figures for drug and alcohol use and treatment are compiled in the 2009 AIHW Report, *Alcohol and other drug treatment services in Australia 2007–08: report on the national minimum data set. Drug treatment series no. 9*. The following statistics are taken directly from this Report.

- Around 154,000 treatment episodes were provided during 2007–08. The vast majority of treatment episodes (96%) were for people seeking treatment for their own drug use and the largest group of clients was males aged 20–29 years.
- Alcohol is the most common principal drug of concern accounting for 44% of all treatment episodes in 2007–08
- Treatment for heroin use accounts for 11% of all treatment episodes in 2007–08.
- Treatment for cannabis and amphetamines accounts for 22% and 11% respectively of all treatment episodes in 2007–2008.
- Counselling is the most common treatment provided at about 2 in 5 episodes of treatment.
- In 2007–08, alcohol and cannabis were again the most common principal drugs of concern in episodes nationally (44% and 22% respectively). These were followed by opioids (14%, with heroin accounting for 11%) and amphetamines (11%). Benzodiazepines and nicotine each accounted for 2% of episodes and less than 1% of episodes were for ecstasy and cocaine.

These studies provide compelling evidence that AOD use affects a considerable number of Australian adults and that many individuals choose to seek treatment for a range of substances.

## 2.5 The links between the experience of child abuse and AOD use

A sizeable body of literature has been written over the last two decades that points to significant links between abuse in childhood and subsequent AOD use. A high prevalence of childhood physical and sexual abuse has been reported in samples of adolescents (Harrison, Hoffman et al. 1989; Clark, Lesnick et al. 1997) and adults (Bartholomew, Rowan-Szal et al. 2002; Simpson and Miller 2002) receiving treatment for substance use disorders.

The relationship between sexual abuse and AOD use has received particular attention from researchers. In community-based samples of young adults, a history of child sexual abuse is associated with AOD dependency (Mullen, Martin et al. 1993; Fergusson, Horwood et al. 1996; Molnar, Buka et al. 2001). Twin studies that involved pairs of abused and non-abused adult female siblings by Kendler, Bulik et al. (2000) in America and Nelson, Heath et al. (2006) in Australia have found that child sexual abuse is independently associated with AOD dependence.

Adult women in treatment for alcohol abuse are more likely than the general population to report childhood sexual abuse (Charney et al. 2007; Makhija & Sher 2007; Simpson & Miller 2002). An Australian study has reported rates of 37%, which is consistent with other international findings (Swift, Copeland & Hall 1996). Simpson and McNulty (2007, p.171) cite a study by McKeganey, Barnard and McIntosh in 2002 of Scottish drug treatment services which found that nearly two thirds (62%) of females have been physically abused and more than one third (36%) sexually abused. Among male users in this same study, just under a quarter (22%) reported that they were physically abused and 7% reported sexual abuse.

Lawrie (2002), researching the needs of Aboriginal women in prison, found that these women had long and serious histories of abuse. Seventy percent of those interviewed (n=50) said they had been sexually assaulted as children and most had also suffered other types of childhood abuse. Of this sample 78% of the women stated that they had been victims of violence as adults and 44% had been sexually assaulted as adults. Importantly, 98% of those sexually assaulted as children stated they have a drug problem. One of the very important findings of this study is the clear link between child sexual assault, AOD use and the patterns of offending behaviour that led to women being imprisoned.

The literature highlights a diverse set of relationships between AOD, violence and trauma. Studies indicate that AOD use is strongly implicated in the commission of acts of violence, including physical assault, domestic violence, child abuse and partner homicide (Mouzos and Makkai 2004; Mouzos 2005; ABS 2006). People with histories of violent victimization may also turn to AOD as a way of coping with these experiences (Briere and Runtz 1987; Gossop and Stewart 2000; Burnette et al. 2008).

A history of child sexual abuse is associated with more intensive patterns of drug taking. Specifically, sexual abuse is associated with earlier initiation of licit and illicit drug use (Harrison, Hoffman et al. 1989), increased likelihood of poly-drug use and frequent drug use (Harrison, Fulkerson et al. 1997; Bensley, Spieker et al. 1999), and earlier initiation of injecting amongst injecting drug users (Ompad, Ikeda et al. 2005). Studies have also found an association between poly-abuse (that is, concurrent physical and sexual abuse) and poly-drug use (Harrison, Fulkerson et al. 1997; Bensley, Spieker et al. 1999).

There is a body of literature that highlights the role of mental health problems in mediating the relationship between child abuse and AOD problems (Gil-Rivas et al. 1997; Charney, Palacios-Boix and Gill 2007; Makhija and Sher 2007). Borderline Personality Disorder, post-traumatic stress disorder, depression, anxiety and suicidality are correlates of both AOD use and child abuse, and researchers have suggested that these abuse-related psychiatric co-morbidities have an important role in the

connection between child abuse and AOD abuse (Fullilove, Fullilove et al. 1993; Jarvis and Copeland 1997; Ompad et al 2005) Forsythe and Adams (2009) argue that numerous studies have found that experiences of abuse are often associated with the development of anxiety disorders such as PTSD which can lead to abuse victims self-medicating with illicit drugs and other substances.

### 2.5.1 The influence of gender

While the proportion of AOD users who are female varies regionally (Hankins 2008), research suggests that AOD dependency is more common amongst men than women (Slade, Johnston et al. 2009). However, Hankins (2008) reports that women substance users have higher rates of trauma related to physical and sexual abuse than men as well as higher rates of concurrent psychiatric illness, particularly post-traumatic stress disorder and other mood and anxiety disorders.

Simpson and Miller (2002) conducted a meta-analysis of 126 studies that examined the relationship between child sexual abuse, child physical abuse and substance use disorders within populations of AOD service users. They found that the average rate of physical and sexual abuse reported by adolescent girls and adult women in AOD treatment was significantly higher than that of women in the community. In contrast, the average rate of physical and sexual abuse amongst adult men in treatment was almost identical to men in the community. Whilst the average rate of physical abuse reported by adolescent boys in AOD treatment was elevated, the average rate of sexual abuse was not.

Arguably, there are important gender differences in the aetiology of AOD dependency and psychiatric co-morbidity, and these differences have important treatment implications (Brady and Randall 1999; Simpson and McNulty 2007). Copeland et. al (1993, pp15–16) identifies special issues for drug and alcohol dependent women which may affect treatment including stigma (particularly for women with children), childcare and child welfare concerns, sexual preference, sexual harassment and sex work and child sexual abuse histories.

Hyman, Paliwal, Chaplin, Mazure, Rounsaville and Sinha (2008, p216) prospectively examined the gender-specific effects of childhood trauma on cocaine relapse outcomes in an inpatient sample of cocaine dependent adults in treatment. They found that childhood trauma increases the likelihood of cocaine relapse and drug use escalation after initial relapse in women but not in men. The researchers concluded that comprehensive assessments of childhood trauma and specialized treatments that address trauma-related AOD use could be of benefit in improving cocaine treatment outcomes in women.

Women with AOD problems present more frequently than men with psychiatric co-morbidities, particularly depressive and anxiety disorders (Berkowitz, Brindis et al. 198) and Borderline Personality Disorder (Trull, Sher et al. 2000). These disorders typically predate the onset of substance-abuse problems and they are often related to histories of abuse and violence (Brady and Randall 1999). For women with histories of child abuse, AOD may provide a means of coping with the aversive emotions that arise from child abuse-related trauma (Jarvis and Copeland 1997) and it may also be a form of self-harm arising from poor self-concept, self-blame and feelings of worthlessness associated with childhood abuse (Makhija and Sher 2007).

Fewer studies have been undertaken with men with histories of child abuse and AOD problems. Simpson and Miller (2002) found that men in AOD treatment do not report higher rates of physical or sexual abuse than men in the community (whilst adolescent boys report higher rates of physical abuse but not sexual abuse), and it may be that the relationship between child abuse, mental health and AOD use is less significant and/or less direct for men than for women. This is supported by the mixed findings of studies of men in relation to child abuse and AOD use.

Langeland and Hartgers (1998) found insufficient evidence for a relationship between physical and

sexual abuse and alcoholism amongst men, whilst Dunn, Ryan *et al.* (1994) found no significant difference in the rates of trauma-related symptoms amongst men in AOD treatment between those who reported child abuse and those who did not. In contrast, Gil-Rivas, Fiorentine *et al.* (1997) found that sexual abuse was correlated with lifetime anxiety amongst men in AOD treatment, and physical abuse was associated with depression, anxiety, suicidal ideation and post-traumatic stress disorder.

An additional emphasis of the literature is how drug use interplays with pregnancy and parenting. Women who are either drug or alcohol dependent are likely to face significant challenges as parents. Stojadinovic (2003) found that some female survivors of sexual abuse reported a range of abuse-related, traumatic responses to pregnancy, including intrusive flashbacks, a sense of a loss of control, increased dissociation, and increased depression and anger. However these associated difficulties contribute to women with children who use drugs facing considerable social stigma, contributing towards the silencing of women drug users. (Boyd 1999, Ettore, 1992).

## 2.6 Understanding AOD treatment—the clinical picture

The majority of studies on people in AOD treatment with histories of child abuse have been on female clients, since women in AOD treatment report higher rates of physical and sexual abuse than men in AOD treatment (see above). Studies of women with histories of sexual abuse in AOD treatment provide a complex clinical picture of a client group with heightened levels of depression, anxiety, somatisation, dissociation, phobias and at increased risk of eating disorders, self-harm and suicide (Fullilove, Fullilove *et al.* 1993; Jarvis and Copeland 1997; Fiorentine, Pilati *et al.* 1999).

Women with histories of child abuse are at increased risk of sexual and physical victimisation in adulthood (Fromuth 1986; Siegel, Sorenson *et al.* 1987) and women with AOD problems are also at increased risk of physical and sexual victimisation (Ladwig and Anderson 1992). Women presenting for AOD treatment frequently have complex histories of abuse and violence, including physical and sexual assault in childhood and adulthood (Fullilove, Fullilove *et al.* 1993). Amongst injecting drug users, women with a history of child sexual abuse are significantly more likely to engage in high-risk behaviours such as sex work and/or sharing needles (Braitstein, Li *et al.* 2003; Plotzker, Metzger *et al.* 2007).

Treatment options for abuse survivors with AOD problems can vary, but treatment of this population is complicated by psychiatric co-morbidities and underlying issues relating to child abuse. The management of trauma-related co-morbidities is complex, because whilst substance use may be an attempt to self-medicate painful post-traumatic symptoms, withdrawal exaggerates these symptoms (Brady, Killeen *et al.* 2000). Relapse can occur when abstinence triggers the return of traumatic memories and/or symptoms (Jarvis and Copeland 1997). Premature disclosure of child abuse, in the absence of specialist counselling, can also contribute to relapse (Copeland, Hall *et al.* 1993).

Further, there is currently a lack of accessible and affordable mental health services for this population (O'Brien, Henderson *et al.* 2007). In the absence of available support, there is reason to suggest that adults with histories of child abuse may use alcohol or drugs as a form of self-care or self-management. This represents an important conceptual shift away from viewing child abuse survivors that use AOD as passive “addicts” in alignment with the model promoted by some harm reduction proponents in which AOD users are understood as decision-making consumers who assess the risks and benefits of AOD use (Moore and Fraser 2006).

There are a range of studies that suggest that drug treatment outcomes for clients with histories of child abuse improve when the client is provided with support in relation to broader abuse-related problems (Chiavaoli 1992; Simson and McNulty 2007). Griffith, Pearson and Bear (2004) argue that, if issues

relating to child abuse are not integrated into AOD treatment, then the likelihood that the victim can achieve lasting change is compromised. At worst, AOD treatment may deprive the victim of a vital coping strategy, exposing the victim to intolerable memories or feelings that may prompt self-harm and/or suicidality (Griffith, Pearson, Bear 2004, p17). Root (1989, p 545) suggests that “people with traumatic histories will usually feel worse after they decrease or cease their substance abuse... [and] unless the therapist warns the individual...[they are] likely to feel betrayed again”. This feeling of betrayal can frequently lead to relapse.

Holt and Treloar (2008) provocatively question why health professionals consider pleasure to be unimportant and why policymakers overlook this issue in harm reduction policy and practice. While it may be the case that there are many potential motivations for drug use, the failure to consider pleasure or even effectiveness as a contributing factor renders the drug and alcohol user’s purpose or motivation as irrational or unintelligible. This is particularly the case for those using drugs to self-soothe, self medicate or to overcome deficits in social skills. For example, it is well recognized that drinking can bolster confidence and promote feelings of well being, both of which can be otherwise rare experiences in the lives of some survivors of child abuse. Moreover, drug and alcohol use is frequently a social or shared experience that connects people to one another, and thus may provide survivors of child abuse with a means of overcoming a sense of isolation or loneliness.

## 2.7 Conclusion

It is clear that child abuse survivors are a population of AOD clients with discrete and identifiable needs that require specialist care. In particular, there is a need for gender-responsive services that address the different determinants and experiences of AOD abuse for women and men. The importance of integrated AOD and mental health services for AOD clients with histories of child abuse has been repeatedly flagged (Copeland, Hall et al. 1993; Gil-Rivas, Fiorentine et al. 1997; Liebschutz, Savetsky et al. 2002) and the research evidence suggests that the general lack of a targeted response to the needs of adults with AOD problems and histories of child abuse is contributing to relapse and ongoing dysfunction amongst this population. This research aims to further explore these concerns and contribute to the debate with recommendations for best practice principles.

# Section 3 — Methodology

The research project is an exploratory qualitative inquiry into the experiences of adult survivors of child abuse who have accessed alcohol and drug services in the last five years, and the perceptions that workers/managers in a selection of AOD services have of this client population. A qualitative approach was selected in order to gather and document clients' and workers' experiences and perceptions in semi-structured interviews.

The researchers are cognizant of the guidelines outlined in Chapter 4.5 of the National Health and Medical Research Council's National Statement on Ethical Conduct in Human Research pertaining to research with people with a mental illness. Accordingly the research process was designed with care to alleviate, as much as possible, the potential for harm involved in engaging survivors of abuse in a research project such as this.

## 3.1 Theoretical lens

The theoretical lens informing this project locates the phenomenon of human experience, in this case AOD use by adult survivors of childhood trauma, within the world of social interaction. Influenced by social constructivism, this research is underpinned by the following principles:

- There is no objective reality
- There are multiple social realities influenced by context
- There is a mutual co-creation of knowledge by the viewer (the research team) and the viewed (AOD users and workers)
- Weber's concept of '*verstehen*', that is, an explicit aim of qualitative research is the empathic understanding of human behaviour
- The interpretive understanding of subjects' meanings—the researcher is actively positioned and acknowledged as the author of reconstruction and meaning.

These principles are consistent with later constructivist grounded theory approaches such as that proposed by Charmaz (2003) and Mills, Bonner and Francis (2006)

## 3.2 Sampling techniques and recruitment strategies

Purposive sampling was undertaken to ensure that a range of workers, clients and AOD service types were included in the research. For inclusion in the research sample the following criteria had to be met:

1. Participants in the client sample had accessed alcohol and drug services in the past five years, were genuine volunteers over 18 years of age and capable of giving informed consent, and have a self-identified history of child abuse.
2. Participants in the worker sample were genuine volunteers employed by a recognised AOD service or a counselling service that provides specialist AOD interventions.

Participants were not recruited on the basis that they have a mental illness however some participants disclosed that they had been diagnosed with a mental illness or a trauma-related psychological condition, including post-traumatic stress disorder. All others discussed ongoing concerns with well-

being and happiness. These conditions do not prevent an individual from providing informed consent.

The available evidence suggests that it is not direct questions about abuse that usually trigger traumatic responses, but rather, environments, experiences or emotions that are similar to the original traumatic event (van der Kolk, McFarlane et al. 1996; Elliott 1997). Such forms of stimulus are unlikely to arise in the context of qualitative research (Becker-Blease and Freyd 2006) as used in this project. In addition, where clients were in rehabilitation services, workers acted as ‘gate-keepers’ by screening client suitability, introducing the research to possible participants and providing direct information to interviewers about potential triggers for distress.

Recruitment strategies included the circulation of information about the project through the ASCA newsletter and in flyers used by workers in AOD treatment and counselling services to discuss inclusion in the project with appropriate clients. Snowball sampling techniques were used to widen the number of agencies and worker participants participating in the research. As with most qualitative studies, sample numbers are small and the validity of the research findings is based on a rigorous analysis of detailed narratives rather than claims to generalisability per se.

### 3.2.1 The participating services

In Australia the AOD sector offers treatment services from the following range of health and welfare contexts and service structures:

- Community-based counselling and support, which may be provided as outpatient adjuncts of health services, by NGO’s, or as part of other key initiatives such as the federally funded MERIT (Magistrates Early Referral In to Treatment) program which aims to reduce crime by assisting with reduction in AOD use. It includes office based and outreach services. The vast majority of these services offer short term interventions.
- Public and private rehabilitation and post withdrawal services, which can include residential programs, supported accommodation and peer based support strategies such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These can be short, medium or longer term services.
- Public and private services focusing on withdrawal (often referred to as “detox”) and which may be home based or residential, and which are short term interventions

The clients and workers participating in this research were drawn from the first two of these treatment contexts. Accordingly, client recruitment was targeted only at those clients in rehabilitation services and individuals who had completed rehabilitation and were ‘down the track’. Clients in detoxification programs offered by the participating organisations were excluded from the project in recognition of these clients’ physical and emotional vulnerability and the risk of potential distress.

## 3.3 The research samples

Data was collected from two separate, unmatched samples of AOD clients and AOD workers. Semi-structured interviews were undertaken with 16 adult survivors of child abuse with mental health concerns in New South Wales who have accessed AOD services in the last five years and 15 workers from a range of AOD services.

The client sample was comprised of self-identified adult survivors of childhood abuse who also reported a drug problem or drug abuse. All identified prior or ongoing difficulties in relation to their well-being and happiness, with a selection having been given a formal diagnosis of mental illness

or a trauma-related psychiatric condition. Ten participants were interviewed whilst residing in a rehabilitation service and the other six were clients of counselling services or were receiving support from a community based self-help organisation. Thirteen participants were women and three were men. All participants came from an Australian English speaking background and one participant identified as Indigenous.

The participants' ages ranged between 20 years of age up to 45+ years with fourteen participants being over 30 years of age. All participants started using drugs or alcohol at a young age, the range of commencement being from 13 years of age to 22 years. Amongst this sample, there were a number of common issues:

- **Polydrug use:** Eight participants identified their principal drug of concern as being alcohol and the remaining eight identified use of substances—however most participants disclosed polydrug use at some point and identified a progression in their drug use to more serious drugs (such as heroin, speed, ice and benzos) by their late teens.
- **Parenting issues and contact with child protection agencies:** Eight of the sixteen participants had children. Of these eight parents, four reported contact with the Department of Community Services (DoCS) in relation to child protection, and three other participants had children living with other relatives.
- **History of AOD problems in family of origin:** Importantly, eight participants disclosed a family history of drug/alcohol abuse affecting their childhoods.

The worker sample was comprised of workers most of whom have worked in a range of AOD services. Six workers were employed in rehabilitation services, six in counselling services where AOD clients are seen, four were employed in court-mandated AOD services and the remaining two participants worked in detoxification programs. There were fourteen female and one male worker participants—only one worker participant identified as having a personal history of drug use. Twelve identified as having a tertiary education and three workers either had certificates or considerable work experience in the AOD field.

### 3.4 Data collection

Survivor participants were interviewed using semi-structured interview protocols, focusing on participants' history of substance abuse, the manner in which they came to access alcohol and drug services, their experiences in treatment, and their reflections post-treatment on the efficacy of service, particularly as it relates to their history of abuse and trauma. Worker participants were also interviewed using semi-structured interviews focusing on their observations of the influence of a child abuse history on substance use and mental health issues in later life, the effectiveness of various forms of therapeutic treatment and service provision and their assessment of the needs in this area and possible strategies to better address these needs. See Appendix One for copies of the Interview Schedules.

Most interviews were undertaken at the participating AOD organisation with a few participants not currently in rehabilitation being interviewed at ASCA's premises. Workers were gatekeepers for the participants in rehabilitation programs. Prior to interview, a researcher would discuss with a contact worker the ways in which a 'context of care' would be established for the interview; in particular, how the participant might inform the researcher that they are becoming distressed in the interview, and the steps that could then be taken to assist them should they become distressed in interview e.g. stopping the interview for a period, contacting their therapist or a support person, or accessing another support option such as Narcotics Anonymous (NA) or Alcoholics Anonymous (AA). All interviews with

survivors were undertaken by either a social worker or psychologist, once again to ensure a ‘context of care’. All survivor participants were reimbursed for travel costs and interview time.

### 3.5 Data analysis

Data analysis was loosely based on the principles of grounded theory to create coded categories and to develop concepts that emerge from the data (Glaser and Strauss 1967). This approach is further refined by Strauss and Corbin (1990) as the breaking down, naming, comparing and categorizing of data, in which hypotheses or theories are generated directly from the data, rather than through a priori assumptions or existing theoretical frameworks. Data analysis is therefore reflexive and iterative, and previously analysed transcripts may be re-analysed as new themes emerge from later interviews.

Written interview notes were coded into various categories based on a particular passage or quote of a given transcript. Once all interviews were coded, individual participant’s comment on a particular issue were recorded and then compared, allowing researchers to identify, compare and summarise the major themes emerging from the data.

### 3.6 Ethical considerations

Confidentiality is of utmost importance in all research—particularly where clients may experience stigma and discrimination as a result of disclosing personal information. Accordingly, all information is de-identified and only disaggregated data will be presented in this Report. The data will be kept for a minimum of 7 years in a locked room in the School of Social Sciences and International Studies, UNSW after which time the data will be disposed of in accordance with the *National Statement on Ethical Conduct in Research Involving Humans*, 12.11.

Approval was successfully sought from UNSW’s Human Research Ethics Committee (HREC) Approval Number 08205 as well as the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service Approval Number X08–0280. See Appendix Two for a copy of the worker and Client Information and Consent Forms.

# Section 4 — The research findings

## Introduction

Client interviews focused on discussions of the participants' history of substance abuse, the manner in which they came to access alcohol and drug services, their experiences in treatment, and their reflections post-treatment on the efficacy of service provision, particularly as it relates to their history of abuse and trauma. In corresponding interviews, worker participants provided their observations of the influence of child abuse on substance use and mental health issues in later life, the effectiveness of various forms of therapeutic treatment and service provision and their assessment of the unmet needs of AOD clients with histories of abuse and possible strategies to better address these needs.

Data analysis was loosely based on the principles of grounded theory to create coded categories and to develop concepts that emerge from the data (see Glaser and Strauss 1967; Corbin and Strauss 1990). In this way our understanding of the intersections of childhood abuse, adult trauma, alcohol and drug use and professional intervention is constructed from the separate and shared perceptions and experiences of clients and workers—effectively privileging the voices of those most involved in the intersection of 'use' and 'abuse' and the multiple and complex issues affecting the provision of treatment services. Where possible exact quotes have been used to maintain the integrity of participants' perceptions and experiences as disclosed in the interviews. Participant's voices are highlighted in *italics* to distinguish from our written analysis of the data.

This study is necessarily focused on those people for whom AOD use and child abuse are interlinked, however the aim of our analysis was to explore the complexity of this relationship. The overarching themes emerging from our data analysis have been organised into five substantial sections:

- Client and worker perceptions of the relationship between trauma and AOD use
- Seeking help and being part of treatment systems
- Service strategies: strengths and gaps
- Building a platform of care and treatment: pitfalls and possibilities

It was beyond the scope of this study to determine the factors that distinguish child abuse survivors with AOD problems from those without AOD problems, although this is certainly a potential avenue of future research.

## 4.1 Client and worker perceptions of the relationship between trauma and AOD

The majority of women using drugs would've had some sort of trauma. Most have had a shit upbringing. You don't hear very often 'I don't know why I use. I've had a great upbringing'. (Female service user)

The empirical literature clearly demonstrates strong links between childhood abuse, especially sexual abuse, and the development of alcohol and other drug (AOD) dependence issues and psychiatric conditions in adulthood. The following section explores the ways in which clients came to make links between childhood abuse and problems in their adult lives as well as worker's perceptions of the

usefulness of recognizing these links in AOD treatment. Both workers and clients spoke of child abuse as part of a continuum of violence that has persisted throughout the lives of many AOD clients, and they indicated that recent and ongoing experiences of abuse and violence had an important role to play in the AOD use of many people with histories of child abuse.

#### 4.1.1 Childhood trauma and the links with AOD use

In interview, all client participants indicated that there was a strong link, although not necessarily a causal link, between childhood abuse and drug and alcohol use. Client participants commonly reported that these links were not always clear to them until they entered treatment. Prior to treatment, they had thought that there were other explanations for their behaviour, most often that they were 'bad' or 'weak', which contributed to feelings that they were 'to blame' for their difficulties in their adult lives.

I believed there are good people and bad people and I was a bad person. My mum and grandmother used to say I was bad, naughty, giving mum a bad time. You end up thinking "I'll show you how bad I can be!" They [AOD workers] wanted to talk about my childhood and I remember saying "I don't see the relevance". (Female service user)

I went to counselling. It was painful and I wasn't making the links [between AOD use and child abuse]. I still held the reservation that no one could help me. I was un-helpable, unfixable. I knew the self doubt and lack of trust. I didn't trust anyone. I really loved my partner but I couldn't work out why he loved me. I used to niggle at him till he shouted at me. That made sense. (Female service user)

In client's experiences, therapeutic services were the primary mode of AOD treatment through which the link between childhood abuse and AOD became clearer to them. Specialist services targeted at particular symptoms (e.g. services that only addressed AOD use or mental health problems) were reported to be the least likely to assist clients to understand their behaviour in relation to their trauma history. This contributed to clients' experiences of internalised shame and stigma.

If a psychiatrist or psychologist had been able to say to me 'you know that twitching you have when you speak of molestation, then that's because of not being safe at home'. Instead they said 'it'll be better in long term rehab. to get a bit of distance and learning life skills.' I thought because I was bad, I was being sent away. (Female service user)

After being exposed to the notion that childhood trauma and AOD use may be interlinked, many clients felt that this proposition provided a good fit with their own experiences. In interview, a selection of client participants retrospectively mapped the way in which their AOD and mental health difficulties developed, often explicitly linking patterns of behaviour with the ways in which they coped with abuse in their childhood and the ongoing pain caused by these experiences.

I used to steal food and binge-eat at 6-7 years. As soon as I had a voice and was going to school I started to comfort myself. Now I have accepted the abuse side of things, my behaviours are more understandable. Back then I thought 'I need chocolate'. Now I know behaviour (e.g. smoking) is the same (Female service user)

Looking back there were always risk taking behaviours to cope, but they were masked by this behaviour being the norm, besides one friend who pulled me aside and expressed concern about my drinking. (Male service user)

At this program the pennies are now dropping. In the past (in other rehabs) we just studied the NA

book. Now I'm looking at trauma, the cycle of violence. Now I see I was in the cycle with my mum and in other relationships. I always thought it was me, that I attracted people like that. (Female service user)

Almost all workers interviewed were aware of the strong links between child abuse and mental illness and AOD use in adulthood. The following assertions by select workers describe some of their thoughts about these links. However, worker's recognition of the link is demonstrated throughout many of the interview extracts utilized throughout this report.

In asking everyone (women) at screening, I'd say 70-80% have experienced childhood abuse and 40-50% have experienced rape as adults. That's of the women who disclose, and not all do (Service worker)

Underneath addiction there is almost always a trauma. For men there have been issues of violence at home and many times abuse. About 65% of men on my caseload had a history of abuse. For many men it was their first time in rehab. and having access to counselling and the abuse looked at for the first time (Service worker).

Workers acknowledged the importance of psycho-education for AOD clients with histories of abuse, which they felt helped to ameliorate the internalized shame and self-blame experienced by many survivors of child abuse. Some workers expressed serious concerns about the failure of other services to address this relationship, which they suggested compromised treatment outcomes for clients.

Depending on the intervention context the importance of the links between self-medication, symptom control and past abuse can be missed. This is particularly concerning because treatment insistence on total abstinence can result in a massive increase in negative feelings and memories that exacerbate mental health conditions such as depression and suicide ideation which in turn can trigger a relapse in AOD use. (Service worker)

The consensus of worker and client participants in this study was that, when undertaken in a sensitive manner and at the appropriate time, informing AOD clients with histories of child abuse of the potential relationship between AOD use and child abuse can be very beneficial. Both workers and clients expressed concern that this relationship was often not being detected by AOD workers and services and/or that important health/treatment information was being withheld from clients who might otherwise have benefited from it.

#### **4.1.2 Secondary trauma: layers and effects**

It is well acknowledged that sexual victimisation in childhood is a strong predictor of sexual and physical victimisation in adulthood (Messman-Moore and Long 2000). This relationship is particularly pronounced for women, which is likely to account for the lifetime prevalence of interpersonal violence (and correspondingly severe trauma-related mental health problems) reported by many female AOD clients with histories of child abuse (Fullilove, Fullilove et al. 1993). AOD use may intensify the cycle of gendered violence, since the life circumstances associated with high drug and alcohol use (for example, vulnerable living circumstances; sex work, or participation in criminal activity in order to fund AOD use) are associated with physical and sexual violence against women. Nonetheless, the relationship between child sexual abuse and sexual assault in adulthood is a pervasive one for women (Johnson, Ollus et al. 2008) and the amount of violence in the lives of female AOD clients is not necessarily attributable to AOD use.

Most of the women have been so abused — have experienced severe abuse, not only from the partners they have chosen, but from strangers. They've been raped in their teenage years, sexually assaulted by total strangers along their journey. The obvious explanation is that they would put themselves in dangerous situations — but you hear of clients that would have experiences severe physical or sexual trauma in childhood, and then, come through to their adult years, and speak about a random rape happened. Look, maybe from their perspective, it's random, and from our perspective, they would be at risk. But it's really quite interesting how it continues through. It just continues through. You often hear of clients who have been raped throughout their lives — horrific stories of gang rapes, any rape, horrific stories and you think “How have you been raped four times, when much of the world has never experienced trauma like that?” And this is not uncommon for our clients. It's all the time, and it's quite scary. Horrendously sad. (Service worker)

The relationship between AOD use, violent trauma and mental illness for women with histories of child abuse may be circular and self-reinforcing. This has particular implications for mothers with AOD problems. Many women with AOD problems and histories of child abuse are also subject to the intervention of child protection services and the removal of their children, which many women experience as profoundly re-traumatising and a source of chronic grief. This issue will be dealt with in more detail in Section 4.3.4.

In this study, male and female client participants reported histories of secondary traumatisation in adulthood in addition to child abuse. Women had commonly experienced physical and sexual violence in intimate relationships and/or in the course of their work or living circumstances.

Common secondary trauma for clients is DV, significant forensic history, participation in sex work, street drug use and witnessing OD's, their own OD's, witnessing assaults in the course of their work, the stuff that goes with homelessness, squats, no water, rodent infestations, kids being removed, HIV infection due to needles and sex work. (Service worker)

Workers noted that AOD use can be associated with exposure to violence and death more generally, and that this had a disproportionate impact on men with histories of child abuse. In this study, workers commented that male clients had often experienced violence in jail or in relation to criminal/gang activity related to their drug use and vulnerable living circumstances.

Other trauma they mention includes ... drug related trauma — seeing dead bodies, violent offences in the context of drug use. (Service worker)

Workers suggested that violence had been a constant ongoing feature of many clients' lives since childhood, and as a result many clients would not mention recent or ongoing violence unless prompted. That is, clients are unlikely to see their more recent traumatic experiences as worthy of mention; they are just something to expect in their life they lead/what they deserve.

They think there is something about them, like they are an easy target to be manipulated. They tend to see it as their fault rather than separate the fact that they aren't responsible for the behaviour and could stand up for themselves. They see themselves as provocative in relationships and have no right to say 'I was assaulted'. Their partners have blamed them and they have a mindset that it is something about them that leads to them being targeted. (Service worker)

Workers observed that the chronic violence that has characterized the lives of many female AOD clients with histories of child abuse had become part of their disposition or orientation to the world.

These clients, workers suggested, viewed violence as an inevitable or intrinsic part of interpersonal relations and they internalized responsibility for the violence of others against them. As a result, they were more likely to form relationships with (or be targeted by) violent men and they had less capacity to conceptualise the violence against them as wrong.

They don't learn things about safety that others do, have a 'submissive' interactive style, an unconscious style of submission which means they get involved with a dominant relationship. Their desire for security and fears of abandonment can mean they hold onto an abusive relationship. The women have such an unformed sense of self so don't have the self confidence to say no or to walk away from a dangerous situation. (Service worker)

Whilst workers tended to see the ongoing violence in clients' lives in terms of relationship or attachment styles learnt in childhood, clients' descriptions of their lives indicated that their vulnerability to violence was not simply a product of child abuse. They were often caught up within a matrix of disempowerment according to a multitude of social indices (such as the stigma of AOD use or sex work) that left them vulnerable to multiple experiences of abuse and violence. Child abuse is thus experienced as part of a lifelong continuum of abuse and discrimination, to the point where clients felt that the violence against them was legitimate and inevitable.

Once you've been hurt as a kid you put yourself in dangerous situations 'cos you think no one can hurt you again. You cop so much abuse. Those people you work with — they are abusive. You think you deserve it "I'm a drug addict", "I'm a prostitute"... (Female service user)

Workers and clients suggested that AOD use had a role to play in blunting the immediacy of these traumatic events and associated responses. There are multiple linkages between AOD use, a history of child abuse and recent experiences of violence and trauma, and in the lives of clients recent violence tended to compound the mental health implications of child abuse and thus reinforce AOD use.

### 4.1.3 AOD as pain management, “medication” and self soothing

Workers and clients were very clear about strong links between child sexual abuse and AOD use. In this regard, workers located AOD use on a continuum of dysfunctional coping strategies, such as self-harm, that are often utilized by abuse survivors to cope with the emotional dysregulation that results from CSA. This is consistent with findings in the literature which highlight the potential for adult survivors of child sexual abuse to develop a range of problematic coping strategies in an effort to resolve the effects of CSA.

I don't see the links between CSA and D&A as causal, but more likely that CSA will lead to problems with self esteem. Many other skills such as regulation of emotions are missed, they aren't able to tolerate distress or to self soothe. So while it is not causal, it is more likely. Substance abuse can be a substitute for coping and to regulate emotions, a way of coping with stress, ironing things out. AOD can be used to fill the void. (Service worker)

It can be very clear about the CSA and drugs, drinking, cutting. They can say it is to do with bad feelings like outrage and helplessness. Others say that I left the family, was on the streets, married the wrong person, started using ... a whole web of problems. AOD does lead to mental health problems and social problems, they do see that it has lost them jobs and relationships. (Service worker)

It is the case that they self medicate because when the abuse happened there was no opportunity (in most cases) for the child to be validated or supported. Few have had a good response from caregivers. So for some it's about the child not being given support and so they had to seek other

ways to cope. They choose AOD 'cos they work; opiates in particular make you feel comfortable in your own skin. There is also genetics involved, drug dependent family members, environment, time, opportunity and other factors. (Service worker)

Workers' demonstrated considerable insight into the subjective experiences of adults with histories of CSA. Their description of the negative emotional consequences of CSA fitted with clients' experiences of their own lives. In interview, clients described powerful internal feelings of pain and shame arising from their experiences of CSA, and they connected these negative emotions with their AOD use.

My mum was really mean, a drunk, left me with other people. Inappropriate people and inappropriate things happened. I knew there was a void and I was hurting and drugs really helped. I didn't hurt anymore. (Female service user)

A lot of girls who have been molested have the scars I have and like speed. Don't know why. I was introverted as a kid. It made me feel powerful. I don't know why. (Female service user)

I started smoking and drinking at the age of 15 after having repressed memories surface. Within the family the situation had been difficult at the time, and I couldn't talk to them. Alcohol was a means of repressing the pain. (Female service user)

Worker participants identified that AOD use can be a (dys)functional way to cope with out-of-control feelings and memories emanating from childhood experiences that effect adult well-being and happiness. Some workers linked AOD use to client's attempts to suppress the intrusive symptoms of post-traumatic stress disorder, such as flashbacks, that are difficult to treat even with psycho-pharmacotherapy.

Drugs help numb the feelings, produces positive feelings that override the negative emotions. Some have been abused to such a degree that it is to obliterate having any feelings at all. For some, the secondary trauma of life since then, struggles with relationships and life on the streets, their inability to cope with daily life, is what then perpetuates the using. (Service worker)

AOD use is such an important tool to manage nightmares, flashbacks, being unable to speak, relationship problems, and if this affects daily living then it is important to work with. (Service worker)

For clients giving up drugs is scary as they know symptoms will come up and it is hard to think of effective replacements, of finding coping mechanisms as effective as drugs. (Service worker)

Workers highlighted that the cessation of AOD use could precipitate the re-emergence of debilitating trauma symptoms in the lives of clients with histories of child abuse. Although they acknowledged the negative consequences of AOD use for clients, workers indicated that AOD use had an important role to play in stabilizing otherwise intolerable trauma symptoms. This proposition dovetailed with clients' descriptions of their own histories of drug use, which some connected to the suppression of specific trauma symptoms, such as depression or intrusive memories.

The abuse is one thing, but it is every day after that you have to contend with. I had sexual, physical and emotional abuse ... by my mother and father. Looking back when I used alcohol hard it was to numb the pain — socially, the loneliness, "I'm a piece of shit and to blame for everything. (Male service user)

I started smoking and drinking at the age of 15 after having repressed memories surface. Within the family the situation had been difficult at the time, and I couldn't talk to them. Alcohol was a means of repressing the pain. (Female service user)

The notion that AOD use is a functional form of self-medication for trauma survivors has circulated throughout the literature on trauma and abuse for some time. However it represents a radical departure from the entrenched moralism that characterizes much AOD policy and practice. Emerging from the moralistic paradigm of AOD use has been an insistence on abstinence that workers in this study indicated was not only unachievable for many clients with histories of abuse, but potentially dangerous.

Depending on the intervention context the importance of the links between self-medication, symptom control and past abuse can be missed. This is particularly concerning because treatment insistence on total abstinence can result in a massive increase in negative feelings and memories that exacerbate mental health conditions such as depression and suicide ideation which in turn can trigger a relapse in AOD use. (Service worker)

There is a sense that if they get their D&A recovery addressed all the other issues will go away as well. However they stop using and feelings and memories regarding the abuse become more apparent. (Service worker)

It took a long time to have faith and trust. She was a counsellor who deals a lot with survivors. She's been amazing. Very supportive. One thing with counsellors and how they approach AOD, they advocate to keep supports in place until you can find other means so that you no longer need those crutches. They see people who have had breakdowns in trying to be abstinent. (Female service user)

#### 4.1.4 Conclusion

Amongst the workers interviewed in this study, the message that there are linkages between AOD use and child abuse has resonated strongly with their own experiences of their clients. As a group of self-selected research participants, it is likely that they are a sample of workers who are particularly interested in the intersections of AOD and trauma, which accounts for their familiarity with these issues. When worker participants spoke about the AOD and mental health sector as a whole, they frequently observed that there was a lack of capacity to identify and treat abuse-related trauma in the AOD sector.

Client participants indicated that the linkages between AOD use and child abuse were evident in their own experiences of their lives, although this linkage was not always clear to them prior to treatment. They often needed a worker to explain how a history of child abuse may have impacted on their AOD use. In acknowledging the relevance of the link between AOD use and trauma, clients were not simply parroting or repeating messages they had received from workers. Clients spoke movingly of the overwhelming negative emotions that arose from their experience of child abuse, which they attempted to suppress through the use of AOD. These negative emotions were not only implicated in their AOD use, but they also coloured participant's experiences of AOD services and treatment.

Both workers and client participants commented that many AOD services are unresponsive to (and therefore contribute to) the emotional distress and negative self-images that are associated with child abuse, which compromised the efforts of clients with histories of child abuse to resolve AOD problems.

## 4.2 Seeking help and being part of treatment systems

It is interesting to note that, in the AOD field, treatment is often premised on the presumption that clients *choose* to use, and that they need to articulate a strong request for help before treatment will be effective. This is very different to other health interventions, such as mental health for example.

With D&A you get help if you jump up and down and say I need help. There is a different requirement for readiness than in other services. The emphasis is on the client wanting help. There is little early intervention. Clients are chronic before they get to services like MERIT or rehab. In acute mental health services will offer help in the absence of readiness, and there are early intervention services. (Service worker)

The notion that people “choose to use” alcohol or drugs fails to acknowledge the limited and constrained choices that face many children and adolescents who have experienced violence and abuse. Victimised children and young people have few opportunities to disrupt or prevent abuse (that is, relative to the power of abusive adults to victimise them) and the mental health consequences of abuse are complex and can endure into adulthood. AOD use can become integral to the coping strategies of abused children and adults who otherwise have not been taught healthier ways of coping with emotional distress or the other consequences of abuse. When viewed through this lens, the notion that a person with an AOD problem must hit “rock bottom” or else otherwise be desperate for intervention before they receive assistance appears needlessly punitive and potentially harmful. The persistence of AOD use for some people, despite repeat contacts with AOD services, may not be evidence of their lack of readiness or commitment to treatment as much as the failure of services to recognise and address the complex role that AOD use plays in their lives.

Clients’ descriptions of service provision in relation to either AOD or mental health issues highlighted the absence of holistic and integrated care for this population. Their descriptions of their AOD and mental health needs suggest that the two are inextricably linked. However, it seems that many services and workers were not equipped or trained to address these needs concurrently. Clients identified many difficulties in accessing helpful treatments for AOD use which also address the impact of childhood abuse. For example, either service providers did not seem to be interested in past abuse or clients were not ready or feeling safe enough to discuss issues in a particular treatment context. This highlights the issue of readiness in relation to both services and clients. There is an appropriate time and place for child abuse survivors to begin to acknowledge their childhood experiences, but given the lack of readiness in the AOD sector to address these issues, it seemed coincidental that some client participants had found the right service at the right time.

For example, this service user described an early AOD intervention that raised the question of incest before she was emotionally stable or physically safe:

I went to a private clinic for detox on my parent’s private health insurance ... I was getting major flashbacks. They talked to me about child abuse but I didn’t get it. Why say this to me? They recommended that I go to rehab to get away from my father. I didn’t go to rehab. I went onto mood stabilizers and started talking about my family. (Female service user)

However, another client participant valued her experience in an AOD program in which the link between her child abuse and her AOD had been explained. This knowledge, she felt put her in the “driver’s seat” in a way that previous programs had not.

Other programs I did didn’t ask about the past. I knew there was a connection as mum was a

heroin addict. But I didn't know about how I'd been groomed [for abuse] from a young child, I didn't know it was connected to that, more to mum using. There is no miracle cure...if you do A plus B it equals C. But awareness is the first step. I've been travelling on automatic pilot and this awareness has put me in the driver's seat. This program has opened my eyes. (Female service user)

Clients' descriptions of their experience with AOD services indicate that, in the words of the woman above, the effectiveness of treatment is not a matter of "if you do A plus B it equals C". Instead, a range of interpersonal and contextual factors played a determining role in the efficacy of treatment, including but not limited to the specific skills and dedication of AOD staff, and clients' own needs at a particular point in time. It is telling that, for many clients, the "turning point" in their treatment involved a worker or a service demonstrating a flexible and compassionate approach that was in stark contrast to many of their other experiences of service. This section provides a summary of worker and client's reflections on the experiences of AOD clients with histories of child abuse in AOD and mental health services.

#### 4.2.1 Eliciting disclosure and initial assessment

In this study, it seemed that AOD services were a fraught environment for survivors of child abuse. Workers indicated that, despite the strong linkages between trauma and AOD use, there was a lack of organisational support across the AOD sector to address abuse-related trauma in treatment. For example, it emerged in the course of this study that most AOD services do not currently screen for histories of abuse and violence. Some workers stated that they chose not to elicit disclosures from clients they suspected had histories of abuse because they were not resourced to care for them appropriately. Others were ambivalent about whether this was necessary at all. There seemed to be specific screening for CSA only at some women's services, and workers at these services strongly advocated for routine abuse screenings of all clients. At one such service, a worker suggested that CSA assessment was not only an administrative procedure but an important therapeutic opportunity:

Our assessment tool is quite stringent, but it is therapeutic in and of itself. We believe that therapy begins from the assessment phase, and so we take assessment quite seriously — and the impact that assessment will have on them. We look at their trauma history, their childhood, their genogram, their family history — in depth — we look at patterns of behaviour that might have occurred over time. (Service worker)

In other services, some workers had developed their own approach to assessment that was more likely to elicit disclosure. Their motivation for doing this was their own professional interest or model of work, their own identification of service gaps, and their own desire to improve service.

I screen for abuse. It elicits disclosure. Our formal screening is about risk issues, drug and alcohol use, mental health, harm minimization of use, DV and child protection issues. We don't formally screen for CSA or trauma, so I have developed my own assessment format, which goes into early childhood experiences. The majority say they have had an experience of abuse. (Service worker)

For the most part, however, the issue of child abuse was only raised in AOD services when clients brought it up themselves, which is clearly a difficult thing to do. On enquiry, workers speculated that the lack of screening was related to a range of factors: the service focus (e.g. detox, where the emphasis was on medical support only, or where the emphasis is on AOD use rather than the reasons for doing so), lack of awareness by workers, lack of interest in past influences on current behaviour (e.g. "It isn't the work of this rehab"), and fear of hearing about trauma (e.g. "I won't know what to say").

There is no emphasis on it [CSA] in screening or treatment [in my service]. It is on the public agenda for licensing and funding, but perhaps they can't actually do it. Perhaps it is so emotive when the focus is on being clean and a lot of the program is group work...it isn't the best place to discuss it. The longer the rehab, the more it could take place but I don't know of any that take it up as a specific issue. Maybe in some women's services they do. (Service worker)

Not every client talks about it. We don't screen for it (CSA) here because we're a D&A service, so tend to ask about mental health and drug use. We use more of a solution focused approach at 'now' and the recent past, rather than the longer term past. Maybe (this approach) also relates to this program, which tends to be a short term service, and there are a high proportion of drop outs. (Service worker)

90% of child abuse histories would not be picked up in a detox setting as the clients come in high, are often homeless, aren't showered, are hungry. Many are out of it so an assessment or history taking would never take place. There is no opportunity to refer on as we aren't aware of their issues. Often the assessment, as far as it was, took place in the open plan office with others present, so it wasn't private enough. (Service worker)

These workers are describing AOD services, detox and rehab, in which the specific needs of clients with histories of child abuse are largely invisible. It seems that some adults with AOD problems and histories of child abuse are so accustomed to the whitewashing of their abuse histories by AOD and other services that they have learnt to become, in the words of this service user, "chameleons".

I have some friends in my life who have experienced violence and CSA... and we have always presented as relatively together. You kind of have to dig a bit and we haven't been as together as we appeared. Some people in the helping professions seem to think you have to be a mess...if not, our issues are missed. Like when I saw the Psychiatrist he said 'you seem to be doing quite fine'. If you have grown up in an environment of violence you get to read people well and take cues from people. You become like a chameleon. You stay calm, you give people what they want so things stay calm. This grouping of people present as quite together. They've learnt to look ok and so won't get help. Other groups of people present other behaviour and look quite different. (Male service user)

A number of workers articulated their concerns about the failure of other workers and services to address child abuse in AOD treatment. They emphasised that clients had the right to health information that would assist their recovery, and they suggested that many workers and services lacked the appropriate training and protocols to manage CSA disclosure.

It is crucial to identify the factors that maintain other behaviours such as AOD. If it is the core of the onion then for long term recovery identifying this factor is crucial. Anyone who has been abused as a child has a right to know about services and have that option for referral. (Service worker)

It is important to screen at other services for various traumas. Clients are often not asked and it maintains a lot of problems. If you have a process, you have to be equipped to deal with the answer. Others don't ask as they aren't equipped to deal with the information that might come out. (Service worker)

## 4.2.2 My way or the highway

In the AOD field there are a number of established paradigms that are considered to be the backbone of intervention. The 12 step model would be a primary example of this. It is safe to say that virtually everyone who has sought AOD treatment has encountered a 12 step program, although there is some acknowledgement that such services, compelling as they are, have their limitations and other options need to be available. In this study, many workers expressed concern about the ubiquity of the 12 step model in the AOD sector, since it was often attended by a prescriptive and linear view of AOD treatment that prioritized the cessation of AOD use over all other treatment goals regardless of the needs of the individual client. In the view promoted by the 12-step paradigm, “looking back” at how experiences in childhood may have impacted upon current behaviour may be judged as a denial of personal responsibility.

People in AOD field need more training in issues of childhood trauma. The belief too, that clients are responsible for their own addiction, that and the lack of skill on the part of workers are the main reasons it's not addressed at present. (Service worker)

At this service we encourage attendance at a 12 step program and attending meetings regularly. These programs also seem to suggest that if they look at the past to understand their addiction it is unhelpful as they are making themselves out to be a victim, using the past to excuse their drug taking behaviour. In this way programs can do clients a disservice. Women get this impression that going back is a crutch rather than facing you have a disease of addiction. (Service worker)

The 12 step program is all about the routine of recovery. A relapse means they're not going to enough meetings, they are running on their own will, not surrendering enough. This can be at the expense of other understandings of the problem. (Service worker)

A number of workers described AOD treatment according to the ‘order’ in which it should take place, and the skills that clients have to possess before progress can be made. This makes good clinical sense to a degree; duty of care must be attended to. However, many of the workers interviewed (perhaps indicative of the sort of critical thinking that is reflective of people interested in taking part in research) expressed concern that a conservative and rigid view of AOD treatment goes substantially unchallenged within many services. This reflected the service experience of many of the clients interviewed. Some workers suggested that service culture has been strongly influenced by the fact that many workers were former clients themselves and so impose their experiences of punitive treatment on the generations after.

Many rehabs employ ex-addicts who power trip, act controlling, ‘do this because I’m in charge, do as I say not as I do.’ The group dynamics are influenced by this so programs sound all well and good but staff are really influenced (by the group dynamics) whether they are good or not. (Service worker)

Some (rehabs) are run by ex-residents who aren’t trained in interventions. It is more about routines and responsibility, they aren’t skilled at counselling. Others don’t have a therapeutic reputation anyway. Some even seem to perpetuate feelings of abuse. There is a hierarchical structure of people who can sanction and punish you for things that you do. This can be okay for some and not for others. If you work with people who self medicate and take that away without working on the trauma it won’t be enough to contain them. (Service worker)

### 4.2.3 Clinical presentation and worker judgments

It is clear that the service setting plays a significant role in determining what behaviours staff will tolerate and what material will be explored. In this study, however, the process through which clients present for service, and how workers assess their presentation, was extraordinarily fraught and subjective. Clients may know they need help but not know the extent of it, or what to ask for. As one client said:

They said 'you have to want it' (treatment) but you don't always know.

Many of the client participants described instances in which services or workers adopted a moralising and authoritarian stance regarding their behaviour and AOD use. Some workers expressed concern that clients' mental health symptoms were being inappropriately stigmatised by workers and services.

Organisations are not well equipped to deal with client behaviour, e.g. aggressive, psychotic or 'borderline behaviour'. Sometimes these diagnoses have been made in the middle of a drug binge. Clients have to comply or are discharged. The staff are not trained or resourced to do anything else. I'd recommend more training and supervision to reduce judgments and intolerance. (Service worker)

A number of client and worker participants reflected on how the moral regime of the 12 step program filtered throughout AOD services and the sector as a whole, creating power differentials between clients and staff.

At a 12 step program if you do something wrong you're out, and you lose all your status along with it. Even if you've been 12 years clean, if you relapse you're back to square one, all your status is gone. You lose everything. (Male service user)

Many of the clients interviewed reported that their behaviour was frequently misconstrued by workers, who viewed any deviation from their "one size fits all" approach as a moral failure on behalf of the client. The service setting and paradigm determined, to a significant degree, how the client was going to be viewed by workers. For example, some services clearly have to select clients who fit their program. However, some workers suggested that the skills and norms of conduct required for admission were often unrealistic for this client group.

We reject clients on the basis of their destructive behaviour, problems with other clients. I guess if they had the inability to tolerate difficult emotions, because our program does bring up a lot of emotions for women who have used substances to push those emotions aside. If they don't have stable accommodation to return to — that's another exclusionary criterion. I guess, when they have absolutely no supports in the community, we would exclude them as well. You wouldn't want to open up all this stuff for them, only to have them return to a community where they have no support. I mean, that is a problem. There is a lack of resources out there for these women, and the majority doesn't have the financial means to seek therapy on an ongoing basis. (Service worker)

They need to look like they are participating, that their own motivation and attitude is positive. Those more aggressive or sitting back tend to be treated with more intolerance. The difference at this (counselling) service is that we might ask 'why can't you engage...?' rather than 'you have to...'. At a residential rehab. there are all the everyday things to attend to about motivation, participating, more reasons to intervene, and so many more reasons for staff to have issues with clients. It is easier to work with co-occurring issues here in a counselling setting because we don't have to attend to the day to day life events, disasters and consequences e.g. criminal justice matters, etc. (Service worker)

Rehab. is about changing active use. Recovery due to being coerced. The physical side to the addiction needs to be managed; the first priority is sobriety. After that, mental health issues are overwhelming, and workers and clients can't manage. The main intervention is routines. (If you disrupt the routine) it could look like you find it too hard, that you are non-compliant, that you aren't at the right service. (Service worker)

In some cases, it was clear that worker attitudes and judgements about clients had a huge impact on whether clients would receive services at all. This is complicated: those clients with traumatic histories and high levels of drug use are bound to not present well. However, if they don't present "well enough", they may be denied all but the most basic intervention. The following sections illustrate some of the factors that influence client presentations and how this can be viewed by workers. Ultimately some see that finding a good worker is the "luck of the draw" and, indeed, they may be correct.

#### 4.2.4 Good worker fit: "The luck of the draw"

A number of clients in our sample said that they felt "lucky" at the "coincidence" of finding the worker that they did, when and where they did. While this can be the same for any service user, particularly in the public system, what is significant is that clients at the time had to actively work in strategic ways to keep the intervention in place. Common examples of this can be seen in the following interview excerpts:

I finally found a good counsellor and saw her for about 7 years. She worked at a sexual health clinic and it was not where I expected to get help. I must have appealed to her sympathies. In fact I didn't disclose my drug usage in case I'd be rejected. I'd really like this to change and that is why this research really appealed to me as things really need to change. (Female service user)

I'm concerned that I feel lucky to have found that counsellor at sexual health. She was free and available. I'd tell my service providers that I can't deal with the CSA without pot. I thought I couldn't deal with it unless I was smoking. I couldn't work out how to do it. I do think that funding wise that if it takes longer to break down the CSA stuff the government isn't going to fund it. They will fund drug and alcohol. But I ended up not disclosing the D&A and risk the rejection of their help. I was 25 and I needed help. It had been a long time, and I couldn't risk not getting help. (Female service user)

Unfortunately service focus, community perceptions and even drug and service "fashions" all influence a client's reception at a service.

If they are young and attractive they will get more help, for example, a young woman on heroin versus a middle-aged woman who is an alcoholic. A lesbian woman has less chance of a good response from mainstream services. (Service worker)

#### 4.2.5 Service limits

The parameters and limits of services are the "bottom line" in terms of the assistance clients can obtain; this is an obvious point. What is significant here is that many services made little or no attempt to bridge the divide between services by doing a comprehensive assessment and assisting the client into the right avenue for help. Some workers told us their service did not have a referral list, and that they felt ignorant of what other services might be available.

I never felt people were disclosing for the first time. The whole team knew of their histories,

but there wasn't even a referral policy. The clinic focused on keeping people alive, getting their wounds dressed. (Service worker)

Most workers railed against the time limited nature of their service intervention, noting that for these clients, longer work is nearly always needed, and many will want to keep working with the person to whom they first disclose their history. The great divide between AOD services, community counselling resources and mental health was also a strong theme within discussions on service limitations.

#### 4.2.5.1 Not enough time, not the right place

The length of service delivery also influences whether the impact of child abuse is recognised and addressed in AOD treatment. Service workers described this as a considerable impediment to holistic treatment in a number of ways. For some worker participants, it meant deliberately not opening up anything that could be “too much” for the client to manage in case the intervention was sabotaged; for others it resulted in frustration that they had made a deeper connection only to have to refer the client on. It is clear that the mental health impacts of child abuse requires specialist and long-term care and many AOD services do not provide the necessary time, space or support.

Seeing we only had a short term process, we tried to slow down disclosure, but they often took the opportunity to disclose deep rooted issues and then could get overwhelmed. (Service worker)

Child sexual abuse came up, often in not very appropriate circumstances. We worked in little boxes, “counselling rooms”, and not with a uniform approach. Some staff were social workers, nurses, psychologists, so the level of counselling varied. In a methadone clinic counselling is not very useful. It is a chaotic environment, you couldn't make a plan for sessions, it wasn't a safe place to talk about abuse. The discussion was generally initiated by the clients. (Service worker)

Restraints to attending to the childhood issues? The chaos of clients lives. The clinic design (re privacy). The client instability and safety. The lack of staff training: they are generally not experienced and there is a prevalent attitude of ‘you've had a bad time but what can we do now?’ (Service worker)

Clients who found that their treatment needs were met were able to make significant progress. They too seemed to remark on this being a kind of “lucky coincidence” given that there are many variables working against treatment success, including the lack of places in the “best” programs.

I was seeing a psychologist at hospital. He knows my family history. I picked up my methadone there. He was hesitant to go into it (the past) as he thought it wasn't the right time for me. He knew it wasn't good to travel there, go into a trauma session, dose and then walk out. Here I am in a safe environment. I don't think community work first would've worked for me. I was too unstable. Now I know what I'm in for I can continue in the community. (Female service user)

My current psychotherapist has experience with trauma and has worked with survivors of Auschwitz. This has been hugely helpful. He has talked about Jewish people not wanting to remember. As a childhood survivor it isn't publicly validated and we are trying to remember something that is hidden and not accepted. I could only remember one or two incidents in the beginning and now I am pursuing more memories. I have been lucky in finding him. (Male service user)

In this study, it seemed that the gaps between service steps increased the likelihood of relapse. For AOD clients with histories of child abuse, detox may be a space in which they began to talk about

issues relating to sexual abuse, although services are not set up to manage this process appropriately. However, clients may detox and then have to wait for a place at rehab. The gap between detox and rehab was not a safe one for these clients, who may have used alcohol or drugs to suppress traumatic symptoms and emotional distress. Without some kind of therapeutic service to bridge the gap between detox and rehab, they are at risk of relapsing, since they have not been provided with alternative skills or counselling to manage abuse-related trauma.

Access into rehab services is difficult. The programs are set up in different ways, the relationships between detox and rehab. People get out of detox and there is a gap before they can get into rehab and they relapse in the middle (Service worker)

#### 4.2.5.2 Inconsistent treatment

Engagement in effective service is also affected by staff resources. Clients who had long histories of disrupted attachment are also affected by organisational issues such as staff who are unsettled, unavailable or constantly changing.

In the public methadone system, clients had access to mental health services. Clients often complained though that their psychiatrists were all interns who moved on every 6 months and they really hated the change over and would stop going for a while. There was no 'extra work' offered, only medication except in rare cases. Our psychiatrists (at D&A) spent an hour with them, but still the changeover at 6 months was hard and access was still variable. (Service worker)

The therapeutic alliance is one of the primary determinants of good outcomes for clients, regardless of treatment modality (Horvath and Symonds 1991; Martin, Garske et al. 2000). Consistency of care is particularly crucial for adults with histories of child abuse, who may struggle with trust and communication in interpersonal relations. In this study, the lack of a case worker or mental health worker upon whom clients could depend on and trust was disruptive to their AOD treatment and a potential contributor to drop out and/or relapse.

#### 4.2.5.3 'Siloed' services and falling between the cracks

Despite the strong links between abuse histories, AOD use and mental health concerns, services in the AOD field are generally separately provided from mental health, and clients and workers strongly emphasised the difficulty in accessing mental health resources. Within the AOD sector itself, services are commonly siloed according to their focus. For example, those services attending to the effects of AOD use had a strong emphasis on the "medical model" (e.g. stabilizing medication) and/or the 12 step paradigm compared to those that emphasise therapeutic intervention, education and living skills. The lack of integration between the multiple models of AOD service, and the absence of linkages with other support services, was a concern for both clients and workers.

I functioned well in rehab with the structure and routine and got 12 months up. But the program was really about getting off drugs, not managing negative feelings. Often I felt hopeless, life is still shit, might as well keep using. (Female service user)

From the perspective of clients, the divisions between different kinds of services forced artificial categories upon needs ("AOD" vs "mental health" vs "sexual health") that were, in their experience, inextricably connected. In the following excerpt, a service user reflects on her fragmented and depersonalising experience of health care, and how the arbitrary imposition of service limits and worker demands has compromised her recovery.

The counsellor got me confused with someone else. She talked to me about performing oral sex and I never did that. I was completely taken over by bad thoughts about being a bad person. At 15 I discovered marijuana and it gave me relief. I took it every day. I was immediately addicted. Then I had a dual problem: the dope and the abuse. I sought help about the abuse. I saw two psychiatrists, accessed the community health centre, saw various doctors. I was suicidal. I was hospitalised for depression. I was really unstable. I attempted suicide at 15. The suicidality became more pressing and I became more emotionally tumultuous over the pot. I was hospitalised for a few days or a week and I disclosed the abuse there. They didn't help much.

The way it was explained to me was that funding didn't allow us to look at the CSA and that the counselling would be complicated due to the pot use. I was steered towards D&A services even though I wasn't seeking help for the pot. I wasn't allowed help for the CSA until I dealt with the pot. I went to a private hospital and walked out after a few days as they refused to talk about the CSA without me giving up the pot. Where I'm going with this is that I have continued to seek help and I can't find someone who understands the needs of both issues. (Female service user)

Mental health workers that fail to address AOD problems, and AOD services that fail to address mental health issues, were consistent themes in client's descriptions of ineffective or harmful health care experiences.

In trying to think about times I've tried to get counselling...the first time was through a psychiatrist when I was a student, because I could get it on Medicare. That would've been 15 years ago. At that time I told my story a bit and the response was 'well you seem to be doing alright', and that was the frame for the next few sessions. Then I missed a few sessions because of my drinking so he said he wouldn't see me anymore. He hadn't asked me anything about my D&A use and I had barely mentioned my childhood experiences. We're not looking at that long ago; psychiatry hasn't come that far!

I went to another service and the problem there was we didn't talk about anything beyond the drinking behaviour. The focus was on managing the problem of drinking, stopping the drinking, nothing beyond that. That is where drug and alcohol services fall down... When I saw the CBT person she didn't ask about drugs and alcohol. We talked a bit about my childhood but I didn't put the 2 together and neither did she. (Male service user)

#### 4.2.6 Conclusion

By and large, client participants described fragmented experiences of service within and across the alcohol and drug and mental health sectors. They had complex needs, but services had prescribed responses and the capacity of workers to adapt this response to the needs of specific clients was limited. Clients responded to these constraints in a variety of ways. Some adapted to it, becoming 'chameleons' who tried to get what they could from what was offered. More often than not, the conditions of clients' lives was such that they simply fell through the cracks in service delivery. Since few services are tasked specifically to address the relationship between child sexual abuse, mental health problems and AOD use, clients and participants indicated that people with histories of child abuse and AOD problems are rarely having their multiple needs addressed concurrently, and hence are at risk of relapse or dropping out of treatment.

## 4.3 Service strategies: strengths and gaps

Worker and client participants identified both strengths and gaps within the existent network of AOD services for clients with histories of child abuse. This section outlines these strengths and gaps, and draws on clients and workers comments about service strategies to point to opportunities for potential workforce development and programming change.

### 4.3.1 Counselling

The research literature suggests that effective intervention with this client group requires services to offer skilled, longer term work that can respond to clients' complex needs in a multi-faceted and flexible way. Workers emphasised that counselling should, ideally, provide an important lynchpin in treatment, acting as a bridge from residential or court imposed treatment into ongoing community support for adults with histories of child abuse. Both workers and clients felt that an individualised intervention is important with people with histories of abuse and AOD problems, although the dominant paradigm in the AOD field is group based work. The accounts gathered in this study suggest that service recipients need to unpack the particularities of their own experience in order to gain insight into the emotional dynamics that may be promoting AOD use.

I moved house so moved counselling services. Counselling gives me the space to talk about myself, to talk and have feelings. People over time have said things (about child abuse) but it made no sense to me. I couldn't get it. Counselling keeps me up enough to do more things, to use more services. It keeps me clean. Has kept me alive. Helps me work through the resistance. (Female service user)

One to one counseling has been a crucial component of recovery as it allows me to talk about my needs and what I want. Group therapy is helpful but it is not as intense and larger numbers can allow you to hide. (Female service user)

Clients and workers consistently emphasised the importance of professional help and the importance of a good therapeutic alliance. However choices of counselling services are very limited. Without private funds, accessing a service for the length of time needed was almost impossible and finding someone with the right skill set is also very difficult. Most services offer, at best, very short term intervention and workers are insufficiently skilled in co-morbidity and childhood trauma. The workers interviewed in this study had developed skills and expertise to enhance their service delivery, only to find they were not always well supported or recognised for this within their workplaces. For example, they argued that there is a lack of quality supervision or professional development within most workplaces.

The biggest referral gap is for long term work, CSA specialist skills, workers who understand the risk of relapse, ie have the drug and alcohol angle too. Over 20 years I haven't seen a change in these areas. There is more public dialogue about it, more awareness, but no improvement in services. (Service worker)

Some of the stories (about services) I hear from clients...there isn't much out there in terms of counselling, and it is hard to find someone they can work with. D&A counselling in the community tends to be time limited and have too narrow a focus. It may be useful for setting some goals regarding D&A and getting something of a story about their lives and the addiction. (Service worker)

What is needed is long enough time to work with people. With complex trauma it could be up to a decade! You need long enough to build trust. You need better staffed and resourced services for women with trauma issues and with CSA, properly funded services. Salaries for competent

service staff. You need adequate supervision for people working in this field. People working with trauma need access to someone who knows about this. A model of service that prevents vicarious traumatisation (Service worker)

It was clearly recommended that counsellors be employed in discrete roles within services.

A rehab. is like a hothouse, like being under a microscope, and sometimes it isn't the place to open up childhood issues. Sometimes they can't avoid it. Some rehabs are incredibly punitive and you can't have the same staff meting out discipline and also doing the counselling. You need a more complex intervention for complex trauma. (Service worker)

### 4.3.2 Group work: educational and therapeutic

The AOD field has a long tradition of group programs, namely the 12 step program models—Alcoholics Anonymous and Narcotics Anonymous. Service workers and clients spoke of the significance of these groups aiding client recovery, as well as an important, ritualised way to chart progress over time.

I will go to NA when I get out. It is important to be reminded where you have come from. I get clean time up and then having a shot seems like a good idea. NA reminds you where you've come from and where you're headed. I used to know people who were 10 years clean and thought that will never be me. Now I know where it is coming from, it won't bring me undone the same way. (Female service user)

(NA) It's really helpful. It helps me know what my head does. It connects you with other people, with sane thoughts. Addicts isolate and it really changes that. I used to think I couldn't exist without drugs, but at NA I can get more confidence. (Female service user)

In contrast to the “one size fits all” approach of some services which might involve an argument for a lifelong commitment to a 12 step program, clients indicated that the relevance of group work for them was linked to particular stages of recovery.

Groups are amazing but there is a lot of telling sob stories and you keep going over the crap and that you'll never be well...it doesn't work for me. The empathy from the others really helped early on, then helping others, but as I recovered it became too controlling and I needed to focus more on the positives. You do need to whinge but you have to let that go in the end. (Male service user)

While groups might be a service “backbone” in many cases, the ways that workers “weighted” this approach varied. Some workers argued they are the primary intervention, others felt that they were an important adjunct to (not a replacement for) individualised counselling. There was also variability in the application of group programs generally. Some services were said to use group attendance in an authoritarian way. Others were therapeutic. The significance for clients was in the information/ education components, the camaraderie and the structure, although, as the following excerpt suggests, these elements had positives and negatives.

At my rehab there was a lot of structure. If you didn't abstain from everything you got kicked out. Maybe therapy would've been helpful, but the big emphasis was church and groups. But that's not for everyone. The thing that comes to mind is the camaraderie and the desperateness about where I was before I got there. I had been on the streets by then. (Male service user)

For a few client participants, the group programs did not suit at all. This is common in the general population: group programs are generally less appealing than individual intervention. However, if an AOD client does not want to attend a group service when it is such a dominant paradigm in the field, it can be frowned upon by workers. Some workers were sensitive to the individual and varying needs of clients, and how group environments can be less than ideal for abuse survivors. Other workers were relatively optimistic about the group approach.

Group work has its place, but it can be difficult to get D&A clients into groups. The groups available for people who have been traumatized are very limited and it is difficult for clients to develop trust in a group. (Service worker)

They tend to like self help programs such as SMART recovery (more respectful than AA etc) to break down their isolation, establish a routine, reduce chaos in their lives. They also like the group program here as it offers a daily routine for a while. (Service worker)

### 4.3.3 Mental health services

The research clearly demonstrates a link between a history of trauma, AOD use and mental health concerns. However, in interview clients and workers gave consistent feedback about mental health service use: AOD clients did not receive sufficient treatment, found it difficult to be taken seriously, found it difficult to access services, were judged for their AOD use, rather than receiving a more complex understanding of their behaviour and symptoms.

I was hospitalized on and off from my mid-twenties but no-one knew what to do with me. They struggled to come up with a diagnosis despite my having 1 admission of 2–3 years and another of 9 months. I didn't get anything out of it. In some of the admissions they didn't even ask me about the drinking. I felt like I was biding time. Ten years ago I was diagnosed as having ADHD and given medication and I found this helpful. I felt it made sense of my need to always be active and never have any down time. Five years ago I was also diagnosed with Bipolar Disorder and got medication that really helped. But I don't like psychiatrists. I have been seen at least 20 of them but they never ask much about why. I used to get through the psychs' sessions as quickly as possible because they do your head in. (Female service user)

The first service I went to at 27 was hospital. I got a night stay and valium. I was discharged. The doctor said to mum to check out detox. At the time I thought I was a bad person and lazy and used drugs as an easy way out. I got this idea from media, education ... you hear that you are supposed to say no to drugs. Craving drugs wasn't dealt with. (Female service user)

Some client participants had had some contact with a GP regarding mental health related concerns, but the treatment did not progress into a fuller assessment. Overall it was clear that GPs have a significant role in gate keeping for this population regarding access to other mental health services. While some clients may use public clinics, a significant number had a link with a GP who clearly attempted to assist. However, the combination of a brief appointment, lack of GP training/curiosity to consider deeper issues, or lack of client disclosure, resulted in referrals not occurring and thus a potentially crucial point for intervention was lost.

I had no contact with mental health, although I was put on Zoloft at 21. I was studying and just using on weekends. I went to a GP and he put me on Zoloft and then on an ADHD medication. I did finish my course. (Female service user)

I went to my GP who knew I was separated. I told him I was feeling really low and he put me on Prozac. I don't know if I told him about the alcohol. There should have been a counsellor involved. He didn't refer me to anyone but he also didn't know about the child abuse. (Male service user)

At the GPs ... I had really bad irritable bowel syndrome and didn't tell my parents. I was too scared. Emotion was belittled. After dad died I went to the doctor and got tested for cancer. I was asked why I hadn't told my parents and I said I was scared. The GP was my point of contact. (Male service user)

Workers described their difficulty in accessing and referring clients to mental health services. Often clients reported a negative experience, or were afraid of the stigma of “mental health” intervention. Thus, after considerable efforts to develop motivation and willingness to attend and to secure an appointment, it was frustrating that the resulting intervention could be insufficient.

At mental health, staff are often on pagers and you are not phoned back. Clients are allocated at admin and the case workers change all the time. I have had files lost by admin staff, I can't trace which case worker was allocated. There is also the stigma of accessing these services. They are more willing to provide long term input for trauma but once you throw in D&A issues it is complicated. Community based programs are mental health or D&A, so they can't work out where the client should go first. I do still try and access mental health services because this program is short term and they do need follow up. I don't know if the clients make it there longer term. (Service worker)

Workers did not find it easy to forge a viable working alliance with mental health services due to particular judgments about AOD clients. They often felt defeated by some of the attitudes they encountered.

They would get a mental health assessment and some medication, their prescriber of methadone would also prescribe other medication. If they were not responsive to the medication they could be seen to be 'whingeing' and told to 'get over it'. (Service worker)

Worker participants understood that mental health resources are very limited. However some felt that the boundaries drawn seemed related more to stereotypes about AOD use and the ongoing “siloing” of client needs, as if one issue has no relationship to any other. There were also differences in accessing services between other health related and non-government agencies, the latter finding alliances even harder to forge.

There is a difference in the referral when they are chaotic and still using. Unless they are acutely psychotic they'll be seen to be D&A clients who have intoxication withdrawal issues. It is an 'us and them' mentality. 'It's not one of our clients but one of yours.' A recent Health policy I read on dual diagnosis said that there should be no wrong door, and I liked the sound of that. (Service worker)

If they are accessing methadone in the community through public health and you try and access another community based treatment program then you can be told “one program or another, you are not entitled to both. (Service worker)

The mental health team — it is difficult to get into a working partnership with them. With acute cases you can get in, but they have long waiting lists and couldn't do any follow up. We used to use hospital services and public health as we were situated in the grounds of a Hospital. It meant

we were seen to be 'in the system'. Generally non-government services find it hard to access government services. Generally there was a lack of working partnerships for an after care plan. We were an abstinence based program and that seemed to help facilitate acceptance for a referral. (Service worker)

The treatment of psychotic and schizophrenic disorders in the Australian mental health system was reported to be prioritized in practice in this study. This means that mental health services may lack the capacity to identify and respond to trauma-related mental health problems (such as “personality disorders”, which are the psychiatric diagnoses most commonly associated with a history of sexual abuse) and which may be contributing to AOD use.

While there are attempts to change responsiveness in relation to co-morbidity, mental health is still overloaded, which means D&A clients are excluded from many mental health services, and those with a personality disorder are written off and sent away. (Service worker)

Certainly it is only people with psychosis who get ongoing assistance from mental health services. People easily get caught between jurisdictions, with community health saying the client has a private psychiatrist, a psychiatrist saying they are a community health problem, a D&A problem, no one taking responsibility. These clients are hard to manage. (Service worker)

The failure of mental health services to respond to AOD clients has led to certain corollaries for AOD services. Some services appear to have tightened their own boundaries, afraid of being a catchment for all the people mental health services have been unable to take on. In a (very) few, management have chosen to fund staff trained in mental health intervention (e.g. clinical psychologists). Where this had happened, it was a source of pride and professional security for staff.

So many of our clients are borderline [personality disorder]. For me, as a worker, it's recognising that clients are borderline. Sometimes that takes a while, sometimes it doesn't. We hear their history, we know what's going on a psychiatric level, and you know where you stand. Those clients are great — you know what to expect of them. And I suppose it's about managing their erratic behaviour, and also not splitting — being firm, as a team of staff. When we have a clear understanding of who might show these characteristics, it's a matter of being quite together, providing one framework. A united front. I think that's the most important thing for a borderline client — that staff are working together, saying the same things. That is usually what holds them. (Service worker)

In other cases, individual workers have embraced the challenge to work with dual diagnosis and complex needs and have sought relevant training, whether their employment circumstances really allow for this or not. A number of workers in interview stated they had selected clients they felt equipped to assist, and “lay low” about it with management. While this is well intentioned, it clearly left both workers and services in a vulnerable position.

For the drug and alcohol sector it is now standard fair to take people with a mental health condition, except for schizophrenia and perhaps some bipolar. You need to have stability. Even if the service doesn't say it does this (ie work with people with a dual diagnosis) it is the reality of working with this client group. (Service worker)

### 4.3.4 Attention to the needs of families and children

With such complicated histories, it is very common for client participants in this study to have children through multiple relationships and to have had contact with the Department of Community Services (DoCS). For workers, it could be excruciating to watch children being under-parented.

Emotionally, it's difficult to see how deficient the parenting they can provide their children is. As a parent, I can see the vulnerability of a child, and it's hard to witness that they are incapable of parenting a child. They often have a little bit of "good enough" in them, but how the child suffers—because a bit of "good enough" is not enough. And I suppose the sadness is where we need to remove the child from the parent in order to thrive in the world as their own self.

That is difficult, because we develop an alliance with the mother—you develop compassion and sensitivity for the mother, knowing her childhood, knowing that she doesn't have the capacity to care for herself, let alone anyone else. So I suppose that is hard—having that compassion for the mother, and yet still having such deep feeling for the child. And realising that sometimes separation is the best thing for the child, and on one level—yes, it's the best thing for the child—yes on one level, but not really on another. That push and pull, emotionally, is the hardest thing to cope with in this work. (Service worker)

In this study, it seemed that AOD services did not attend well to issues of parenting and the needs of children, even when funded to do so. In interview, a number of workers spoke of their concerns about the approach of many AOD services to clients with children. They suggested that staff could find it difficult to take family relationships into account, and were at times dismissive of the relationship between parents who are drug affected and their children. Some workers (particularly those with children) were concerned that the lack of skill and/or interest in family intervention in some services acted to negate the mother-child bond. This was then justified as part of the treatment philosophy that the parent "has to straighten themselves out first".

In our service the woman is our client and her recovery is our focus. This can mean she forsakes her children if the obligations or worry regarding her children seem to compromise her recovery. Making decisions regarding care of children, for example 'putting up with' a poor relationship, accepting financial support, even fighting to get children back, can be framed as 'selfish' and not in keeping with recovery. In one case recently it was thought that doing these things to care for a grown child was not in her interests, that is, in the interests of her recovery. Even in a residential facility for woman and children like ours, it is not child focused. The mother is the client and the children come too. In fact although we have the capacity, we don't even have as many women and children stay here as we could, which is interesting. (Service worker)

It seems that services had extremely limited referral options for families. Services for fathers and their children seemed not to exist. It seems expected that parents will find alternative arrangements for their children while in residential treatment. Given the context of their parenting, this could mean a DoCS placement. The lack of attention paid to parenting in AOD treatment means parents may leave treatment somewhat recovered but with no greater parenting ability or attunement to their children. The effects of parental AOD use on children are not addressed. Even at services that were said to be for parents and children, many clients did not feel well supported in their parenting.

They say they're child friendly but it's not. Mothers here are more stressed. There is nothing for them (the kids), no TV, they're stuck in the house unless they go to school. There's no program for them. They go into a playroom when the mothers are in groups but they're bored. One mother

took off 'cos her 7 year old was bored witless. One boy has hungered for attention. He is better now that another kid is here. But they are desperate to watch TV. They put pressure on mothers to keep the kids occupied and be a good parent, while the parent is sick and that's why she's here. They have to do chores, like they're in the kitchen but the kids are in there too screaming and the parent will be in trouble if dinner is not done. It is really unfair for parents and children. Others are not allowed to give help 'cos it's their responsibility. Parents are really stressing and others are upset by it. I miss my kids. I hear a girl is coming in. There were boys before and that was ok. I don't know if I can handle being in here without my daughter. I feel like leaving. (Service user)

Some workers also expressed concern about the lack of attention being paid to the parenting needs and vulnerabilities of people with AOD and mental health problems.

Many staff are not parents themselves. No one is in tune with the dynamics and family relationships. They see it only in terms of recovery, perhaps at all costs. (Service worker)

We really need more mental health services in the community, especially with mums. There is only one service that I know that deals with mental health services particularly for mums. So I think that is a huge problem. (Service worker)

All of the clients interviewed in this study reported significant sexual, emotional and physical abuse and neglect throughout their childhoods, although almost none had had any intervention by statutory bodies. Some identified the intergenerational links, and a certain helplessness about breaking the cycle without someone (outside the family) showing them how.

I'm thinking even with DoCS, when they intervened with my son...it's gone from grandmother to mother to my son. My son knew I was using and I had no idea of the impact of my 'subtle behaviours' on him. Had DoCS shown me what I was doing it would've helped. I didn't get pointed in any directions. It was all about dirty urines and court. I was 16 when I had my son and just didn't know. Not all mothers that use are bad mothers. They need guidance unless the child is in immediate threat of harm. If a service had worked with me I'd have been really willing to break the cycle then. I pretty much gave up hope. It was a really big opportunity missed. (Female service user)

As adults and parents themselves, all client participants had had some level of DoCS intervention with their own children. Generally, they did not report the Department's involvement as a constructive experience. However, rather than reporting that DoCS should stay out of their lives, clients in fact stated their disappointment in the Department, suggesting that it could have been a much more useful resource at a time they knew they needed help.

I have a son, and DoCS intervened, saying I needed clean urines to keep him. They didn't give me any help, no counselling or welfare. I couldn't stop using, and we went to court and he was taken out of my care. All I was told was 'stop using' but I couldn't. I had a DoCS worker, but no counsellor. I was told to stop using or they'd take my son out of my care. They wanted me to go to parenting classes but the parenting wasn't related to drug use. They said do A, B, C, then I did that and there was more to do. I just ended up using. Now he is with his grandparents permanently and I have a relationship with him thank God. I thought he was better off without me. I suffered at mum's hand and I didn't want that for him. But him [son] being taken away enabled me to use more. (Female service user)

Workers were aware that the majority of women with children will have some DoCS involvement,

and that this can create an imperative, albeit forced, for change. However they reported feeling really stumped about referring clients to community services. They were clear about their reporting obligations, but in wanting to offer non-statutory assistance to clients, there were really significant hurdles to overcome.

(In making referrals) It would have been good to have a reliable, free service where people could go. Although probably only the odd one would go at that point, particularly if they have kids. I found that parents were suspicious of free services as they thought they would disclose something that would get their kids taken away. They were less suspicious of a fee for service but couldn't pay for it. There was a poor relationship between D&A and DoCS. D&A services feel that DoCS is biased against methadone users and DoCS feel that workers are too protective of clients. (Service worker)

It was very clear that services for parents and children that focus on the needs of all individual family members, the family as a whole, and the special issues raised as a result of intergenerational abuse and AOD use are almost non-existent. This is despite the fact that the majority of people with a chronic AOD problems will at some point become parents, and in the face of the social and financial cost of the foster system. This is a highly significant service gap, and one that has heart-wrenching social and community implications. Workers who are employed in services catering for families have very mixed experiences; allowing families to seek treatment together does not necessarily mean that they will receive care from trained family workers, or that parents will emerge from AOD treatment with greater attunement to the needs of their children. The following quotes indicate the differences between a service that struggles to really embrace a family focus, compared with one of the rare services who have developed specific interventions aimed at relationship change.

There is drug use behaviour long after drug use stops. Clients don't know about not leaving, about nurturing, their attachments are poor, they have never learnt any other way. I remember one client who used to turn her baby to the wall, who would cry and protest. Everyone was upset by this. It was seen to be her drug using behaviour, rather than her difficulties or ignorance about attachment issues. Workers felt angry with her, rather than seeing her as not knowing any other way. (Service worker)

We work with families and this is unique to our service. I think it takes into account that they are human beings who don't exist in isolation. The effects of their life, and their using, has huge implications for their family, and specifically their children and partners. In most cases, the children are suffering through their using, so we try to show our clients how their children are suffering, and how we can work with their children to make it better for their children. We do a lot of role modelling, we show clients how to treat children with respect, and how they should do the same. (Service worker)

### 4.3.5 Housing

When clients enter rehabilitation services, it assures them of secure housing, sometimes for the first time in years. In some cases they have to give up their housing to enter a lengthy rehabilitation program. This has significant ramifications for those clients, such as adult survivors of child abuse, who are at risk of "presenting poorly" to workers since they do not fit the "one size fits all" treatment paradigm. For example, if a client's conduct is interpreted as a transgression against the moral standards of the service, and they are excluded from the service, their risk for re-using increases immediately. They can lose hope, they can be homeless, they can resort to old habits to secure their life circumstances again.

The link between rehab and housing is very damaging. You can be kicked out of rehab as a result of a breach and be homeless. This re-traumatizes them and robs them of any self-efficacy they may have. These links are very complex. Staff don't always recognize acting out behaviour for what it is. If they don't recognize the trauma in the AOD use then it leaves clients with the sole responsibility. More workers now are alert to the presence of trauma but perhaps are not trained to work with it. (Service worker)

Some services used criteria such as 'secure housing' and 'a support network' as part of their assessment in offering treatment. Services justified using such screening criteria on the basis that treatment could provoke a negative or traumatised response in clients, and services did not want clients to be without back up when discharged. Understandably, services have a duty of care and limited places. However, it is also clear that this therefore excludes many of this population from applying for places in such facilities, a double bind that leaves many clients out in the cold.

One strict criteria is that they need to have stable accommodation when they leave. If they don't have somewhere to go home to, then we always bar them from the second stage of our service. The reason for this is that, if they don't have a place to live, how can they work on these emotional issues? They need to have a stable environment to go back to once they've opened up. (Service worker)

If it (CSA) comes up in my work and the client has some stability, such as housing, some work history, not currently using IV, I would get into the issues a bit more. I am concerned about clients with higher levels of instability. (Service worker)

#### 4.3.6 Conclusion

Worker and client participants in this study noted that the current state of AOD service provision to clients with histories of child abuse was characterised by areas of strengths and areas of weakness. The absence of a linked and integrated approach to AOD and mental health problems was a common theme in clients' experiences, as was the punitive nature of child protection interventions and the absence of general support in relation to housing. It is interesting to note the ubiquity of a punitive paradigm of service delivery across AOD, mental health and family and community services in relation to this population.

In the accounts of workers and clients, the needs of many adult survivors of child abuse with AOD problems (whether those needs are in relation to AOD use, mental health problems, or parenting or housing difficulties) are being systematically construed as evidence of individual failing, rather than as symptoms of abuse, systems failure, or as opportunities for a constructive and potentially therapeutic engagement. The survivor is being constituted as an unworthy or otherwise deficient person by a range of departments, services and agencies that are ostensibly funded to respond to (rather than impose labels upon) their needs. Given that internalized self-blame and shame may be contributing significantly to the AOD use of some adult survivors of child abuse, it is worth reflecting on whether the hegemony of a punitive, stigmatizing approach is inadvertently reinforcing AOD use in this population.

## 4.4 Building a platform of care and treatment: pitfalls and possibilities

Workers and clients had strong views about how AOD services could adapt to the needs of clients with histories of child abuse. This section draws upon their suggestions and considers the practicalities of responding to abuse-related trauma in AOD settings.

### 4.4.1 When and where to intervene with childhood trauma?

From worker and client responses, it was clear that screening for childhood trauma at all service points would be helpful, if only to assist in better referral. However, workers suggested that detox and early rehabilitation are inappropriate places to provide more comprehensive intervention for trauma experiences, and for a range of reasons: the limited duration of service contact, the lack of training for workers in such facilities, and the fact that clients often have pressing and immediate survival needs at this point. Workers argued that, without a context that provides for physical and emotional safety, clients may not have the capacity to tolerate and benefit from a trauma-focused intervention. However, workers indicated that there is still an argument for staff being mindful of the likely presence of abuse-related trauma and taking it into account in case planning as an improvement in treatment for this client group.

At detox I don't think it is appropriate [to discuss/raise abuse] as most clients are intoxicated. Perhaps later in their detox it could happen to factor into referrals. It needs to be carefully done at this point. Their next step is rehab. It would be good to be aware of it, but not to go into it. (Service worker)

I've talked about trauma in the context of dysfunctional relationships and child sexual assault. But we've got a limited amount of time. Three weeks. So it's not an ideal situation — you don't want to open up some old wounds and then kick them out a short time later. (Service worker)

People also need stability in their lives. Many don't have basic housing or food. Clients have to have their lower needs met before they can focus on their history of abuse. You need to start focusing on Centrelink, housing, physical illness first. (Service worker)

A number of workers suggested that rehab was a more appropriate setting for abuse-related interventions, although they felt that a number of barriers to therapeutic treatment exist in rehabs as they are presently configured. Workers concerns centred around the limited role and skills of staff, and achieving privacy within such a public setting.

I don't hear that clients engage well with any counselling at rehab. I don't know if this is because they don't click or there is a skill set problem. At times it is really a check-in focused on 'are you ok, you're on dinner roster tonight', and it's called counselling. (Service worker)

Stuff comes up here [rehab] and it is the opportune time to deal with it. However, having it on site can reduce a sense of privacy...everyone knows everyone's business. Maybe people don't disclose because workers appear in different roles: counsellor, group worker, facilitator of house meetings etc. (Service worker)

Within the dominant AOD service paradigm, service users are expected to fit into the facilities' regime and tolerate the open discussion of their histories amongst staff and clients. Material relating to their clients lives and histories are often bought up and explored in groups and individual counselling in

ways that are not transparent or negotiated with the client. For people with a history of abuse, such experiences may be very reminiscent of other boundary violations. However, workers indicated that if clients complain they can be seen to be “not with the program.” Even in rehabs where therapy is available, underlying issues relating to trauma and abuse may be overshadowed by a range of life issues.

Rehab is the point to intervene in childhood issues. Therapist support is available daily rather than once a week. Women in this client group need that much support. They have issues with current sex work, self harm, mental health, and physical illnesses such as Hep. C, financial problems, homelessness, aren't / think they aren't employable, have the threat of jail. Amongst the Aboriginal women there is also the cultural shame. (Service worker)

#### 4.4.2 The importance of the therapeutic alliance

Most clients indicated that the effectiveness of treatment has been, for them, determined by a combination of their readiness and a good fit with a practitioner. While this was most often a counsellor, it could also be a case worker or, in a number of cases, a GP. This is supported by research by Lambert (1992) and replicated by many research studies since (see for example Sue & Sue 2008; Sprenkle, Davis and Lebow 2009) which suggests that the therapeutic alliance is the greatest contributing factor in therapeutic change, accounting for 40% of the variability. Clients wanted more than a professional with the right skill set; they wanted someone they felt they could relate to and trust.

I saw lots of other counsellors a couple of times each, but it didn't click. I needed things to make sense. I have good intuition, and it needs to resonate with me. (Male service user)

Some clients described a particular professional who had been central to their recovery. In their descriptions of these key professionals, they emphasised the importance of the worker's awareness to abuse-related issues and a commitment to their wellbeing.

I got a referral to a GP who I really trusted and I talked to him about the issues and he gave me a good referral to a psychotherapist. I'm still with him now and we're finally getting somewhere. I haven't drunk for 2 years. I feel I could have a drink now and it wouldn't be a problem. We're dealing with the issues now. (Male service user)

Obviously the GP I saw had awareness. She asked questions which led to a good referral. People could benefit from health professionals generally having greater awareness of risk taking behaviours, that there can be more to it. (Male service user)

Residential programs are really important. My therapist is studying me, and I need to be studied. I know she's there for me. P&P—I also found a good one. He was passionate about helping people. Finding the right person has been important to me. (Female service user)

In these quotes, clients were responding to the interpersonal as well as the professional skills of particular workers. They indicated that finding a worker that they “fit” with was a turning point in their treatment and recovery. However this “fit” was not solely the product of the interpersonal particularities of a worker and a client. It seems that the development of a therapeutic alliance can be promoted by contextual as well as interpersonal factors. For example, in the following quote, a worker suggests that her service is particularly good at developing working relationships with clients, and she expresses her frustration that this alliance cannot be “transferred” to other workers or services.

The clients with a good therapeutic relationship here, well three quarters of them say they'll do

long term work. I provide a referral, they go two times and often say 'it's not working'. I don't have any idea why this happens. If they've had a good experience here then it is very normalizing and you can convince them they could try someone else. (Service worker)

In services that promoted a more individualised and compassionate relationship between workers and clients, it seems that effective therapeutic alliances were easier to establish, particularly with those clients (such as abuse survivors) who can experience frequent problems in establishing and maintaining interpersonal relations.

#### 4.4.3 Internal and external service options

Workers stated that, if specialist intervention for childhood trauma was to be available to AOD clients, a great deal more staff training would have to take place. They also indicated that such specialist interventions should be supplemented by greater availability of skilled counselling in the community. Workers suggested that, for AOD services to be more responsive to the needs of adult survivors of child abuse, there was a need for greater capacity for therapeutic work within the AOD sector *as well as* outside it. They suggested that such a multi-level response was important for client choice and client privacy. Clients own experiences and views reinforced these recommendations from workers.

In worker's accounts, the benefit of an increased level of specialist assistance in-house was related to facilitating stability and readiness with the client so that there is a greater chance of a treatment being safe and successful.

Some inpatient service is important. If the person is not confident in regulating their emotions then you don't want to trigger ongoing using. If you start treatment in-house you have a better reading of whether the client is stable enough to do the work. Many can then be referred to community based services. Others can be monitored further and then referred on. (Service worker)

Being seen to be a useful resource for crisis issues or symptom management can be an important bridge into more comprehensive assistance. In their current and constrained contexts, workers were making informed assessments about what they could realistically achieve with clients with complex needs, in the hope of drawing the client into longer-term work.

I try and look at what we can reasonably do. What does the client want and need? If I have a heroin using client who can't turn up to sessions, who is in sex work, I might know there are trauma links but if the client is hardly here and on the nod when they are, then my focus is to try and get her into treatment and a Doctor here for a Pap test. I think that if you can set up an encounter where the client can have a good experience, then maybe you'll have the client coming back. (Service worker)

In the experiences of both workers and clients, staff members in many AOD services do not understand or recognise the effects of trauma. They may also respond fearfully to a disclosure. In AOD services, it seems that adult survivors of child abuse face frequent minimisation and invalidation of their traumatic experiences, either through outright dismissal, or through a seemingly commonplace 'rule' that you have to work on things in a particular order, leaving trauma last.

The link to trauma (for these clients) is not necessarily seen across the board. I see the link. I don't think services could currently accommodate more of an emphasis on trauma, especially as they don't employ therapists who could deal with the information. (Service worker)

Some get flashbacks and so on straight away and we need to ground them, help them feel safe, process at their pace. If it (abuse) comes up you need to work with it. Whether it comes up directly in the 6 months here or not, so many women have experienced trauma you need to be trained in it. However, we suggest that their biggest priority is living without D&A. Ideally we work with both but it can be de-stabilising if the focus instead becomes the trauma. (Service worker)

#### 4.4.4 Generalist and specialist services

Worker's experience is that those clients who are seeking assistance in relation to CSA often balk at a sexual assault service. It is too confronting to have that level of focus and assumed readiness to explore such a painful experience, especially in the absence of knowing who their new worker might be. Clients and workers also saw the issues as so complicated and interwoven with other present-day factors and circumstances that a generalist service would be both more appealing and a better fit. A generalist service could, at its best, also attend to welfare and other social and educational issues.

I wonder if clients find it a lot harder to turn up at a single issue service, and whether 'going for counselling' is easier. Maybe too the hospital system is another institution that is hard for clients to attend. I have noticed that clients who have a positive connection with a GP will often accept a referral on to mental health better, and that first point of contact being more general ... like a GP ... can lead to a more specialized referral after more work. (Service worker)

I usually go with public services — hospital based or community health — for generalist counselling. I have referred to sexual assault services but people don't usually take it, I don't know why. I hope it is because they see their problems as broader and it's not a matter of just playing out CSA. Perhaps thinking that is all I'll talk about such as the details etc is too hard (at a sexual assault service). (Service worker)

I've never had anyone accept a referral to a CSA service, either women or men. Those who are chaotic are hard to refer anyway, and are even hard to engage here. Even those who are not chaotic don't want to open that can of worms. We explore around the issue ... 'that thing in your past'; situate it as an antecedent and make links without delving into the trauma. (Service worker)

When the client wishes to pursue issues relating to abuse further, some workers said that taking clients to the first session with a generalist or specialist service can be important.

It is a scary thing to do to go to a stranger to talk about something shameful. They feel guilty and embarrassed...it is a very hard thing to do. And on top of that it is really hard to navigate the system. It helps to go to the first session with them, especially with a CSA service. Otherwise they may not go at all. (Service worker)

Clients would often like to keep working with the person they have chosen to disclose to, so bridging to the secondary service via referral takes skill. Many clients don't make it, for a whole lot of reasons. Some workers indicated that sexual assault services and counsellors were not necessarily equipped to respond to a client with a complex presentation that includes AOD use.

With a general women's (or mixed) counselling service the clients seem to find it easier to accept a referral, rather than for a sexual assault counsellor. Also, I have had difficulty referring to a sexual assault counsellor if the person is not yet abstinent. Counsellors in these services ask for more readiness than can be expected. Ideally a service would have low fees or be Medicare supported, a multidisciplinary team with a DBT group for issues like Borderline Personality Disorder. (Service worker)

#### 4.4.5 Gender specific services

In this study, both clients and workers were unanimous that gender specific services are crucial in the treatment of adults with histories of child abuse and AOD problems.

The services I have contact with are not gender specific but do deal more with women. They don't want men (using, with criminal charges) on the premises when women are present. Men also don't want to be in the minority. (Service worker)

Counselling services (if there were more) should be separated by gender. Women's trauma is often based on their sexuality so not having men around can be less intrusive. Even a gardener here can be a problem. (Service worker)

I went to some groups [for abuse survivors]. But those facilitators weren't trained and so it was variable how good they were. There were more women, too many for men to feel comfortable, and the women were intimidated by the men being there. Separate groups would be better. In the end, as things didn't work for me, I drew on my own resources, which was gold for me, but may be not for others. (Male service user)

As women's traumatic experiences have generally occurred at the hands of men, both clients and workers have said that it is both provocative and emotionally unsafe for women to be asked to seek treatment in the presence of men.

I'm glad that services are all women because it is the only way I could talk about my past experiences — if services are mixed women are inhibited and all sorts of sexual dynamics are set up. (Female service user)

There is definitely something to be said about the emotional energy that exists in a women only service. Women are thinking of that same perspective — not that a man couldn't, but if a man was here it would trigger a whole bunch of new stuff that we'd have to cope with. That we don't want to, because there is an element of safety being around women. I also feel that they share very intimate material that I think would be harder to reveal to a member of the opposite sex — particularly around sexual assault. I think they feel more comfortable and safe doing it amongst women. It's particularly full-on, even for a woman to have to hear it. It would be interesting to talk to the clients about this — there are lots of complex patterns of transference and counter transference. We often get women who are gay women, and it often comes up in therapy — who they are attracted to in their unit, what's appropriate and what's inappropriate — the boundaries and all this. Having a women only service gets rid of that for a lot of clients. (Service worker)

There is a dearth of therapeutic men's services. As one worker said:

I recently tried to find a service for a male CSA survivor, and it is hard enough for women, almost impossible for men.

However, as for women who have been abused, there is an argument for separate services for men.

Yeah, it was important to me that there were services for men. I had done all this work and was better but still didn't feel good. It was only (later) these repressed memories came up about my

(female relatives). My sexual abuse had been at the hands of women, so for me men were a lot safer. (Male service user)

Workers and clients indicated that those services that do exist for men often seemed to have a culture that perpetuates rather than challenges the male stereotypes about the nature of problems, feelings, trauma and change. For example, clients told us that men's services are particularly lacking in terms of treatment and counselling, and seem to reinforce negative male stereotypes.

I was really scared. It was hard as there were a lot of crims who were bonded to there. Some people who'd never been exposed to that came out criminals. It was really harsh, and I'm quite sensitive. (Male service user)

In (a men only) rehab you need more therapeutic stuff. In a lot of those places you have to be tough to defend your turf. They're a bit like a prison. A lot of the staff were ex-residents. It would've helped me to have a counsellor there, but it (counselling) was very limited. There was one guy ... but he was so busy I couldn't get to see him. The groups were everyone telling their stories. It was really intimidating. (Male service user)

It (CSA group for men) had a prison type vibe. The group was too big, about 20 men. It was way too confronting. I wanted to talk and I needed smaller groups and more skilled leaders. (Male service user)

It is clear that men may experience particular difficulties in relation to seeking help for childhood trauma. There is a stigma in relation to vulnerability and fear about how childhood abuse reflects on their adult sexuality. The defences they form to survive can make it harder to elicit help.

There are so many barriers to men getting help: financial, leaving jail, men found it difficult to work more deeply on emotional issues, the view of society tends to be that women can seek counselling. Men find it harder to identify that they have been victims and seeking help is extremely difficult for them. There needs to be help tailored to men's needs. (Service worker)

They (men) would cope with the abuse by being violent or perpetrating the behaviour as well. There was nowhere to refer men like that. It was difficult to work with them as a woman. Men like that talk about the abuse with such intensity, both the events and the description of it is more violent in speech and in mind. It makes it hard (as a worker) to sit with it. (Service worker)

The man I'm thinking of was quite reluctant to go to counselling at a sexual assault service. He preferred to talk about it (his difficulties, the CSA) in relation to his depression. He wasn't depressed, but he found this a more acceptable thing to call it. (Service worker)

#### **4.4.6 Developing a culture where expertise and skill is fostered and nourished**

The AOD field has as a somewhat unique characteristic, with ex-clients going on to work in key treatment and support roles within AOD services. Many staff in the field have their own life experience as their primary credentials rather than professional qualifications. This was considered by workers and clients in our sample as a help and a hindrance. Both workers and clients also felt that AOD staff are insufficiently trained in the ramifications of child abuse, particularly the links between abuse and various symptoms/presentations. They also indicated that staff may be afraid to ask about the past as they don't know how to respond.

The general experiences of the clients interviewed in this study, as well as the critical appraisal of worker participants of their own and other services, suggests that many staff have a singular focus on AOD treatment and its management. Areas outside this direct focus are considered to be a ‘distraction’ from the core work at best and an ‘excuse’ for AOD use at worst. Frequently, staff members do not have access to experienced and knowledgeable supervisors, and so rely on the support and input of their peers. This can become insular and ineffective for experienced workers.

Client’s evaluation of their service experience often highlighted these common problems across the AOD sector, particularly the lack of adequate training and professional expertise amongst staff, and the regimented and punitive regimes established by ex-users.

Problems with AOD services? Staff who used to be residents. They weren’t trained properly but they need professional training. It’s not right what happened to me. (Female service user)

My problems with services? Other patients either paroled or had been in jail and didn’t want to be there. Other addicts had responsibility for running the service which seemed to be ‘slave labour called therapy’ — even the food was out of date. There was no proper 1 to 1 counselling. Instead there was lots of bullying and coercion and lots of intrusion from staff stopping or controlling contact with family and other professionals. Other clients had behaviour problems — and there was no segregation of genders. There were 4 male clients verbally attacking me in the group meeting which made me feel like going and having a drink. I decided to leave when I realised I was pregnant and the staff would not let me see a doctor (Female service user)

Workers also lamented the culture of their own and/or other services. There seemed to be a widespread perception that there was a disjunction between the goals of AOD services (that is, the cessation or stabilisation of AOD use amongst clients) and the knowledge and expertise of many staff to achieve this goal.

For services, it is the unskilled staff, the service demands — for us it is the mandate to decrease drugs and so decrease crime, the ethical issues — if untrained workers tackle this are they doing more harm than good? (Service worker)

Workers highlighted the complexities involved in working effectively with clients with histories of abuse. Undertaking this work, they indicated, required a level of training and professionalism that was rarely in evident in some services. In this study, where programs have been able to fund staff positions that attract people with professional backgrounds, and where intervention reflects current research and best practice, it was clear that their working environment is more stimulating and that workers are interested in and proud of their work. Clients also know when they have heard/experienced something very different from the standard AOD paradigm.

Rehab staff can have an air of quiet desperation and can be quite burnt out, but at (this rehab) there is a hope and confidence that the women can recover. (Service worker)

We are all trained — we haven’t just done basic counselling courses, we’ve got degrees, we’ve got masters, we’ve got specialisations. You know, we are just that much more trained as well, to cope with this. (Service worker)

#### 4.4.7 Staff support

It is well documented that professionals who are working with adults with histories of child abuse can experience vicarious traumatisation. In this study, staff found it valuable to be supported within their workplace by colleagues and management. Where relevant expertise was not available in house, staff members were glad of the opportunity to seek supervision/consultation externally at the workplaces' expense. A small number of workers interviewed in this study were in therapeutic or support roles that were unique to their services (and rare in the AOD sector as a whole); these staff indicated that outside support and supervision was crucial to their effectiveness in their positions. In particular, workers commented on the importance of informal as well as formal debriefing opportunities. This foregrounds the importance of a collegial and friendly working culture in which staff feel comfortable looking for care and support.

Firstly, we are all women. So we have quite an emotional connection that exists between us. We do a lot of informal debriefing, so we can walk out of an intense session and have the opportunity to spill out to the worker next to you, and get some informal support. We do have more structured support and supervision, which happens every fortnight, with a trained psychotherapist. (Service worker)

Although, whenever you need it, it's there — you can always call on our manager. She's very good at providing that support to other staff. She's really good at protecting her staff. And making her staff feel as though — even if we are doing something that we aren't sure is right, it is right, because it's come from the right place. The question is how to make it feel right if it doesn't feel right. She's like a mother hen. So it's a nurturing environment, in and of itself. Because we are all women, and we feel connected. And we all understand how this work can bring up a lot of deep emotional stuff, personally. (Service worker)

We also meet everyday for lunch, where we can switch off from the work. And that kind of feeds you emotionally. We can just laugh and talk about the funny side of what's happening. So there's a lot of informal things, and then there's a lot of formal things. (Service worker)

#### 4.4.8 Sharing experiences with peers

This client group found involvement with others with similar experiences to be invaluable. Group approaches are, of course, well integrated in the culture of the AOD community due to the influence of the 12 step programs. In interview, clients indicated that they had found many opportunities to share their problems and their progress. A number of clients suggested that abuse as well as AOD issues were being effectively addressed in group environments.

They might've planted a seed there (in a community based service) but I needed residential, the groups, the other women. There you can have a really good talk but you have to get up and go back to your life and you don't have a life. Here there is ongoing support. Seeds are planted here and you can think it through, feel like you can do things. On the outside it is hard. (Female service user)

With ASCA, I get the newsletters, hear other stories, attend some of the seminars. I have been reading about the ongoing effects and now realise why things have happened, why everything has been a struggle and why I still struggle. One seminar said that children lose their human rights. This fits for me. I didn't know I had any rights. How do you learn that when it has been part of your psyche? ASCA adds more parts of the jigsaw. (Male service user)

I learnt life skills in the groups that I didn't learn with my own family. (Female service user)

It was clear, nonetheless, that group intervention had a limited lifespan for some individuals.

I often found that groups were 'full of the same old stories'. (Female service user)

#### 4.4.9 Treatment is likely to be long term work

Research tells us that clients with a trauma background can benefit from a range of therapeutic and educational intervention centred on living skills, symptom relief, affect regulation and self care, as well as longer term therapeutic counselling. Client presentation is complex.

It is very complex...virtually impossible to say where one issue begins and one issue ends. Whatever the stage in recovery or the method of recovery: methadone, abstinence, forced intervention...it is complicated to tease out the issues. It is difficult to separate out the symptoms of detox.(withdrawal and anxiety) and symptoms related to mental health (anxiety, depression), PTSD etc. After about 2-3 months we see an unraveling of symptoms. (Service worker)

Beyond the difficulty in ascertaining where the AOD and mental health issues, begin, end and intersect, people who have been abused will have many defences in place that work well for their survival but often against their ability to undertake (therapeutic) work quickly. It takes time to undertake a credible and accurate assessment and to build a therapeutic alliance. For those clients with histories of abuse and AOD problems, there may be health issues and physical impairments related to their chronic drug use which will impact on how able they are to respond to many of the (cognitive) treatments available.

The level of cognitive impairment from D&A means that the clients don't always have the insight. Extreme social impairment due to trauma, addiction or both in another complication. This can make it a slower process. Time limited services aren't effective in these cases. (Service worker)

Thus, for all of these reasons, service workers and clients unanimously argued for medium to long term support. This was a need that, in the experiences of both workers and clients, was not being met either within the AOD or mental health sector.

You can't just put the fire out and drive off. You need to address the homelessness. You need to attend to the individual. My main point is that child abuse is an ongoing issue. After an attack of any sort, you're back out of hospital and seen to be ok. They think once the scars have healed and you're back at work you're ok. This needs to be dealt with holistically, see the individual as more than that. (Male service user)

We need to fix the problem not just maintain recovery...which means a temporary fix and then they fall back into what ails them, intergenerational patterns, things never addressed, e.g. the abuse...so people can be more well in themselves, more functional for themselves and their children. With more long term care people are likely to be helped (in these ways). It is the only way to break patterns of long term dysfunction and poor coping with children, with intergenerational drug use as a means of coping. (Service worker)

Clients spend 3–4 years just learning how not to use, restore their health, get a home, work, just settling, and then memories and symptoms etc become more apparent and then they have to pay attention to the symptoms. We tell clients that this might come up. Then it is very difficult to refer. The clients need high levels of skill, money, resources at a level they can't access, transport. They

also need a home environment that is conducive to that work. So many women get half to a third way in the process of healing and get stuck and then end up on medication, scared to go any further, can't go back, stopping the process (of remembering) by high levels of medication. (Service worker)

#### 4.4.10 Networks of collegiality and care

AOD workers must work with other services, given the specific mandate many have, and the brevity of their intervention. The research supports the fact that the needs of AOD clients with histories of abuse are multi-faceted, and so workers need to ascertain inter-service cooperation. However, it was a consistent theme in interviews with workers that orchestrating a referral was very difficult to do. There were a number of reasons for this: long waiting lists, too few services, lack of affordable services and complicated entry procedures. In rural areas, it can be almost impossible to engineer a referral. Clients also prefer to stay working with the person they have connected well enough with to disclose their abuse history. Moreover, clients with histories of abuse and AOD problems require more intensive and specialist mental health care than they can afford.

Referrals don't always work...it's not what they want. They, like most human beings, want to be understood. Perhaps they don't feel safe and trust enough. Perhaps the public services aren't working. Fees are a big inhibitor. Some Psychologists do bulk bill but I need a bigger list of them! (Service worker)

When I refer to mental health I always warn the client about the long waiting lists. I talk to them about private services and while it is easier to access if it is affordable, it is still hard to find someone with D&A and CSA experience. (Service worker)

Staff need more skilled public psychological services (to refer to), but my concern is that these clients can't access them because of financial restraints and advertising — how can they know about them and get there? (Service worker)

Clients and workers often stated that the criteria for service entry could make it almost impossible for the client to succeed in accessing AOD or mental health treatment.

Services tend to be highly structured and our clients are chaotic. The policies of 'miss 2 appointments and you are out' can't work with this client group. Their mental health concerns can make services difficult to access. Their intoxicated presentation is a barrier, and their reluctance to talk about the CSA. The shortness of our program is a barrier. Often people haven't had a positive experience of support before and you just build that up and it's all over. (Service worker)

It isn't easy to find places to refer or to access them. For example you can phone them and you can't get through, as soon as they hear the client is on drug treatment then it is difficult. Some won't take them, feel hesitant, see the D&A as a stigma, don't believe they can work on their issues. And that's just with me calling, let alone if a client rings! (Service worker)

There is the inconsistency in how places are run — one service you ring in at 7am, one at 9 but only Mondays, Wednesdays and Fridays, one you can only speak to one particular staff member and you have to catch them. There is no rhyme or reason, clients just have to jump through the hoops. If they try and get into all of them it can drive them crazy! Some don't want to see you till after you go to court, until you are low dosing, off your methadone, so much abstinence. We need services that can hold the dual diagnosis as well. We need staff who assess for at least anxiety, depression and mood disorders, or who struggle with adaptive functioning, living skills. If you are

cognitively delayed then there is nothing. (Service worker)

In both generalist and some specialist services, there may be limited understanding of AOD client behaviour, which is often exacerbated by their attachment style. Clients often display great difficulty with attachment, engaging in ambivalent and disorganized ways, which services can't tolerate. It is a complicated problem. Services can't leave open places for clients who are regularly non-attending. At the same time, it will take considerable skill and patience to encourage a more regular pattern of service use.

There is also a problem with client punctuality and attendance. It can start out bad, but after coming here they do learn to be able to attend appointments. In a new service they may do this again, turn up with expectations not met, and if they aren't mandated (to that service) then they have no reason to hang in. (Service worker)

#### 4.4.11 Conclusion

In interview, clients and worker participants identified a number of potential areas of growth and development for the AOD sector in relation to clients with histories of child abuse. There was a general consensus that detox was not an appropriate site of therapeutic intervention for issues relating to child abuse, nonetheless screening for CSA was certainly tolerable at this stage, and indeed clients and workers may benefit from being mindful of the impact of childhood trauma. Workers and clients raised general concerns about the inflexible nature of much AOD service delivery and the lack of general training on abuse and trauma within the AOD workforce. Clients identified a range of individual and contextual factors in AOD services that promoted or detracted from resiliency and recovery, which foregrounds the importance of a flexible and supportive service culture as much as the particular treatment modality. Nonetheless, workers often felt constrained in their response to clients with complex needs by the lack of referral options outside the AOD

# Section 5 — Implications for improved practice

This project provides a brief snapshot of the experiences of a small sample of adult survivors of child abuse who have accessed alcohol and drug services as well as a small sample of AOD service workers' perceptions of this group's needs. In particular the research has produced original information identifying the complex issues involved in AOD service provision to adult survivors of child abuse from the perspectives of a client group whose voices are rarely heard in the research literature.

This section summarises the findings of the project and provides a range of recommendations for improving clinical practice and intervention more generally with this client group. We have attempted to ensure that all recommendations are achievable however the availability of funding and other resources clearly affects their implementation. The recommendations are not presented sequentially but rather in relation to the major findings of the project. Clearly a selection of the recommendations and their successful implementation are interlinked. However there are a number of recommendations that could be implemented in their own right which would contribute to the overall goal of improving practice in this complex and challenging area.

## 5.1 Increasing capacity and skills

Consistent with the literature, the research interviews with service workers identified widespread acceptance of the links between childhood trauma and AOD use. Despite workers often implicit acceptance of the co-occurrence of childhood trauma and adult AOD use, their responsiveness to this client group in relation to their childhood trauma appeared somewhat limited. When worker participants spoke about the AOD and mental health sectors, they frequently observed that there was a lack of capacity to identify and treat abuse-related trauma in either sector.

It seems plausible that despite the 'commonplace' links which were generally made, workers either unconsciously or consciously 'tune out' the symptoms of childhood abuse—effectively re-silencing the victims. In practice, this means that they don't or can't attend to the details of childhood trauma because it is not understood to be core business. 'Siloing' of services is not uncommon in many welfare arenas and this type of single focus practice often results in workers failing to address complex or multiple needs of clients. In addition both workers and client participants commented that many AOD services are unresponsive to (and therefore contribute to) emotional distress and negative self-images that are associated with child abuse, which compromised the efforts of clients with histories of child abuse to resolve AOD problems. It is clear that expertise required to respond to the intersections between CSA, AOD and mental health requires specialist training.

**Recommendation:** Funding to be provided to an organization such as ASCA or ECAV to develop and deliver core training packages for AOD and mental health workers on the relationship between child abuse and AOD use.

### 5.1.1 Service screening for childhood trauma

It is likely that intervention for people with childhood and secondary trauma who use AOD is likely to continue to occur primarily within AOD facilities. The findings of this study suggest that increased screening for childhood trauma particularly at the point of detox would be very beneficial for clients.

Both client and worker participants reported that frequently there was a service hiatus between treatment in detox and obtaining a place in an AOD rehabilitation service. For this client group who report that their trauma symptoms escalate, often unbearably, when their prime self soothing strategy (AOD use) has been removed, this service gap often contributed to clients relapsing into AOD use to cope with the escalation of symptoms. While it is clear that identification of childhood trauma may be critically helpful at transition from detox to rehabilitation services, it is also likely that identification in rehabilitation could predict additional support needs during and when leaving residential units.

**Recommendation:** That a simple screening tool be developed that would assist workers in detox and rehabilitation units to identify possible risk of relapse and the support needs of adult survivors moving into the community. Workers could be trained in implementing the screening tool as part of the overall training package in recommendation 1.

### 5.1.2 Knowing where to refer

In this study, it seemed that those workers that do, or would like to, address the impact of child abuse on AOD use struggle to identify a continuity of care for their abused clients, given the lack of identifiable specialized services and workers to refer to. Certainly workers and service user participants strongly reinforced the need to work on creating more bridges between services so attending to client's complex needs can occur seamlessly.

**Recommendation 1:** That a web-based directory of services and workers be developed identifying potential referral options including private, government and community based workers and agencies increasing referral opportunities and identifying options for specialized consultation and support for workers.

**Recommendation 2:** Services for people still considering treatment, or those who will not present at a mainstream service, would benefit from a designated phone line provided by an organisation such as ASCA to provide information, referral and support.

### 5.1.3 The helpfulness of 'knowing and understanding'

Client participants universally self-identified the linkages between AOD use and child abuse evident in their lives, although they qualified this by adding that the linkage was not always clear to them prior to treatment. They often needed a worker to explain how a history of child abuse may have influenced their AOD use. In acknowledging the relevance of the link between AOD use and trauma, clients were not simply parroting or repeating messages they had received from workers. Clients spoke movingly of the overwhelming negative emotions that arose from their experience of child abuse, which they now understood they had attempted to suppress through the use of AOD. These negative emotions were not only a primary contributing factor in their AOD use, but they also affected participant's experience of the helpfulness of AOD services and treatment. Many of the participants noted the importance of making these links to their recovery because the awareness and understanding of these links allowed them to move away from seeing themselves as 'mad' or 'bad'. Moving away from these self-descriptions was seen as a first step to stopping the need to use AOD to cope.

**Recommendation 1:** That web-based information be developed that could provide user-friendly information for adult survivors about the links between childhood abuse and AOD use. This information could also be accessed by staff in AOD, mental health and sexual assault services.

**Recommendation 2:** That further research be undertaken to determine the factors that distinguish child abuse survivors with AOD problems from those without AOD problems.

## 5.1.4 Prevention: Adolescent education

Some clients emphasised the role of education in schools and the importance of being able to discuss the desire to use AOD, and the possible pleasure involved in AOD use, not just providing simplistic messages to ‘say no’. This is just one aspect of clients’ call for more preventative services, rather than an emphasis on picking up the pieces after an AOD problem has become entrenched. The following quotes eloquently explore this suggestion:

We had mandatory counselling in year 10 but it was easily avoided. We needed more education on the desire for drugs, the craving, not just saying no. Also that it is o.k. to get help. Legitimize craving — talk about it. (Female service user)

Everyone is turning up with a fire extinguisher and I needed a smoke alarm. We can build fire proof buildings and have OH&S and every detector possible. We have sprinklers and fire drills, and very little fire prevention. For me, there was no prevention, no smoke detector...I now realise how big the fire was. (Male service user)

**Recommendation:** The development of an information package for year 11 and 12 students to be included in Personal Development Curricula in partnership with School counsellors who may play a role in any disclosure of child abuse during information sessions.

## 5.2 Building capacity

This study demonstrates that adults with histories of child abuse and AOD problems require specialized assistance for their complex needs, and highlights the limitations and failures of being caught between AOD and mental health services when seeking intervention. Both can potentially fail this client group in different ways. Of the two, and within the current system, mental health services would seem to have more tools to attend to the symptoms of trauma. However, this study highlights that within mental health, like within AOD, attention to childhood trauma may be lacking. This client group could be equally disadvantaged, under-treated and misdiagnosed around their core issues within mental health services as they are in AOD services.

By and large, client participants described fragmented experiences of service provision within and across the alcohol and drug and mental health sectors. Despite their obvious complex needs, services worked from prescribed responses and the capacity of workers generally to adapt this response to the needs of specific clients was limited. Clients responded to these constraints in a variety of ways. Some adapted to it, becoming ‘chameleons’ who tried to get what they could from what was offered. More often than not, however, they simply fell through the cracks in service delivery. Since few services are funded or have staff specifically trained to address the relationship between child abuse, mental health problems and AOD use, clients and participants indicated that people with histories of child abuse and AOD problems are rarely having their multiple needs addressed concurrently, and hence are at risk of relapse or dropping out of treatment.

The absence of a joint and/or integrated approach to interlinked AOD and mental health problems was a common theme in clients’ experiences. AOD clients with histories of child abuse would likely benefit from a workforce that is sensitized to the relationship between AOD use and child abuse, as well as from the provision of specialist counselling opportunities, co-located in AOD services and/or available in the community. All those interviewed for this study reinforced the need for more specialized, accessible, professional, community based counselling services. Establishing more specialized positions within rehabs would also be preferable, although building the capacity of existing worker(s) who could

be identified for specialist training and be a nominated agency specialist is an achievable first step to specialized service provision. However, the ways in which confidentiality and role separation is negotiated within services requires thought and sensitivity for such specialist services to be effective. Agency specialists could also be responsible for in-house staff training and for networking with other agencies in their area.

**Recommendation 1:** For AOD agencies to develop and enhance inter-agency relationships and networks with local mental health, community health and sexual assault services assisting referral and opportunities for worker consultation.

**Recommendation 2:** Ensure that AOD and mental health workers have access to core training and web-based information material in childhood trauma and AOD use.

## 5.3 The importance of developing a flexible and supportive service culture

Consistent with feedback provided by client participants on their service concerns, service workers recommended better assessment procedures and for the clients to have more opportunities to choose pathways to change that better fit their stage, circumstances and treatment preferences. Clients identified a range of individual and contextual factors in AOD services that promoted or detracted from resiliency and recovery, which underlines the importance of a flexible and supportive service culture as much as the particular treatment modality. Both workers and clients with complex needs would clearly benefit from a flexible and supportive AOD service culture

**Recommendation 1:** Ensure that workers are provided with competent and skilled supervision commensurate with their needs and the service mandate.

**Recommendation 2:** Ensure that workers are provided with training and development opportunities that advance their work with complex client presentations, and which therefore build service capacity and worker competence.

### 5.3.1 Longer-term intervention and ‘step-down services’

Beyond the difficulty in ascertaining where the AOD and mental health issues, begin, end and intersect, people who have been abused in childhood may have built many defences that work well for their survival but often against their ability to undertake (therapeutic) work quickly. It takes time to undertake a credible and accurate assessment and to build a therapeutic alliance. For those clients with histories of abuse and AOD problems, there may be health issues and physical impairments related to their chronic drug use which will impact on how able they are to respond to many of the (cognitive) treatments available.

The level of cognitive impairment from D&A means that the clients don't always have insight. Extreme social impairment due to trauma, addiction or both is another complication. This can make it a slower process. Time limited services aren't effective in these cases. (Service worker)

Thus, for all of these reasons, service workers and clients unanimously argued for medium to long term support. This was a need that, in the experiences of both workers and clients, was not being met either within the AOD or mental health sector.

You can't just put the fire out and drive off. You need to address the homelessness. You need to

attend to the individual. My main point is that child abuse is an ongoing issue. After an attack of any sort, you're back out of hospital and seen to be ok. They think once the scars have healed and you're back at work you're ok. This needs to be dealt with holistically, see the individual as more than that. (Male service user)

And, to be honest, alcohol and drug services aren't enough — they need more than that. They need long-term support. (Service worker)

Clearly there remains a need for more step-down or medium term support services such as the outreach housing model and community based counselling so that survivors of abuse who have longer term needs have a greater chance of treatment success.

**Recommendation 1:** That services prioritise the referral of adult survivors to longer term counselling services and that they negotiate a longer period of engagement with their funding bodies for identified survivors of child abuse for these referrals to be effectively achieved.

**Recommendation 2:** Further research to identify medium and long-term recovery needs of adult survivors of child abuse who use AOD.

This study also highlighted that some individuals who have been abused and who have used AOD may still be able to function well, work and afford services themselves. It is important that services and workers also have appropriate referral information available for such clients.

### 5.3.2 Implementing a key worker model

All research participants (service users and service workers) were asked to identify the most important service elements for optimum recovery. The results were remarkably consistent. All participants identified a need for a longer time to access services as discussed in the previous section. Alongside this they nominated service safety and security, including the possibility of a central worker to connect to over this longer period of time. They envisaged intervention as necessarily broad, with educational, life skills and counselling components, individual and group opportunities, and the recognition that while there are common needs, every client may also be different.

Service workers and clients emphasised issues of access in service delivery. Commonly this client group have been homeless since their early teens, have little support and few resources to bring to the change process. As two service users below poignantly suggest, a really trustworthy, consistent and available worker would be ideal, indicating how much something akin to re-parenting is desired by this client group, who have so often missed a great many safe family experiences.

An ideal worker is hands on — in touch with all aspects of a client's life, ensures that clients attend meetings, are always available, helps clients do what they don't want to do (like shopping for all of the clients in the house) and help clients do things differently in order to grow. (Female service user)

The genuine interest and concern by staff models good relationships (which I didn't have growing up). A soft gentle environment where there is camaraderie amongst clients helping each other. (Female service user)

Workers too have noted this need, and suggest that it is also more effective and rewarding for them to deliver this kind of support. They suggest that individualized treatment is more respectful, but also likely to be more successful.

There needs to be a central case worker and a long term approach. Clients get overwhelmed with their concerns and it is easy for them to become unhinged, and for service arrangements to become unhinged. It is in the long term that you can attend to underlying issues. (Service worker)

**Recommendation 1:** Clients should be given opportunities to select a primary service provider. In multi-worker services, clients should have the opportunity to get to know staff before being allocated to their choice of worker. In acknowledging the importance of the therapeutic alliance, worker-client fit needs to be understood as crucial to service success, and agencies need to consider how best to operationalise a suitable selection process. Where staff groups are smaller, a mix of internal and external service options could be offered.

**Recommendation 2:** Skilled supervision and clinical management needs to be provided in order to support a focus on the clinical alliance. Such a focus can be complicated to manage in residential groups particularly and will require training for staff to implement, and ongoing support for staff to collectively manage client requirements.

### 5.3.3 Breaking the silence — learning from others

This client group found involvement with others with similar experiences to be invaluable. Group approaches are, of course, well integrated in the culture of the AOD community due to the influence of the 12 step programs. In interview, clients indicated that they had found many opportunities to share their problems and their progress. A number of clients suggested that abuse as well as AOD issues were being effectively addressed in group environments.

There needs to be groups where you can see other people with the same struggles as well as the educational classes and activities. Abuse and violence being openly spoken about as it makes it easier to disclose and talk about the reasons for drinking. In short term you are getting somewhere and getting to know staff and you have to move on. AA is so clique-y and right line — there needs to be an alternative for those not in the ‘in crowd’. (Female service user)

With ASCA, I get the newsletters, hear other stories and attend some of the seminars. ASCA adds more parts of the jigsaw. (Male service user)

I learnt life skills in the groups that I didn't learn with my own family. (Female service user)

It was clear that group intervention was highly valued by all participants although there was a split opinion about the effectiveness of AA and NA models for all clients. The 12 step programs were acknowledged as helpful for most clients in detox and rehab units in the short term but many of the research participants talked of wanting to access group support that moved beyond a singular focus on abstinence.

**Recommendation:** This study has identified a number of support opportunities for community-based services and interventions, as might be delivered by ASCA or similar organisation. Organisations such as this could provide support groups based on the mutual-aid support group model of group work intervention.

### 5.3.4 Gendered responses

Something of a paradox emerged in relation to the question of gender and service delivery. Most (although not all) sexually abused people have been victimised at the hands of men. It is therefore unsurprising that many clients and workers in women-only services identified a number of benefits of working in a single sex environment.

This study identified the dearth of therapeutic services for men, however the literature reinforces that men prefer mixed services rather than male-only services. Currently, services for men seem to be related to after-prison, authoritarian models of care rather than offering therapeutic assistance.

Thus there will be a need for women and men's accommodation (e.g. at rehab) to remain separate for each gender group. However, therapeutic and educational services may be able to be provided for mixed groups where this is chosen by clients. This is a model already in use in 12 step programs, so is familiar to the field.

**Recommendation 1:** Women's services require additional funding to meet the medium-long term therapeutic, educational and social needs of this client group. In particular, services to attend to their (a) generally extensive primary and secondary trauma backgrounds and (b) their parental responsibilities and attachments are crucial and urgently required.

**Recommendation 2:** Men's services are required that provide medium-long term therapeutic, educational and social opportunities. This includes gender balances in staffing where appropriate, and opportunities to link with mixed gender community resources where such services are likely to provide a more helpful experience for clients.

### 5.3.5 The needs of families and children

Given the needs of service users who are parents, and the needs of their children and the generations to come, it is of concern that clients and workers commented on the extremely limited options for effective intervention with families. The lack of family focus reflects the current, pervasive service paradigm of 'change yourself first' with all other needs considered to be secondary, a distraction, or even selfish. (It was very concerning to interviewees that a client's children could be seen to be a "distraction".) Workers within the few existing family-based facilities indicated that current services can't go far enough, can't really hold children in mind, suggesting that family intervention remains a poor second to the individual adult focus. These experienced service workers were unequivocal about this focus needing to change, reflecting a heartfelt desire to make a difference in this crucial area.

Being able to offer more parenting support ... Being able to do that in an outpatient service would be amazing — just having a space for mothers to be able to talk about their experiences. For mothers with difficult childhoods, lots of things are triggered when they have babies. Just having a space to talk about it, to share experiences, and to ... have all that emotional space, just to be their with their babies and talking about what's going on for them. And I guess a halfway house, where they can come and go, and we could provide that care directly. (Service worker)

Services that attend to the needs of client's families and that respect the parenting goals and attachments within families are extraordinarily limited. Clearly the need to break intergenerational patterns of abuse would be in the interests of both families and the wider community. Many of the service users interviewed for this study reported that their parents had either AOD or mental health issues requiring medication, or both. Many had already had DoCS intervention with their own children. Such families are crying out for specialized intervention.

**Recommendation 1:** Increased services for women and their children are urgently needed. Such services need to be truly family focused and utilize child inclusive practices. They will therefore require staff trained in family therapy and child development.

**Recommendation 2:** Resources offered to families are required that respect the integrity of the parent-child relationship wherever possible, addressing children's longer term attachment and care needs.

**Recommendation 3:** In addition, resources offered to families need to ensure a focus on strengths-based parenting education, and to offer access to ongoing family support.

**Recommendation 4:** Services that offer accommodation for children need to offer educational and therapeutic programs for them that attend to their particular needs and experiences.

**Recommendation 5:** Research needs to be undertaken to ascertain the needs of fathers and their children.

## 5.4 Understanding AOD as self-soothing or a coping mechanism

In the accounts of workers and clients, the needs of many adult survivors of child abuse with AOD problems (whether those needs are in relation to AOD use, mental health problems, or parenting or housing difficulties) are being systematically construed as evidence of individual failing, rather than as symptoms of abuse, or as opportunities for a constructive and potentially therapeutic engagement. The survivor may be constituted as an unworthy or otherwise deficient person by a range of departments, services and agencies that are ostensibly funded to respond to (rather than impose labels upon) their needs. It is interesting to note the ubiquity of a punitive paradigm of service delivery across AOD, mental health and family and community services in relation to this population. Given that internalized self-blame and shame regarding their childhood abuse may be contributing significantly to the AOD use of some adult survivors, it is worth reflecting on whether the hegemony of a punitive, stigmatizing approach is inadvertently reinforcing AOD use in this population.

Further, the current pervasive framework for AOD treatment, so strongly influenced by a medical model of addiction and the 12 step approach, is based on the view that all people with AOD problems fall into the same category: Those who abstain are ‘committed’ and those who continue to use are avoidant and in denial. It is interesting to note the ubiquity of a punitive paradigm of service delivery across AOD, mental health and family and community services in relation to this population. Nonetheless, clients with a trauma background who do use AOD as a genuine prop to survival (albeit an unhelpful one long term) do require a staged approach to drug withdrawal and parameters within which they can still seek treatment without being compromised psychologically. The needs of adults with histories of child abuse and AOD problems call for a general reassessment of the prevailing punitive and moralistic view of AOD use, and a more complex understanding of the role that AOD use can play in people’s lives as a coping mechanism and in particular as a form of self-soothing.

**Recommendation:** Further research to develop a conceptual framework that better underpins clinical understandings of the ways in which the use of AOD is used by adult survivors to manage the effects or symptoms of child abuse in later life.

## Conclusion

The original aim of this research project was to shed new light on the use of alcohol and drugs by adult survivors of child abuse and the challenges that this poses to professional practice in alcohol and drug (AOD) services. The life stories of adult survivors of child abuse and AOD users are often presented in research without the active participation of those individuals. Their stories, their experiences, their expertise on their own lives remains absent from service evaluations as well. This research has worked

with clients and workers from the AOD sector to directly address this research aim and in so doing, this research has privileged and given voice to the experiences of both groups. As such the research has provided unique insight into the intersections of child abuse, adult trauma and alcohol and drugs from the perspective of both workers and clients.

It is intended that this report will be of use to practitioners within the AOD sector, as well as generic counselling services. The research findings and the associated recommendations may be used in strategic planning and training of relevant workers and professionals in allied human services and health fields. As there is no available Australian research in the area, this project makes an important contribution to the Australian and international research field. However further research is required to build on and extend our knowledge about the intersection of these areas and the provision of professional services to this particular client group.

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# Appendix 1

## Client and worker interview schedules

# The experiences of adult survivors of child abuse in drug and alcohol treatment

## QUESTIONS: CLIENTS

1. What sort of help have you needed? How easy/difficult has it been to find the right sort of help?
2. What sorts of services have you found most helpful? Why?
3. What sorts of services have you found least helpful? Why?
4. How have services understood your problems?
5. Do you understand your current difficulties as problems of mental health, addiction, or something else?
6. What do you think are the key reasons you use drugs and alcohol?
7. How much do you relate your current difficulties in life, such as using drugs and alcohol or symptoms of... as related to events in childhood or adolescence? Which events in particular seem important? How have they influenced symptoms of...and drug and alcohol use?
8. What has been the effect of mental health diagnoses/use of mental health services/ medication? Is it helpful to be in the mental health system?
9. As an adult, have you experienced other traumatic or upsetting events that have influenced recovery? In what way?
10. What help, if any, did you or your family get when you were a child? Were DoCS or the police ever involved? What would you like to have happened differently?
11. If you were to give up drug use, what would be the best/most difficult part of your life now?
12. Overall, do you think services you have had contact with have left you feeling positive/negative/unsure about seeking help in the future? Why?
13. What would you like to have happened differently in using services?
14. If one thing could change about your life now, what would you like it to be?
15. If you could invent the best service for people like you, what would it look like? What would your hopes be for such a service?
16. What would be the best sort of worker to help you along the way?

### Note:

- Mapping of difficulties and use of services.
- Age and gender of clients.

# The experiences of adult survivors of child abuse in drug and alcohol treatment

## QUESTIONS: WORKERS

### Demographics

1. What is your expertise/experience in working with this client group e.g. years of service, types of roles?
2. What is your professional background/qualifications?
3. What training have you had, if any, in relation to abuse and trauma?
4. What services have you worked at?
5. Do you have a preferred theoretical framework/therapeutic philosophy that influences your work?

### Service delivery

1. What is your clinical experience in working with clients with a CSA background, drug and alcohol and mental health concerns? What would be a typical client/scenario that presents at your service/s?
2. At your service/s what do you screen for and why do you choose the screening emphasis that you do?
3. In your service experience (current and past roles) how do you see the services you offer as addressing issues of childhood trauma? What difference do you ultimately think it makes?
4. How do you conceptualise their primary concerns/needs in seeking help? How do you see the relationship between their presenting concerns and mental health issues?
5. How much do you think their CSA history is influential in their clinical presentation?
6. What other life trauma seems significant for this client group?
7. How do you prioritise the various aspects of case management? What do you see as the ideal case mix for this client group? What are the barriers in achieving this ideal mix?
8. How often do you refer out, and for what reasons? What services outside of your own do you commonly seek?
9. How successful are your referrals? Why?
10. What do you see as the main difficulties in working with this population? For clients? For services?
11. What do you see as the main service gaps in working with this client group? What constrains you in terms of current programs available?
12. What do you see as the main restraints to your clients' recovery?

# Appendix 2

## Client and worker information and consent forms

## Participant information (service worker) statement and consent form

### Project: The experiences of adult survivors of child abuse in drug and alcohol treatment.

You are invited to participate in a study regarding your experience of working with clients seeking assistance with their drug and alcohol use. The University of New South Wales (UNSW) and the Advocates of Survivors of Child Abuse hope to learn from your experiences in working with this client group, what options were available for referral and treatment, what barriers there seemed to be in assisting your clients to seek help, and what you see may be service gaps or shortfalls. Your organisation has agreed to contribute to the research, and you were invited to be a possible participant in this study because you are an experienced worker with this client group, and are therefore in an excellent position to provide information about your past and current experiences of providing treatment services and/or referral options. This research does not seek to evaluate your current service as such, but more to get an overall sense of your experience working in the field and assisting this vulnerable and complex client group.

If you agree to participate in this study, you will be asked to sign the Participant (Service Worker) Consent Form. We will then invite you to talk about your work experiences in relation to providing treatment/referral. A researcher who is also a counsellor will interview you, and with your permission, tape the session and/or take notes from your discussion. It is expected that interviews will last approximately 1 hour. All identifying information will be deleted from the notes. You will have the opportunity to see these notes later and you may have a copy of them. At a later date some aspects of your particular work experience may be written up as a case study (maintaining complete confidentiality). Again, participation in this is entirely voluntary. Following the individual interview, focus groups may be established to further generate reflections and discussion on service experience and to explore new service ideas, based on your collective expertise.

Although we cannot offer any immediate benefits to you, the participant, we hope that an increased understanding of the workers and systems assisting people who have experienced abuse as children and who have later struggled with drug and alcohol addiction will better inform the practice of professionals and policy makers who have an interest in this area.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential, and will be disclosed only with your permission, except as required by law. If you give us your permission by signing this document, we plan to publish the results in journals, present results at professional conferences, and to furnish a summary of the results to participants. In any publication, information will be provided in such a way that you cannot be identified.

### Ethics approval and complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote the protocol number X08-0280.

The conduct of this study at the MERIT and Adult Drug Court services within has been authorised by the Sydney South West Area Health Service. Any person with concerns or complaints about the



## Service worker consent form

**Project: The experiences of adult survivors of child abuse in drug and alcohol treatment.**

I, ..... (name)

of ..... (address)

have read and understood the Information for Service Worker Participants on the above named research study and have discussed the study with

.....

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

.....

Name

.....

Signature

.....

Date

.....

Nature of Witness

.....

Signature of Witness

## Participant (client) information statement

### Project: The experiences of adult survivors of child abuse in drug and alcohol treatment.

You are invited to participate in a study regarding your experience of seeking assistance with your drug and alcohol use. The University of New South Wales (UNSW) and the Advocates of Survivors of Child Abuse hope to learn about your past experiences of seeking help, the triggers that brought you to seek help, and what you might need in the future. You were invited to be a possible participant in this study because you are a current client of a service taking part in the research and are therefore in an excellent position to provide information about your past and current experiences of drug and alcohol and other treatment services. This research does not seek to evaluate your current service as such, but more to get an overall sense of your experience seeking and receiving help for your personal concerns.

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. We will invite you to talk about your life experiences in relation to disclosure of problems, current and past and any past attempts you have made to get help for yourself from services such as drug and alcohol, counselling, and so on. A researcher who is also a counsellor, **not** your own counsellor, will interview you, and with your permission, take notes from your discussion. It is expected that interviews will last approximately 1 hour. All identifying information will be deleted from the notes. You will have the opportunity to see these notes later and you may have a copy of them. At a later date some aspects of your particular situation may be written up as a case study (maintaining complete confidentiality). Again, participation in this is entirely voluntary.

Risks to you are minimal, although participation may prompt you to think about issues that may or may not be clear for you. Although it is most likely that you will have thought about the focus of the interview, it is possible that the discussion may introduce new ideas or stimulate further thought in this subject area. If you experience any discomfort you will be offered a consultation with your own worker/counsellor as soon as possible.

Although we cannot offer any immediate benefits to you, the participant, we hope that an increased understanding of people seeking services, such as yourself, who have experienced abuse as children and who have later struggled with drug and alcohol addiction will better inform the practice of professionals and policy makers who have an interest in this area.

Any information that is obtained in connection with this study and that can be identified with you will remain confidential, and will be disclosed only with your permission, except as required by law. If you give us your permission by signing this document, we plan to publish the results in journals, present results at professional conferences, and to furnish a summary of the results to participants. In any publication, information will be provided in such a way that you cannot be identified.

### Ethics approval and complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote the protocol number X08-0280.

The conduct of this study at the MERIT and Adult Drug Court services within has been authorised by the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study may also contact the Research Governance Officer [or other officer] on [telephone number] and quote protocol number [insert local protocol number].

Your decision whether or not to participate will not prejudice your current or future relations with the services with which you are involved. If you decide to participate, you are *free to withdraw your consent and to discontinue participation at any time.*

If you have any questions, please feel free to discuss your participation with your counsellor and/or the project researcher. If you have any additional questions, these can be forwarded via to the researchers using the contact details above.

You will be given copies of this information sheet and your consent form to keep.

**You are making a decision whether or not to participate. Your signature indicates that you have read the Participant Information Statement, and you have decided to take part in the study.**

.....  
Signature of Research Participant

.....  
Signature of Witness

.....  
(Please PRINT name)

.....  
(Please PRINT name)

.....  
Date

.....  
Nature of Witness

.....  
Signature(s) of Investigator(s)

.....  
Please PRINT Name

## Participant (client) consent form

**Project: The experiences of adult survivors of child abuse in drug and alcohol treatment.**

I, ..... (name)

of ..... (address)

have read and understood the Information for Participants on the above named research study and have discussed the study with

.....

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

.....

Name

.....

Signature

.....

Date

.....

Nature of Witness

.....

Signature of Witness