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Supporting Women to Access Appropriate Treatment (SWAAT) Study

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GLOSSARY OF TERMS

ABSTINENCE
In this report, abstinence refers to the act or practice of refraining from using illicit drugs or alcohol.

CASE-MANAGEMENT
Case-management is the process of coordinating the care of a service user through a shared care plan and resolving any gaps and blocks that arise.

CLINIC
In this report women may use the term "clinic" to refer to methadone maintenance clinics.

DUAL DIAGNOSIS
In this report, dual diagnosis specifically refers to the experience of mental health difficulties in addition to substance use.

FELLOWSHIP
In this report, Fellowship refers to the society of men and women who are involved in organising and providing Alcoholics Anonymous, Narcotics Anonymous or Cocaine Anonymous group meeting.

GETTING CLEAN
'Getting clean' was a term used by participants to refer to attaining abstinence from drugs or alcohol.

OUTREACH
Outreach refers to services actively 'reaching out' and providing help to those who may not otherwise look for support in the community.

PEER
A peer is an individual who is also engaged in the treatment programme within the community.

PEER-LED
In this report the peer-led treatment model refers to the active engagement of peers in the delivery of treatment in response to harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.

RECOVERY
Recovery is at times used interchangeably with the term 'abstinence'; however, recovery encompasses more than abstaining from substances. As such, recovery is used in this report to denote the women acquiring benefits across a range of areas including (but not limited to): health, relationships, well-being, education, employment, and self-care. It is understood to be an on-going process.

RECOVERY CAPITAL
Recovery Capital is the extent and quality of assets (resources) supporting a person when initiating and maintaining their recovery from alcohol or drug addiction. These assets may be internal (such as close family support networks) and external (accessibility to affordable healthcare).

SEX WORK

Sex work is the exchange of sexual services, performances, or goods for individual compensation or exchange. It is acknowledged that 'sex work' may not the most fitting term as it lacks the implication of exploitation and coercion that some women were subjected to. Many key stakeholders used this term throughout their accounts, and so it was used throughout the report.

SOCIAL WORK INVOLVEMENT

In this report, it refers to the active and ongoing input of the discipline Social Work in the care of the child and or parent.

SUBSTANCE USE

In this report, women were attending treatment for substance use, thus they were engaging in harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.

EXECUTIVE SUMMARY

The number of women reporting drug and alcohol use in Ireland is rising steadily. In addition to this worrying trend there are concerns that women are less likely than men to attend drug and alcohol treatment services. International evidence suggests services struggle to respond to the complex needs of women who use drugs and alcohol. Such needs include stigma, domestic violence, sex work, pregnancy, maternal responsibilities, comorbid mental health difficulties and lack of family support.

To explore these important issues further this timely study aimed to gain insight into the experience of women with drug and alcohol treatment needs in two regions in greater Dublin, Ballyfermot and Tallaght. The study employed a combination of qualitative methods including in-depth qualitative interviews with women attending drug treatment services and key stakeholders, a live online community consultation and an online submission forum. The interviews were transcribed verbatim and transcripts anonymised. Thematic analysis was conducted and emerging themes generated. Twenty-two women and 22 key stakeholders participated in in-depth interviews, 28 participants attended the online consultation and 25 individuals contributed to the online forum.

The 22 women attending treatment services ranged in age from 21-61 years. Half of them were attending the service less than two years, while three women were with the services for more than 20 years. Almost all of the women reported experiencing significant trauma at some point in their lives such as domestic violence, abuse, parental drug use, poverty and bereavement/ loss. Over half of the women associated their experience of trauma with their drug and alcohol use. Eighty-two per cent of the women were mothers, many of whom reported concerns around losing custody of their children. Barriers to accessing and attending drug treatment services identified by the women included age, stigma, lack of childcare facilities and lack of information regarding available services.

The data collected from key stakeholders concurred with the themes that emerged from the interviews with the women. In addition to the key stakeholders' concerns regarding the level of trauma experienced by the women and the barriers to accessing treatment they reported an increase in the number of women who were caring for children with special needs adding to the complexity of their situation and ability to access treatment services. The key stakeholders also noted that existing treatment services are disjointed and require reconfiguration. Improvements in interagency communication and team working was identified as a priority in order to provide holistic care to women. The key stakeholders reported the lack of experience among some professionals as concerning. Both the women and the key stakeholders strongly advocated for the development of gender specific treatment services tailored to women's needs around pregnancy, childcare, domestic violence, sex work, co-occurring mental health issues and homelessness. Both groups believed recovery and peer support should be integral components of such gender specific services.

The following are the report's recommendations based on the international evidence base and the study's findings. The recommendations are intended to inform wider policy and practice at local and national level.

Recommendation 1: Develop an adequate trauma informed response for women who use drugs

Recommendation 2: Establish gender transformative, integrated treatment and support services for women who use drugs

Recommendation 3: Establish a working group between Ballyfermot and Tallaght Local Drug and Alcohol Task Forces and the child and family agency (Tulsa)

Recommendation 4: Develop pathways for women to sustain recovery

Recommendation 5: Expand pathways to education and training for women

Recommendation 6: Support women to rebuild and sustain healthy family relationships

RESEARCH TEAM

Professor Jo-Hanna Ivers is an Assistant Professor in Addiction. She leads the Neurobehavioral Addiction Group at the Discipline of Public Health & Primary Care at the Institute of Population Health, School of Medicine, Trinity College Dublin. Jo-Hanna has worked as a researcher in the Discipline of Public Health & Primary Care as part of a broader addiction team since 2009. During this time she has completed several large-scale addiction studies including the evaluation of the National Drug Rehabilitation Framework. Jo-Hanna has specific training and extensive experience in a wide range of research methodologies including qualitative, quantitative, neuro behavioural processes, biopsychosocial intervention and outcome evaluation. She has published in a number of high-impact international peer-reviewed journals and has extensive experience of addiction treatment. Prior to research, Jo-Hanna worked in frontline addiction services.

Ms. Francesca Giulini is a Research Assistant in the Discipline of Public Health & Primary Care at the Institute of Population Health, School of Medicine, Trinity College Dublin. Francesca has worked with Prof. Ivers' Neurobehavioral Addiction Group and has been lead researcher on a number of studies since she joined the discipline in 2018. She has a range of research skills including qualitative, quantitative and neurocognitive behavioural intervention. Before joining the Neurobehavioral Addiction Group Francesca worked as a volunteer at Vitos Forensic Psychiatric Clinic, in Hadamar, Germany working with addicted populations.

Dr. Gillian Paul is an Assistant Professor in Public Health and Health Promotion in the School of Nursing, Psychotherapy and Community Health in Dublin City University. Gillian is an experienced public health researcher with an interest in a range of community and public health issues including maternal and infant health, smoking, chronic illness, loneliness and carers. She has expertise in quantitative and qualitative methodologies and has published

widely in peer reviewed journals. Prior to her academic career she worked as a midwife and a public health nurse caring for mothers, infants and children in hospital and community settings in both Ireland and the UK.

ACKNOWLEDGEMENTS

We would like to extend a very sincere thank you to all the women and key stakeholders who participated in this research. Participating in research can be demanding, particularly when trying to complete a treatment programme, and we greatly appreciate the time and effort invested by everyone involved. A heartfelt thank you is extended to members of the research advisory group for their support and feedback throughout the study.

SWAAT RESEARCH ADVISORY GROUP MEMBERS

The Research Advisory Group (RAG) was made up of the research team, representatives from both Ballyfermot and Tallaght Local Drug and Alcohol Task Forces, and service providers from both communities. The RAG was formed at the outset and remained in place until the final report was agreed. The group consisted of:

- Ms. Sunnivia Finlay: CEO Ballyfermot Support, Treatment, Aftercare & Rehabilitation (STAR) project.
- Ms. Francesca Giulini: Discipline of Public Health and Primary Care, Institute of Population Health, School of Medicine, Trinity College Dublin.
- Professor Jo-Hanna Ivers: Discipline of Public Health and Primary Care, Institute of Population Health, School of Medicine, Trinity College Dublin.
- Ms. Clara Geaney: Co-ordinator, Ballyfermot Local Drug and Alcohol Task Force.
- Ms. Denise Joy: Supporting Women to Access Appropriate Treatment Co-ordinator
- Mr. James Kelly: Manager Tallaght Community Addiction Response Programme (CARP) project.
- Ms. Niamh McGuinness: Senior Development Officer, Tallaght Local Drug and Alcohol Task Force.

RATIONALE FOR CURRENT STUDY

Research suggests that women who use drugs and alcohol experience less social support than their male counterparts. Women who present for drug and alcohol treatment are more likely to have had a family history of substance use and/or partners who are also drug users. Women are also more likely to have friends and family members who support their substance use and are less likely to have active support through recovery.

Thus, gender-specific issues merit significant attention at policy and service levels if women's treatment needs are to be appropriately met. However, in the Irish context, the literature focusing on women accessing treatment remains relatively scant, particularly around their rationale for not attending treatment. The available research highlights how gender can shape, define, and influence access to treatment.

To address this knowledge gap, the current study aimed to conduct a detailed examination of women's experiences, particularly their interactions with treatment and support services. The perspectives of treatment providers and other key stakeholders working at a community level have been particularly important in this study. The specific research aims, and methodological approach are outlined in Chapter 2.

CHAPTER 1: BACKGROUND

INTRODUCTION

The use of alcohol and illicit substances can negatively affect the physical and mental wellbeing of a person.[1] While long-term health consequences of substance use vary by substance, they can include heart or lung disease, cancer, HIV/AIDS, and hepatitis,[1] as well as mental health difficulties such as depression, anxiety, psychosis,[2] and increased risk of suicide.[3] According to the European Monitoring Centre for Drugs and Drug Addictions (EMCDDA)'s 2020 annual drug report,[4] approximately 96 million or 29% of individuals between the age of 15 and 64 in Europe have used illicit drugs at least once in their lifetime. In Europe, 38.4 million women reported lifetime substance use in 2020 which represents about 40% of people using illicit drugs.[4] The number of women who reported lifetime substance use has been steadily increasing in recent years.[5-8] Substance use in Ireland is more common among men than women, though the exact prevalence across Ireland has not been reported.[9, 10]

FACTORS INFLUENCING WOMEN ACCESSING TREATMENT

There are gender differences in the way that men and women experience substance use initiation, addiction progression, substance use consequences, treatment access and treatment outcomes.[11-14] While accessing substance use treatment can be difficult for both men and women,[15] women consistently under-present to substance use treatment services.[13, 16, 17] It is estimated that less than 10% of American women aged between 18-44 years receive treatment services when needed.[18] In Ireland, most people who use drugs are treated in the community and only three in ten people accessing services for substance use are female.[19]

It is likely that the small number of women receiving substance use treatment is related to sociocultural factors hindering women from accessing treatment.[20, 21] These factors can

include stigma,[20, 21] economic disadvantage,[21] maternal responsibilities,[20] low-levels of family support[21, 22] and the inability of services to respond to their complex needs.[20, 21, 23, 24] Furthermore, specific groups of women who use drugs such as mothers, those who experience trauma, domestic violence, those with comorbid mental health difficulties,[13, 15] and women who engage in the sex trade report particular difficulties in accessing substance use treatment services.[25]

STIGMA

Stigma refers to the discrimination and negative attitude towards individuals based on a distinguishing characteristic and is commonly experienced by men and women who use drugs.[26] There is a public perception that people who use drugs are 'dangerous', 'unpredictable', unable to make their own decisions regarding treatment or finances and are to blame for their addiction. These perceptions have a tendency to influence service providers and policy makers in terms of how they interact with this population.[26] While both men and women who use drugs experience stigma the experience is gendered due to drug dependence challenging social and cultural expectations of women as nurturers, mothers, daughters, sisters, and caregivers.[27, 28] Women who use drugs report significantly higher levels of stigma than men.[29] Fear of stigmatising experiences is one of the most reported factors hindering women who use drugs from accessing substance use treatment.[20, 21, 24, 25, 30, 31]

Stringer and Baker[28] investigated the role of parenthood and marital status had on stigma experienced by men and women who use drugs. While parenthood was associated with a 46% greater likelihood of reporting a perceived stigma event in both genders, further analysis suggested women perceived stigma as a constant. Therefore, women with complex needs including those who are caring for children or other family members, are pregnant or have comorbid mental health difficulties experience higher levels of drug-related stigma.[25, 28, 32-36]

The consequences of intense stigmatisation include low self-esteem, feelings of guilt and shame, exacerbation of mental health difficulties and reduced help-seeking.[24, 34, 36]

Negative attitudes towards people who use drugs are so pervasive that they are not only at risk of stigmatisation from others but also themselves.[35, 36] Women who use drugs experience less social and familial supports then their male counterparts[20, 22] which, in turn, can perpetuate self-stigmatisation.[24] Moreover, women who are engaged with substance use services may feel the need to distance themselves from families and social networks where problematic substance use is still active, thus limiting their supports further.[37] Though family relations can be a barrier to help-seeking a qualitative analysis of family dynamics by Goldberg et al.,[38] suggests that family relations are more frequently cited as motivational or facilitating factors. In addition, positive and accepting relationships with service providers and family members can decrease self-stigma and feelings of shame, while promoting recovery.[37]

Dermody et al.,[39] interviewed 25 women who used drugs in Limerick and reported that more than two fifths of participants were concerned about being judged when presenting to healthcare providers. Furthermore, research engaging vulnerable populations that intersect with women who use drugs, such as women who are homeless[40] or women who engage in sex work[41] have also highlighted experiences of negative attitudes and stigmatisation. Golden et al.,[42] investigated the relationship between the experience of stigma and mental illness in a cohort of 87 patients with Hepatitis C in St. James Hospital in Dublin and found that Hepatitis C is very often associated with injecting drugs, which in turn can correspond with greater reported stigmatisation.[42] Societal stigma and self-stigma, and their negative impacts on women's tendency to seek treatment and support, are recurring themes in the literature.

PREGNANCY

Pregnancy is a gender-specific challenge for women who use drugs. Substance use during pregnancy can have significant negative effects on the foetus and infant, including

withdrawal symptoms at birth and a variety of long-term or fatal consequences in early childhood.[43] The shift in identity to motherhood and increased healthcare access can provide a unique opportunity to engage women in treatment for substance use early in their pregnancy.[37, 44-46] Women who use drugs are frequently motivated by pregnancy to protect their unborn children, leading to higher levels of engagement in harm reduction and treatment-seeking behaviours.[34, 47-49]

However, pregnancy and motherhood can increase feelings of guilt and shame and introduce new fears concerning loss of custody of a child,[37] which in turn impacts on substance use disclosure.[44, 48, 50] In some countries, substance use during pregnancy is defined as abuse of a child due to the potentially harmful consequences to the unborn. This legislative framework puts women who are pregnant and using drugs at risk of criminal charges and consequences.[24, 35, 51] These experiences of fear and judgment not only inhibit mothers from seeking treatment for themselves but may also limit enrolment in early interventions for children who have been exposed to substances in the womb.[50]

Although pregnant women are prioritised for treatment, parenting women were less likely to receive substance use treatment between 2007-2014 in the United States of America (USA).[18] This study reported that pregnant women were significantly less likely to complete treatment than non-pregnant women.[52] Treatment retention may be improved through integrated services that provide childcare, parenting classes, transportation, or housing support.[43, 53] Young-Wolff et al., investigated factors influencing pregnant women's engagement in counselling practices that were integrated into prenatal care and found that younger women, women with lower incomes, and those who were single parents were more likely to engage in counselling.[54] In contrast, women who had more children, used only alcohol, and received substance use screenings later in pregnancy, were less likely to utilise counselling services. The study suggests that integrated prenatal services may be well-placed to provide

access to a hard-to-reach and vulnerable populations of young pregnant women who use drugs.[54]

There is a paucity of evidence and research relating to pregnant women who use drugs and their experiences of treatment and healthcare services in Ireland. Scully et al.,[55] reviewed the implementation of a Drug Liaison Midwife in the Coombe Women and Infants University Hospital in Dublin and while the data is largely descriptive, the authors suggested that a Drug Liaison Midwife may improve the relationship between pregnant women who use drugs and the obstetric and substance use services involved in their care. It should be noted that participants in this retrospective study were already engaged with substance use services when referred to the Drug Liaison Midwife.[55] The limited information available on how pregnancy influences treatment-seeking behaviours amongst women who use drugs in Ireland points to a substantial gap in targeted evidence-informed service and policy development for this population.

PARENTHOOD

Fear of child protection services and loss of child custody is a well-documented and understandable barrier to treatment-seeking among mothers who use drugs.[24, 30, 33, 34, 36, 37, 48, 56] In one study in the United Kingdom (UK), Andersson et al.[33] found that women in recovery were more likely to have lost child custody than men in the same position. Similarly, Canfield et al.[57] reported that 37.5% of mothers in their cohort who were accessing the National Health Service in South London and Maudsley had at least one child in alternative care. Once women were engaged with child protection services, these agencies appeared to stipulate that clients must attend substance use treatment if they wanted to retain custody of their children. As such conditionality is clearly applied as a treatment facilitator by child protection services in the UK.[30, 43]

Mothers who use drugs in Ireland have voiced fear of losing custody of their children as a barrier to help-seeking.[39, 58] According to the *Children and Young Peoples Service Committee*, the Dublin South City constituency had the third highest proportion (6.3 in 1000 children and young people) of children in the care of the Irish Child and Family Agency, TUSLA, in March 2017.[59] Using information from an unidentified drug and alcohol task force area within Dublin, Galligan and Comiskey[60] estimated the percentage of children likely to be affected by parental substance use. They reported that approximately 15-24% of children were impacted by parental illicit substance use and 14-37% of children by parental alcohol use. In 2019, TUSLA published national practice guidance addressing hidden harms to children living with parental substance use clearly indicating mothers who use drugs as a population in need of support. [61]

PARENTAL RESPONSIBILITY

Internationally, women are disproportionately responsible for the care of children.[20, 21, 56] Mothers and pregnant women who use drugs are frequently unemployed, single parents,[34] without stable housing and with a history of domestic violence.[57] Without a safe space for their children, services are often out of reach for these women[25] and childcare provisions in addiction services are lacking.[25, 28, 35-37] Mothers who use drugs may experience concern and anxiety about being separated from their children during treatment and could benefit from services that allow for the presence of children, provide additional services for children, and/or include parenting support.[30, 56, 62] Women's disproportionate family responsibilities coupled with a lack of services that respond to their needs as mothers and caregivers magnify the structural barriers they face when seeking treatment.[20, 21]

Difficulties relating to maternal responsibility are also reflected in the Irish setting. According to the Central Statistics Office in Ireland,[63] 94.5% of those looking after children and managing the home in the general population are women. Insufficient child accommodation in Irish addiction services has been identified as an issue over 20 years ago[64] and remains a

substantial barrier to treatment access and retention for mothers who use drugs.[39, 58] The Coolmine Therapeutic Community's Ashleigh House is currently the only residential treatment service in Ireland where women can bring young children while completing treatment. In 2019, a total of 70 women who use drugs were treated in Ashleigh House, 40 of whom were mothers.[65]

DOMESTIC VIOLENCE AND TRAUMA

Andersson et al.[33] identified that despite women reporting shorter periods of drug use and positive recovery outcomes they experienced lower levels of wellbeing and more adverse experiences, including the loss of custody of a child as well as domestic and sexual victimisation.[13] A 2018 meta-analysis utilising 285 international studies found that domestic violence was significantly related to substance use.[66] This analysis further identified that the relationship between experiencing domestic violence and substance use was significantly stronger amongst women than men.[66] Despite the well-established relationship between substance use and interpersonal violence victimisation,[33, 66, 67] women who use drugs are often turned away from domestic violence services and shelters.[68] Similarly, substance use services are frequently not designed to accommodate the daily realities of women, mothers and care givers who also experience domestic violence.[69, 70] Thus, this population continues to experience systematic barriers to both services. The absence of an integrated model of care and support forces women with complex needs to choose between accessing support for their substance use or for their experience of domestic violence, resulting in many women never receiving support for either issue.[69]

Dermody et als[39] study found that amongst the female substance using population of Limerick, women were six times more likely than the general population to have a history of five or more Adverse Childhood Experiences (ACEs). ACEs included a variety of abuse, neglect or household dysfunction before the age of 18 years.[39, 71] Experiencing four or more ACEs

increases negative physical and psychological health outcomes in adults as well as the likelihood of early death.[71] Importantly, 91% of Dermody et al.'s[39] cohort reported domestic violence in adulthood, compared to 14% of women in the Irish general population.[72] Furthermore, 95% of participants considered their substance use to be at least somewhat related to traumatic experiences in the past,[39] highlighting the need for integrated and trauma-informed care in Ireland.

A domestic violence support agency in Tipperary incorporated a programme of staff training in order to challenge the belief that women who use drugs are potentially violent or disruptive. Morton et al.[73] demonstrated that by combination of staff training, review of shelter policies to minimise punitive actions around substance use, and cooperation with substance use services domestic violence organisations can be better informed and more sensitive to women who use drugs.

MENTAL HEALTH

Throughout Europe, up to half of those who use drugs are reported to also experience mental health difficulties[74] and women who use drugs tend to enter treatment with more severe substance use, and more complex physical and psychological difficulties[36, 43] then men. According to the UK's 'Life in Recovery Survey', women who were in recovery or treatment for substance use reported poorer mental health and lower levels of wellbeing compared to their male counterparts.[33] This corroborates previous studies which suggest that women who use drugs experience higher rates of psychiatric comorbidities including depression,[75] self-harm and suicide attempts.[76] People with substance use and comorbid mental health difficulties often have more persistent, severe and resistant symptoms then people experiencing either one or the other.[3]

Agterberg et al.,[32] investigated treatment barriers for men and women who attended substance use services with comorbid mental health conditions. The study reported no

significant difference between symptoms of depression, anxiety or trauma-related stress by gender. However, the authors propose the lack of differentiation may be because both men and women had close to maximum scores on depression, anxiety and trauma measures. Treatment barriers were related to depression and stigmatisation such that participants who reported higher levels of depression and perceived stigma also reported more treatment barriers and were more likely to report unmet needs. Women faced greater barriers associated with family responsibilities and mental health.[32] Furthermore, women who were homelessness and experienced comorbid substance use and mental health difficulties reported more barriers to substance use treatment than their counterparts with a single diagnosis. These added barriers included longer waiting times, ineffective experiences of treatment interventions and services that were unable to meet their needs in general.[77]

High co-occurrence of mental health difficulties among women who use drugs has also been demonstrated in Ireland.[39] A report from the Coolmine Therapeutic Community reported that women scored significantly lower than their male counterparts on psychological health at intake[78] which corroborates international literature.[33, 36, 43] The Research Outcome Study in Ireland (ROSIE) was the first longitudinal treatment outcome study for people who use opiates in Ireland. Although the study reported improvements in most of their criteria over time, it did not find a significant difference in mental health measures at the three-year follow up compared to intake.[79] Minyard et al.[80] suggest that mechanisms related to treatment access for individuals with dual diagnoses frequently function on the organisational and staff level. To improve treatment access this will most likely require changes in knowledge, skills, attitudes of staff as well as organisational culture.[80] A recent rapid assessment report conducted in Ballyfermot in Dublin identified a lack of appropriate mental health and domestic violence services in the area.[81]

HOMELESSNESS

Homelessness is associated with not receiving substance use treatment after seeking it.[82] People who are homeless and use drugs in Canada are more likely to report unmet mental and physical health needs.[83] Among women who attended 'Healthcare for the Homeless' in the US, rates of alcohol use were four times higher, and substance use 12 times higher than in the general population.[84] In addition to the previously mentioned mental health difficulties, this cohort of women experiencing homelessness reported treatment barriers including the cost of services, waiting lists, service location and inability to identify substance use services.[77] Women of this population who engaged in alcohol or substance use were highly motivated to address related issues in a primary healthcare setting. [77]

In 2018 the poverty rate for unemployed women in Ireland was 49% which demonstrates an almost 16% rise since 2013.[63] While homelessness is rarely the consequence of a single event, action, experience, or issue, substance use can play a role both in initiation and continuation of homelessness among women.[85, 86] In Ireland, women who are homeless and use drugs are less likely to obtain stable housing than women with less complex needs.[40] This is a significant issue as a lack of stable housing hinders women from accessing substance use services, especially if they have children under the age of 18.[39] In addition, being homeless may compound the stigma experienced by women who use drugs and make it more difficult for them to achieve treatment requirements such as a period of sobriety.[58]

SEX WORK

Similar to homelessness, engaging in sex work is associated with not receiving substance use treatment after seeking it.[82] Women who trade sex are more likely to engage in substance use.[87] Though disclosure of sex work engagement can be helpful in processing both addiction and trauma histories, women of this population report fears of stigma and judgement when help-seeking.[88, 89] Further, women impacted by sexual exploitation and drug use find it difficult

to meet the entry requirements set by substance use services (e.g. negative urine samples), that limit their help-seeking behaviour, access to drug treatment and other supports.[90]

Ruhama is an Irish organisation supporting women affected by sex work. In 2019, 69% of the women contacted by the Ruhama outreach van in Dublin reported issues related to substance use.[91] Women who use drugs and trade sex in Dublin report multiple layers of stigma associated with substance use, sex work and related health issues such as HIV or HCV when accessing healthcare.[41] A review of services for women involved in sex work in the Tallaght area in west Dublin found enough women engaging in sex work in the area to warrant additional services to address their needs.[92] Furthermore, women who engaged in sex work in the area suggested that specialised services for their population should be provided by the Health Service Executive (HSE) and local addiction services.[92]

WOMEN LIVING OUTSIDE CITIES

Substance use is not solely an urban phenomenon. Kramlich et al.,[93] and Stone et al.,[70] have investigated barriers to substance use treatment by women who use drugs in rural areas. They reported that these women experience additional barriers to treatment access such as geographical and social isolation, lack of transportation and the amplification of stigma in small communities.[70, 93] Parenting women living outside of cities were 90% less likely to receive treatment, and 50% more likely to identify access related issues such as opening times and lack of transportation as barriers then women living in cities.[94] While barriers shared by city dwelling women who use drugs and those who live outside cities are exacerbated by not living in or near urban centres,[94, 95] treatment motivations do not differ significantly between the two populations.[47] Whist substance use services outside of Dublin are more likely to be integrated[96] there is a lack of literature investigating substance use services in rural Ireland.

HEALTHCARE PROVIDERS

Numerous recent qualitative studies investigated women and other service users' experiences of accessing appropriate services.[27, 34-36, 45, 69, 90] One of the most reported structural barriers to treatment utilisation was a lack of information regarding what services are available and what supports they offer.[23, 36, 69, 77] Women who use drugs are more likely to seek treatment in a health setting outside of traditional substance use services such as primary care, mental health or social support services.[13, 97] The lack of, or late referrals by front line healthcare workers such as general practitioners or obstetricians to specialised services[34, 36] may be key to understanding limited service awareness amongst women who use drugs. In addition, negative experiences with healthcare professionals are common among this population and may further exacerbate feelings of fear and mistrust, discouraging women from seeking treatment.[24, 27, 35, 75, 98] This highlights the importance of person-centred and informative care in settings where women who use drugs may present,[99, 100] as well as the development of trust between women who use drugs and local addiction services.[23, 101]

In Ireland, women in the general population have reported experiencing difficulty and discrimination when accessing health services.[102] Knowledge deficits in relation to treating people who use drugs among emergency department staff have also been identified.[103] Women who use alcohol in Ballyfermot in Dublin reported that they do not prioritise their own health and wellbeing and that services were not set up to meet their needs.[104] A report launched by the Ballyfermot Local Drug and Alcohol Task Force[104] to support women who use drugs to access local treatment found that while both frontline healthcare workers and women who used alcohol were enthusiastic about the prospect of increasing appropriate referrals to specialised substance use treatment services, the organisation of healthcare services to facilitate this increase in engagement was lacking. The report recommended increasing cooperation between local health and substance use services, including staff training, information exchange and health promotion.[104]

INTEGRATED CARE

Women who use drugs often require more supports than are provided by substance use services, including sexual and reproductive health provision.[27, 35] Women in treatment for opioid use in Michigan, USA, displayed high rates of adverse sexual health outcomes including abnormal cervical smear results (51.5%), sexually transmitted infections (57.3%), and unintended pregnancies (61.2%).[31] While both men and women support the idea of incorporating sexual health services into substance treatment programmes,[31, 105, 106] an implementation study of a sexual health service within an opioid agonist treatment clinic found low levels of uptake.[105] This corroborates findings by Owens et al.,[107] that indicate that although women who inject drugs and engage in sex work generally want to avoid pregnancy, their utilisation of prescription contraception is low, even when they are accessing healthcare. Factors other than availability affect women's utilisation of sexual health services including fear of judgement, fear of child protection services, cost and lack of transport to sexual health services.[31]

CONCLUSION

In order to address the complex needs of women who use drugs as well as specific issues surrounding childcare, stigma and the experience of physical and sexual violence this rapid evidence assessment (REA) located a significant number of studies advocating for gender-sensitive and integrated community-based services.[13, 21, 25, 34, 69] It is clear that integrated treatment services for pregnant women in other countries include childcare, legal system supports, child welfare supports and mental health supports but other practical measures such as transportation and housing supports were less commonly available yet highly valued by women.[108] Women who access integrated services are more likely to report positive outcomes and experiences.[108] Gender-responsive substance use treatment in prisons has also had very positive impacts on recidivism[109] while mothers attending women-only programmes report lower arrest rates and improved uptake of mental health services than women attending

mixed-gender treatment programmes.[110] As such, this REA strongly indicates that a gender transformative and integrated treatment and support service for women who use drugs is likely to report improved outcomes.

Ashleigh House is the only women-specific residential treatment service in Ireland, providing educational and career guidance as well as housing and resettlement support.[111] Recently the Parenting under Pressure programme (PuP) was introduced and evaluated at Ashleigh House [112, 113] and was found to enable parents who use drugs to care for their children more confidently and appropriately, which in turn is likely to have a positive impact on overall family and child wellbeing. Given the strength of the international and local evidence and the paucity of targeted gender-specific and integrated services for women who use drugs in Ireland, this finding is a key backdrop in this study.

Figure 1.1 Key Messages from Literature Review

- Gender transformative, integrated treatment and support services for women who use drugs are likely to report improved health outcomes.
- Specific populations of women who use drugs including mothers, pregnant women, those with co-occurring mental health difficulties, those who experience domestic violence, homelessness and those who engage in sex work consistently report significant barriers to treatment access in the international literature.
- Fear of losing custody of one's child, societal and self-stigmatisation and negative experiences with healthcare providers reinforces barriers to access.
- Primary care professionals have an important role to play in facilitating treatment access for women who use drugs as they are frequently the first point of contact.
- Female engagement in treatment and support services is enhanced when providers offer greater flexibility in their opening hours, the provision of childcare and integrated female-only services while ensuring that healthcare workers are appropriately trained to meet the needs of this vulnerable population with respect and dignity.
- Given the strength of the international and local evidence and the paucity of targeted gender-specific and integrated services for women who use drugs in Ireland, this finding is emphasized as a key backdrop to this study.

THE CURRENT RESEARCH

The barriers to treatment women face in the Irish setting appear to resemble those suggested by the international literature. Though statistical information on substance use and treatment provision in Ireland is available, more specific research on the experience of women who use drugs is limited. Whilst women experiencing homelessness and women who engage in sex work in Ireland have reported experiences of stigmatisation, as well as structural barriers to help-seeking, there is a need for a more comprehensive investigation of the barriers faced by women who use drugs.

The current study aims to increase our understanding of service access among women who use drugs,including alcohol, in Ballyfermot and Tallaght. There are three main research questions: (1) *What facilitates women who use drugs and alcohol to access services in Ballyfermot or Tallaght;* (2) *What hinders women who use drugs and alcohol to access services in Ballyfermot or Tallaght;* and (3) *What can be done differently to support women to access services.*

In order to answer these questions, the research team conducted interviews with women who are engaged in community-based substance use services within the two identified study areas, as well as key stakeholders working with this population. Through the integration of data collected recommendations regarding the provision of services that may make it easier for women who use drugs to access services are provided. It is important to note reference to women who use drugs includes women who use alcohol. Also reference to accessing services includes both specific drug and alcohol treatment services and wider support services such as childcare, family support, employment services and health services.

CHAPTER 2: METHODOLOGY

STUDY DESIGN

The research employed a combination of qualitative research methods to gather data from

1. Women who use drugs
2. Key stakeholders who are directly involved in the delivery of services to women who use drugs
3. Key stakeholders who are indirectly involved in the delivery of services to women who use drugs

AIM AND OBJECTIVES

This evaluation aimed to assess the experience of women with drug and alcohol treatment needs in Ballyfermot and Tallaght Local Drug and Alcohol Task Force areas. Factors influencing the choice of the methodology include the need to draw on a range of experiences from individuals accessing, providing or developing services across the treatment services in both Task Force areas to 'give voice' to participants' experiences.

Objectives of the research:

- To review national and international evidence on women attending drug and alcohol services
- To explore the specific issues facing women in both communities
- To identify how best to increase support-seeking amongst women
- To gain insight into how best to strengthen both communities' capacity to respond to the needs of women
- To collect robust data that will inform the development of new and existing services for women
- To identify any gaps in services for women

- To make recommendations based on these findings

SAMPLING

A purposive sample of women participating in treatment programmes across both Task Force areas were invited to interview and to make a submission online. In addition frontline workers, managers (of both addiction and support services), and other key-stakeholders (i.e., individuals who are not services providers but play a vital role in service provision, policy or community development) were interviewed. It was intended to include participants from General Practice. However, data collection coincided with the COVID-19 pandemic and consequently due to excessive work demands these participants were not available for interview. General Practitioners did however participate in the online written submission.

DATA COLLECTION

Data collection took place from November 2020 to March 2021. Three key questions directed the data collection, namely:

(1) What has worked to help women access treatment for drug and alcohol use in Ballyfermot and Tallaght?

(2) What has not worked to help women access treatment for drug and alcohol use in Ballyfermot and Tallaght?

(3) What needs to be done differently to help women access treatment for drug and alcohol use in Ballyfermot and Tallaght?

DESIGN

A combination of desk research and qualitative research methods were utilised to gather data from women as well as service providers (frontline and management) and other key stakeholders in both communities. The multimodal approach included:

(i) A comprehensive literature review

(ii) In-depth qualitative interviews

(iii) A community consultation workshop

(iv) An online open submission

A major strength of qualitative data is the rich thematic texture that can arise from this type of systematic undertaking. The primary goal was to engage a wide range of stakeholders and offer a number of opportunities to participate in the research. The findings from each of the qualitative methods are outlined in Chapters 3 to 5.

ANALYSIS

Interview recordings were transcribed through a professional transcriber. Transcripts were anonymised and linked only to a participant identification code. Thematic analysis was conducted on the transcripts in accordance with Braun & Clark [114] and Terry et al.[115]
The authors read the transcripts multiple times in order to further familiarise themselves with the material. Each manuscript was then read line by line and coded as suggested in Terry et al.[115] Upon completion of the coding process, codes were reviewed by the authors. Some codes were compiled at this stage due to their similarities. Coding was approached from a deductive standpoint, while the generation of themes was inductive and informed by the research question. This process was completed for all qualitative data before the generated themes were presented.

ETHICAL APPROVAL

Ethical approval was obtained from the Faculty of Health Sciences Ethics Committee, Trinity College Dublin.

CHAPTER 3: FINDINGS FROM QUALITATIVE INTERVIEWS WITH WOMEN

INTRODUCTION

This chapter presents findings from qualitative interviews with women receiving treatment for drug and alcohol use in Ballyfermot or Tallaght. The study set out to conduct an in-depth examination of the experiences of women who use drugs or alcohol with specific consideration to the pathways to treatment. Of particular importance were the barriers and facilitators to accessing appropriate treatment in their community. Twenty-two women were interviewed for the study. Nineteen lived in either Ballyfermot or Tallaght. Three lived in bordering communities but were originally from Ballyfermot. All women who were interviewed for the study were receiving a service in Ballyfermot or Tallaght at the time of the interviews. The COVID-19 government restrictions changed during data collection, thus of the 22 interviews conducted 16 were face-to-face and 8 were conducted remotely via Zoom or telephone. This chapter focuses specifically on thematic findings arising from the experiences of the women.

DEMOGRAPHICS, EARLY LIFE, AND TRAJECTORY OF DRUG USE

The women were aged between 21 and 61 years (average age=38.6years) at the time of their interview. Just under one quarter (n=5) were aged 25 years or younger. All were of Irish origin, one of whom self-identified as an Irish Traveller. The women's childhood descriptions typically referenced a range of difficulties and deprivations, including experiences of poverty, parental substance use and family difficulties.

All of the women used drugs for the first time as children (i.e., under the age of 18 years). The women reported that their first treatment experience occurred either between the ages of 18 – 25 years (n=7) or 26 – 35 years (n=15). Table 3.1 summarises the participant demographics.

Table 3.1 Participant demographics

Participant demographics (N=22)					
	N	**%**	**Mean**	**Range**	**SD**
Age	22		38.6 years	21-61 years	9.40
Time in current service	18		35.8 months	Min 2 months – Max 15 years	51.13
Time with service < 2 years	12	54.55%			
Time with service > 3years	6	27.27%			
Time with service > 10 years	3	13.64%			
Problematic substance use					
Cannabis/Weed	7	31.82%			
Alcohol	1	4.54%			
Heroin	10	45.45%			
Cocaine	7	31.82%			
Crack cocaine	7	31.82%			
Alcohol	9	40.91%			
Benzodiazepines	8	36.36%			
History of Polydrug use	16	72.73%			
History of Methadone	13	59.0%			
Service location					
Ballyfermot	8	36.36%			
Tallaght	14	63.64%			
Women who are parents	16	72.0%			

THEMES EMERGING FROM THE INTERVIEWS

TRAUMATIC LIFE EVENTS

Trauma was a dominant factor in the women's narratives. The vast majority of the women interviewed (n=20) had experienced trauma at some stage in their lives, and in most cases multiple traumatic life events. The women's perspectives on the future were connected to their past experiences and, in particular, their enduring struggles with experiences of violence, abuse or the death of a loved one.

Many women (n=13) shared experiences of abuse, parental drug use and domestic violence, which were central to the initiation and escalation of their drug use.

> *"My mother and father – there was a lot of violence there because my father would have, like that, I would have said at the – now looking back alcohol didn't agree with him. And me mother would have had a dependency on drugs, like, sleeping tablets, relaxing tablets and stuff like that and it was dysfunctional because of all that, you know? So yeah there would have been violence growing up"* (Sharon).

> *"So I kind of got involved, I wouldn't say – I would never say he put it in my mouth or put a gun to my head ..... but it was there and I also used it as a way to cope with what was going on in the house, the control and – it wouldn't even be so much violence, but the threat of violence or the threat of a certain mood and an atmosphere, which was just not good"* (Elaine).

> *"He [partner]was controlling but I didn't see, when I was younger I didn't, but he was quite controlling about every aspect of me. He used to tell me, like, I was fat and ugly and you know when you hear that long enough you believe that and he used to say to me that I couldn't do anything without him, you know. And I heard it for so long that I really didn't think I'd be able to cope without him, you know"* (Marie).

More than half of the women (n=12) experienced multiple episodes of bereavement, including the loss of children, parents and partners. Most of the deaths were traumatic and premature.

Drug use and drug overdose was implicated in the majority of these experiences. The women had experienced enormous grief and loss.

> *"I've a 24 year old daughter and a 19 year old daughter and I buried another daughter in a car crash. I've a four year old granddaughter and I come from a family of five. Me Mam died when I was ten in a car crash and she was pregnant with me brother, it was the night of me Dad's birthday and it was just history repeating itself then when I buried my daughter in a car crash she was 8½ months and it was back in 2001*" (Nicole).

> *"The father of four of my children – [names redacted], they're for [ex partner's name redacted], yeah. Four kids for one fella and the two eldest girls are for two other fellas. Yeah. And the three of them are dead. Why? Drugs"* (Maura).

> *"… I was actually pregnant on [name redacted] from me baby's daddy but he died when I was eight months pregnant. He died in the bed beside me. He would have died from drugs. Yeah, he stopped breathing…"* (Rachel).

> *"I'm 45, I'm – I'm a mother of four. I buried two partners through suicide, and I've been on drugs 30 odd years"* (Michelle).

WOMEN WHO ARE MOTHERS

The vast majority (n=16) of the women interviewed had children. Despite the challenges with drug use the women faced, there was a strong sense from the narratives that they were actively seeking ways to 'get recovery' to improve their circumstances for their children.

> *"I was one of them functioning addicts as they say, but at the end it got really bad and me daughter wanted to live with her Nanny and me other daughter and me sons wanted to live with their dad. They didn't want to come home anymore and I really just wanted to give them a better life, like, so that was one of the reasons why I said 'I'm not – never doing drugs again" (Jennifer*).

> *"Watching me daughter, me 20 year old, struggle with the baby as well. I was, like, 'oh my God if I just give up the drugs I could be there for her', you know? So of course when*

you're using you're blind to all this, you know, but it was – I was getting a bit of awareness from coming up to the NA meetings …" (Marie).

Most of the women were often the only parent in the household (n=12) with little access to childcare supports. Of these, several women (n=8) spoke about the multiple barriers they faced in securing childcare, which directly created blocks for them when attempting to access or sustain treatment.

"…. and like that with childcare you can't –like, what stopped me going into treatment to – for a month or two months was me children ... and it got then to the stage that me addiction got so bad I lost me children anyway, but if I had been able to link into the service and have childcare I mightn't have lost them and I could be, like, eight years in recovery" (Catherine).

"Yeah, the big one for me would have been just childcare. Just, like, even trying to get on a day programme and me son being so young, not being in school .... there's no accommodation for him whatsoever, like, anywhere. It's very, very hard. It'd be great if in every day [speaker's emphasis] programme there was childcare facilities. And that's kind of – I think that's what stops most women from getting clean because of the fact that they have nobody to mind their child while they go into the service…I don't really know what – see, I never had any problems, like, as a – the only thing I would have struggled with was the kids" (Jennifer).

"Now I'm not saying next door but I mean they should be more [childcare] available because they weren't available for me, you know, and local as well because even though I haven't got young children I still – I still needed to look after my family. Oh that's – would have been a big thing for me, I couldn't go into treatment because who's going to take care of me kids?" (Marie).

Despite the fathers playing an active part in their children lives, the primary responsibility for children most often fell on the mothers, often to the detriment of seeking help.

"….they [fathers] can take to the bed. You know, if they want to get clean they can go to treatment, if they want to go away they can go away, you know, even down to – like I remember things even when me and the baby's dad were living together, you know, it

was like 'my head's wrecked, I need to get a meeting'…. And I'd kind of be looking and I'd go 'yeah, alright. Go on'. My own head would be wrecked, I'm here all day with four kids but you need – you know, so it's very kind of self-directed, It really is, do you know that kind of way? Yeah. So I think it's just they've less responsibilities even though they don't" (Paula).

Almost one-third of the women were parenting a child with special needs some of whom expressed feelings of guilt and shame from having an addiction problem while parenting and caring for their child.

"He [son] was very sick when he was a child. I had him at 28 weeks, he was premature. So – and he was diagnosed with cerebral palsy so he had to have all, like, physiotherapy and occupational therapy and speech therapy and I was told he wouldn't walk or talk but he's 6ft 2 now and he can walk and he can talk….But he – when I was in the height of me addiction he was like the mammy, sometimes he used to bring me food to feed – when I lost the other two children he took over as being the mammy in the house" (Catherine).

The majority of women feared sharing their story and seeking help, as the perceived outcome was punitive. For mothers there was the potential threat of losing custody of their children. The fear of being 'too honest' was immediate and direct and acted as a barrier to the women seeking help for drug and alcohol issues.

"That would have been the biggest barrier, thinking that if I told somebody in a professional way that I would be punished, you know, having the perception that if you're a certain way then you're going to be punished for that. So I – I would have had this perception that if I went in to go to somebody they'd say 'oh my God, you're a bad mother', you know, 'actually from what you just done now and what you're doing we're going to take your kids away'….. It's stuff like that that would have stopped me from reaching out and asking for help. Definitely" (Sharon).

"And not to be judged so harshly and not to be threatened with getting our children removed. Or our children not being returned to us quicker ….. because we're being honest, you know, like I can be too honest at times to these type of people that I fuck meself up more. You know, like where first me children were going to be returned to me

in – in six months and now it's going to be twelve months because I was honest about using crack cocaine, not just cocaine, you know. So that can put a big barrier up, you know, or I know there's women out there who are afraid to phone and ask for help for – for the thought of thinking that they are [speaker's emphasis] going to lose their children ..... if they come clean about being on stuff, you know? Even about getting equipment for using drugs they're afraid to ask for in case they're going to be reported to the social welfare – social services" (Michelle).

"*No. Well sometimes when I was really bad I'd be afraid that the kids would get taken off me if I went to someone and told them how bad it was. But they realised how bad it was and anyway without me going to seek help. And then after the kids were gone I got worse before I got better. But no – no [laughs] not really. Yeah, like, I would – I was more afraid that they'd find out how bad I was and that the kids might be taken off me and I didn't want that to happen*" (Catherine).

ENGAGEMENT WITH HEALTH SERVICES

Accessing adequate health services was not easy for the women. Many shared experiences of the challenges they faced in accessing appropriate health services. The women shared experiences of unmet needs, which left them feeling dismissed and let down.

"Health professionals, I suppose it all depends on who you're dealing with as well. Like, some health professionals can be really, really lovely and some can be very judgemental. You know? And like that as well it's all in how you come across yourself" (Michelle).

"I actually started off there and – but what I didn't know was that it was actually for people who were, like, kind of stable and, like, had kind of come out of their addiction or whatever, they were clean. But I was just getting progressively worse and but, like, my keyworker, like, she wasn't great, like, to be honest. She kind of just watched me basically just, like, destroy my life. Kind of sat back…"(Georgia).

"Just not good to be honest because it was, like, 'we hear what you're saying' and it was just 'well, you need to stop smoking heroin and just stick with the', what do you call it the [half laughs] 'with the antidepressants'. But it wasn't helping me to be in the moment, if that makes sense. Do you get me? I needed help, I needed support, I wasn't

getting it off him (General Practitioner]. So it was, like, walked - I walked out the door in tears, like" (Catherine).

The majority of the women interviewed (n=17) were either receiving methadone maintenance treatment or had been in the past. They shared challenges they faced during the course of their treatment. Embedded in their narratives were references to the constraints that clinics imposed and risks to the stability when attending for treatment.

> *"I was on with me private doctor [General Practitioner] and I messed up and he thrun [sic] me down to the clinic, which completely fecked me up, going back to a clinic, which completely just destroyed me, it got me back into mixing with people that I hadn't seen in a long time. Seeing – seeing more dealers, you know, that would be hanging around the Square [shopping centre] or hanging around near the clinics. It got me scoring more, going back to the clinics. You know? And the fact that I – I messed up so badly by getting – by getting thrun off that doctor and thrun onto a clinic it just made me feel worthless and shite*" (Michelle).

> *"And it was methadone, you know, 'well put you on a methadone clinic'. Back then I kind of – I functioned very well back then, you know? So I – I kind of was, like, 'no, I don't want to be on methadone when I'm pregnant', 'oh no, no it'll only be six weeks to eight weeks, we'll just stabilise you. It won't be a maintenance, it'll be a quick detox' and so anyway I agreed. And it wasn't like that at all. No. I didn't – so that was when I was 21 and I didn't get off the clinics until I was probably about 32"* (Paula).

Several of the women (n=6) saw themselves as passive recipients of their treatment programme, which offered little opportunity to exercise power or control with their ongoing treatment.

> *"I've 15 years with the one doctor and he has never asked me have I ever wanted to detox. I'm actually on 90ml of methadone at the moment, I'm on that since it must be since I started on that. That has always been me dose for as long as I can remember and he's never asked me once would I – do I want to detox or do I [speaker's emphasis] want to you know like, or 'it's about time you started kind of coming down'. I think he's just – I think if that – if they, you know, gave you more options or asked you or put a plan in*

place, do you know? So you're not just clean and then that's it and you end up back using because you don't know what to do with yourself. It's all you're used to" (Nicole).

"because like that I was constantly up against a battle of if I went in and I had a flu my doctor wanted to put me back up on methadone and, you know, it was like 'you know, you can't do it', 'no I will do it', 'no, I'm telling you, you'll be back to me and – this is …', giving me all these statistics of the amount of people that relapse. It was awful and like that, you know, at the time you don't have any self-esteem …No. And here's someone in a position of power telling you it's not going to happen. And abusing it to the hilt, you know?" (Paula).

MENTAL HEALTH DIFFICULTIES

Most women recounted past and present experiences of psychological distress and a considerable number reported a diagnosed mental health issue. In addition, several women reported having had experienced suicidal ideation and issues related to unresolved grief and loss.

"But the shame is, yeah, the shame part of it all is because of what the substance does to you is the major factor I think, you know, of the depression and the mental health. For someone actually to feel that bad where the only thing left is – is suicide, you know, you don't want to be going to the school, you don't want to – you don't want to see – you don't even want to look at yourself in the mirror, let alone for your neighbours to see you. Isolate yourself" (Maura).

"No. Not diagnosis, but the reason for me stopping smoking weed was I started getting real paranoid. Like, I would think, I would be sitting in a room with friends and, like, if they looked at each other I'd think 'oh my God, they're talking about me'. Or, like, it got to a stage where, I wouldn't even walk outside the door on me own to go to the shop. I'd feel like everybody was looking at me, so like that would have had a very impact – it impacted on my mental health, like, whereas probably if I was still smoking it I would have been diagnosed with psychosis because I was looking up the early stages of it. But I just – that was just me self-diagnosing myself, so I stopped. But probably, yeah, I probably would have" (Jean).

Several women presented to health services at a crisis point in their lives, which frequently coincided with a deterioration in their mental health. The presentation of a dual diagnosis of mental health and addiction often led to an increase in medication, an intervention that was unhelpful. The lack of cohesion between services meant the needs of the women went unmet.

> *"when I – I was suicidal. The kids were gone and I was just screaming for help and everything – it just got too much for me and I went to the emergency room but the wait – they just put you in a room on your own for hours, so I walked out and they sent the Guards back to bring me back and they just gave me a prescription and sent me on me way"* (Nicole).

> *"I was on my third child and I got – I was very, very badly depressed after me second child. Right. And I – like that, you know, I had gone to me doctor and it was just more medication, just throwing more medication at me. And I knew it – it was kind of a catch 22 because I knew 'that's not what I need, I don't need more medication thrown at me, I actually need help here'. But then on the other side I was so wrapped up in me addiction that I thought 'yeah, great, gimme the medication'*. So!" (Paula).

> "*... but the problem was with mental health and addiction they don't go together. As in if you're looking for help, so I was caught in between and I think that's something that really needs to be looked at. So if people have mental health issues but are also maybe stable on their methadone and they're doing really well but they've got mental health issues, that maybe we need to bring the two together. Because they just won't take you in because they can't – whatever the rules or the laws are maybe they can't …. I don't know. But I just find that there is a gap there with mental health and addiction"* (Elaine).

STIGMA AND BARRIERS TO RECOVERY

More than two-thirds of the women (n=14) expressed feelings of stigma, shame and judgement due to their drug use. Community ties were often tenuous, and the perceived feeling of judgment overshadowed the thoughts of sharing their story in the hope of getting help.

"*It really is – it's more anxious about what – where people think. Like, it isn't set up for us [women] and especially around here it's like you're frowned upon, you're called 'oh she's dirty', you know, like, 'she's a junkie. She's this, she's that'. So I think it's – women kind of keep it private whereas men are going around and they'll speak about where or what they want. Like, I – me personally I wouldn't. My experience with my friends I know they wouldn't*" (Jean).

"There's a lot of stigma …. attached to it, you know. And even coming from me own story, you know, my – my thinking around it before I'd any awareness, you know, was 'well I can't actually say', you know, 'because me kids will be taken'. Or, you know, 'what will people think?', you know. So there is a lot of that as well, you know like, people, secret users, you know that kind of way, that they're terrified to put their hand out for help" (Paula).

"I lost pretty much everything over it[addiction], my child, my dignity sometimes, things I had to do to get the money for it, which I won't go into at the moment. The only thing I have left, and I'm really holding onto it by a string, is my accommodation so that will probably go next" (Noelle).

"Yeah it did affect my help seeking because, again, I was terrified to say that I was .... you know, a mother that was struggling. For some reason the perception I had was that you become a mother then, you know, you do nothing wrong and you just be a mother and, you know, you don't put a foot wrong and that's where it kind of all went wrong for me, it was this expectation of meself. So yeah it did to me because I felt I had to be a certain way because I was a mother. You know, but still human at the end of the day with or without kids so that's the difference" (Sharon).

In addition to stigma the women spoke about the struggles they faced in recovery. One woman shared her story of having her financial support cut and having to make a difficult call to cut the family finances in order to further her education and prospects for the future:

"You know, like, trying to go on and better meself in recovery. Like, I'd be on me own and I've four beautiful kids, I'll be six years clean in January coming..... But in that space of time, like, I've – I've done things to try and better meself and come up against barriers, being told 'no, you can't do that', you know? So …But it – it – so I'm the sole provider for – for me children and I try to – so I did me – me addiction studies, me level 5, and that

was grand because it was the one day a week and that was fine. And then I went on to the Liberties … and I remember them telling me 'your – your Carers will be gone now'. And I was, like, 'what?', they were, like, 'no, no, you'll lose your Carers'. Now, I couldn't get me head around this because I was,[attending], 'the same hours my son's in school I'm going to be in college', but it's fulltime so you'll have to decide'. So I had to actually make a call between, you know, giving up me Carers or furthering meself in me education. Now I chose me education and I gave up the Carers" (Paula).

"So financially it's [recovery] a lot harder, you know that way?. But god is it worth it" (Sharon).

While there was a huge value placed on recovery, there was no doubt that it was difficult particularly for women with children.

it's really, really hard for – for women with kids, especially when they're left on their own with them, Like, how do you manage, you know, running a home and doing dinners and rearing kids and all the while, you know, you've to make time for [fellowship]meetings and meeting up with a sponsor, you know. Doing the work, you know, and it takes a lot of work. And, you know, I'd know a lot of these women that are still out there and I see it in them, like, I see the potential in them and I see that, you know, if they had the right things at their disposal they would take off" (Paula).

APPROACHES TO ACCESSING TREATMENT AND SEEKING HELP

The women's awareness and perceptions of services were strongly influenced by a sense of hopelessness rather than a desire to seek help. The majority of the women spoke of reaching 'rock bottom' before seeking help. The fear of disclosing their home situations to service providers would place their children in a vulnerable situation and thus stopped them from accessing help. Likewise, the loss of custody of their children or the threat of such was often the point of initiation treatment.

Friends were a key source of information and role models for the women on their treatment and recovery pathways. Peer recovery was a key motivator for change.

> *"My friend actually just rang me and said that 'would you be interested in doing that?' because I think there was flyers going around or – I – I didn't get one meself now, I think just me friend did and she just rang me and I went down here"* (Lena).

> *"Just from living around Ballyfermot. Everyone goes to them, you know, everyone, like you know? Yeah, word of mouth. STAR, I always knew STAR was there. But I never knew this building was here .... until Advance actually linked me up to it and I was, like, 'oh my God! I never even knew there was a building over here!' Do you know that kind of way?"* (Lorraine).

> *"A friend of mine done well and she told me, I met her and she looked amazing and she brought me there, only for her I'd of never known"* (Lesley).

The realization that seeking help needed to be self-directed was clear from participants.

> "*Well as I said, like, yeah that was me, like, I just smoked that 24/7, like. And then I was, like, 'I can't be doing this anymore', like. So that's how I came here, like, and was just 'I need to knock everything on the head', like. Do you know that kind of way?"* (Lisa).

> *"But how to encourage people to come, I don't really know how you would encourage someone unless they wanted to reach out themselves"* (Lesley)

> *"It depends on the person I think. I think it's got to be them initially. It's got to come – there's no point in saying to somebody 'right, you're going into treatment tomorrow'. They'll just come out and use again. They have to come to you and say 'right I've had enough. I've done enough, I need this to stop and I want to go in' or 'I want to avail of this' or what is available to me?*"(Leanne).

The women shared their intrinsic motivation to seek recovery for themselves and the realisation that there was a problem, was a clear indicator to seek help.

> *"Like, I wanted to get clean. It didn't work but I did want [speaker's emphasis] to, do you know? That was the start of something inside me saying 'I – I want a better life', do you know that way?"* (Audrey).

"Yeah some would have, yeah, definitely. Like, just why go to treatment but it's only when you want to stop yourself that you can give up, do you know what I mean?" (Rachel).

"so I limit, I can limit all those things and I thought 'well you just need to do it' and I suppose I realised at that point that I couldn't. I couldn't do it myself, I needed something or some system to help" (Melissa).

AREAS FOR SERVICE IMPROVEMENT

The women identified several aspects of services that could be improved including the development of age and women specific services, in addition to increasing the visibility of recovery across sectors.

Age was a consideration for several of the women when it came to accessing appropriate treatment. The women discussed the various needs of their peers, particularly the need for treatment services to tailor their efforts when responding to the needs of women across various age groups.

"*And I think it's not spoke about with women, so I think even, like, me and some of me friends, there's NA, there's AA. They're all for more, like – not all for, but you see more older people like late 20s or 30s where I think the issue is my age, 21 and under, there's – there's a lot of girls suffering. So I think more facilities like [name of treatment centre] that could be run for girls from 21, any age, that could support them to go forward into treatment. Because I mean, like, around here it's going to get very, very bad if there's no help for people under the age – teens*" (Jean).

"*I'm one of the older addicts in Ballyfermot! I'm 44, 45 tomorrow. Like, the people who come here now as well are young people who are probably on weed, on tablets. They haven't had the experience that I have but I work with me keyworker in here and we meet every week and – well we work together every day, she's here with me, do you know what I mean*?" (Rachel).

The women spoke about the need for women-specific services. The shared experience was seen as a critical source of encouragement and support.

> *"I think, yeah, they should definitely be women only for it's – you know, locally. Because I think more women would do that, you know, I really do because even though we're modern day Ireland I'm trying to, you see I would be called old stock [laughs], God I'm old! I'm trying to explain to you, I still have that in my head about years ago we would have been ruled by the church .... and all of that's still there, so women didn't talk, you know what I mean? And that's still – my generation is still there, you know what I mean? So I find that – but now it's all changing and women will talk. I'm just saying it should be more women orientated for them women that lived in that. Because the amount of people – women are still in that hell and that have an addiction ..."* (Marie).

> *"Not to be sexist but if you are a woman coming in seeking treatment it feels nicer to speak to, that's just me personally, to speak to a woman about the issues. But how to encourage them, that's a difficult one because for me I feel you kind of have to be ready as well, you have to want to – want to change"* (Lesley).

> *"Yeah, I feel that they should have women only because when you're going through that the last thing you want, especially with my experience, you don't want to be around men, you know what I mean?. And, like, I know – God, I'm not saying anything against them, I just – if there was women only areas I think women would be more inclined, especially because I've a lot of friends that have bad histories with ex partners, so you know what I mean? Even they got them in the door there first and then [speaker's emphasis] they, you know, like meself they build up the confidence to do that and they'd go outside but I think, yeah, they should definitely be women only for it's – you know, locally"* (Marie).

Several women (n=5) spoke of the obvious lack of visibility of recovery in non-substance use services. Almost as though recovery was operating in parallel to treatment services.

> *"First of all, for it to be highlighted. Recovery is not highlighted in those services enough. I don't think I've ever once gone into, when I was on the – with a doctor, into a clinic and seen an advertisement for the likes of TRP or you know, NA or AA or whatever A you choose to go to. It's not highlighted enough…"* (Paula).

"*Not knowing that there were recovery centres, not knowing about NA, not knowing about recovery. My idea of treatment was going to a psychiatric unit and sign myself in, sort myself out, and go back out and start using again. I didn't know any other way and I didn't know that there was NA, I didn't know* " (Sharon).

"*it's like what I said about you know, putting the information out there, like, I didn't know anything about the Fellowships*"(Lorraine).

A considerable number of women (n=10) spoke about the lack of information on pathways to treatment within their communities. The need for broader dissemination of information on access to treatment and recovery supports was at the forefront of the women's requests for change.

"They don't know there's a way out because it's not – it's not shared enough. It's not given out, it's not spoken about, you know? So there needs to be more advertising, publicising, I don't know what you want to call it but it needs to be put out there that, you know, this is – this is an everyday ongoing thing. This happens all the time [speaker's emphasis], a huge percentage and – and if you're one of them then there's help out there ... you know" (Sharon).

"But I think more information that there are centres here because you don't know, like, you don't know what service is or – I didn't know until I was hospitalised and told that this service is here. I think, like, it should be – should be made – there should be more awareness raised around these type of centres I think" (Lesley).

"So I wouldn't be – word of mouth and stuff like that. So yeah that'd be – yeah, it'd be just the stigma and then not knowing, because it's not very – it's not very advertised, like, the doctor never told – just – the doctor used to ask just if I was going to [fellowship] meetings but never – I never told him how bad the problem was. So they didn't know what they were – the extent that I was having issues" (Catherine).

SUMMARY OF FINDINGS

- Prior exposure to traumatic early and later life events was associated with progression into problematic patterns of drug use.
- Women in the study typically described a childhood marked by poverty, bereavement and family adversity.
- Notwithstanding their challenges with alcohol and/or other drug use, women participating in this study expressed a strong desire to access recovery services.
- Lack of access to childcare services was cited as the most significant barrier to accessing treatment.
- As conclusively reported in the international literature, there is an urgent need for the expansion of gender-sensitive treatment approaches that support women's particular needs around maternity services, childcare and domestic violence.
- Peer-led interventions were particularly appreciated by the women who participated in this study pointing to a demand for expanded access to community-based recovery coaches and peer support services.

CHAPTER 4: FINDINGS FROM INTERVIEWS WITH KEY STAKEHOLDERS

INTRODUCTION

Twenty-two interviews with key stakeholders took place. They were from a variety of backgrounds and disciplines including managers and frontline staff from local addiction services (Tallaght Rehabilitation Project, Community Addiction Response Program, Jobstown Addiction Drug Dependency, Ballyfermot Advance Project, Ballyfermot Star Project), family services (Barnardos, Familibase), domestic violence services (Saoirse), suicide prevention services, the Health Service Executive, Tusla and the Department of Social Protection. In addition, interviews were conducted with key stakeholders that indirectly worked with women such as members of both Ballyfermot and Tallaght local Drug and Alcohol Task Forces, policy makers and a local politician. All interviews were conducted remotely via Zoom. Table 4.1 presents details of the addiction specific services included in the research.

Table 4.2 Clinical demographics of the addiction specific services included in the research

Demographics of Substance Use Services									
Service	**Location**	**Time running**	**Women served annually**	**Groups offered**	**One to one offered**	**Reintegration and development**	**Medical and harm reduction**	**Substances used by clients.**	**Additional services**
Ballyfermot Advance Project	Ballyfermot	18 years (founded 2003)	142[a,b]	Smart Recovery,[c] Peer Support Group[c]	Counselling, Key work, case management, Brief Interventions		Needle & Syringe Programme.	Heroin, Cocaine, Alcohol, weed, Crack Prescribed/Street Tablets	Family support, Drop-in services, Homeless services (food, Laundry, Shower), Outreach program
Ballyfermot-Star	Ballyfermot	23 years (Founded 1998)	88[a]	Personal Development, Relapse Prevention, Workshops, Life Skills Groups, Pro Social Activity Group	Key working, Counselling, Case Management, Holistic Therapies	Community employment scheme, QQI Modules, personal Skill Training, Professional development Training, literacy programs		Heroin, alcohol weed, Crack Cocaine, Benzos	Family Support, Realt Beag – Child & Family Centre
Community Addiction Response Program (CARP)	Tallaght	26 years (founded 1995)	105[a]	Narcotics anonymous, cocaine anonymous Crack support programme Family support groups	Key working, Counselling, case management	Community employment scheme,	Methadone maintenance, urine analysis, needle & Syringe Programme, crack pipe distribution	Cocaine, weed, heroin, alcohol, Crack, benzos.	Family therapy, Youth project, Polish addiction service & support, Homeless services (food, Laundry, Shower)

Jobstown Assisting Drug Dependency (JADD)	Tallaght	25 years (founded 1996)		Group development	Key work, advocacy, counselling Brief crisis intervention	Community employment scheme, QQI Modules personal Skill Training, Professional development Training, literacy programs	Medical support, Methadone Maintenance needle & Syringe Programme	Crack cocaine, alcohol, heroin,	Family support, Advocacy, Homeless services (food, Laundry, Shower), Drop-in service
Tallaght Rehabilitation Project (TRP)	Tallaght	24 years (established 1997)	37 [d]	Spouse groups, aftercare groups, workshops, relapse prevention groups, reflection group, process groups. Narcotics anonymous, Cocaine anonymous	Key working, counselling, crisis intervention. Therapeutic intervention	Community employment scheme, Educational modules, Personal development modules, Boxsmart, Drama, holistic groups, hosting international women's day and recovery month	Client detoxes are facilitated with local GP'S when requested	Alcohol, cocaine, weed, crack cocaine, heroin, benzodiazepine's Poly Drug use, Addictive behaviours (i.e., gambling).	Outreach, Family support, Referrals, Sign posting, advocacy, Recovery coach involvement with the Recovery academy Ireland

Note:

a. **Numbers presented are from 2020**
b. **This number is the cumulation of new female referrals and individuals in treatment in 2020.**
c. **Groups are not currently running but will begin when possible.**
d. **This number is a cumulation of female participants engaged in the rehabilitation day program and after care service from 2020 to 29.04.2021**

THEMES EMERGING FROM INTERVIEWS WITH KEY STAKEHOLDERS

TRAUMATIC LIFE EVENTS

Almost all of the key stakeholders (n=18) spoke of the trauma that the women endured. Trauma was not necessarily a historical issue for women they were working with, but it was most likely an ongoing issue. Vast levels of intimidation, coercive behaviour and violence against women were reported. Key stakeholders frequently cited the need for services to be trauma-informed.

> *"I think just I suppose the piece that I didn't really talk about is that intergenerational trauma, I touched on it a little at the start in relation to, the parents needing to be nurtured, themselves, they have suffered from their parents"* (Jolene).

> *"We need to look behind that and look at the bloody trauma and the desperation and where it's coming from and I think that – that if projects and frontline workers are trauma informed then that's more likely to happen"* (Frankie).

> *"So without going off track we found that that's a big issue for women specifically is how they're – how they're utilised in the community by gangs has been challenging. They're – they're continuously I suppose being intimidated. There's violence, not just from the – that gangs who provide the drugs but also from their adult children, coercive control from their partners, quite often they're the ones still told to go out and tap or steal or – or engage in prostitution as a way of funding both theirs and their partner's drug use. So they have so many – so many barriers and obstacles before they get to the treatment piece* (Jamie).

Similar to the women's interviews, key stakeholders emphasised the need for services to be age-appropriate, recognising the age-dependent needs of women.

> *"That – that would be the other piece, just regarding the – the trajectories that this cohort specifically is on, they do have different needs to – not different needs completely but I find that they have different needs to – to substance misuse of people under 25, let's say. Though they can all be experiencing trauma we just have people who've been through the whole methadone programme from the 90s have a different experience of – of their drug treatment needs and the landscape. I do think we have to interact with them differently"* (Jamie).

"when we're talking about responding to what women need there's a piece around their age I suppose as well, because obviously, an older woman will have very different experiences to somebody younger so there's a need I suppose when we're providing some sort of responses to be – to be cognisant of that and I suppose again maybe I'm stating the obvious I suppose the other thing that comes to mind when we talk about age and again I'm wearing maybe my nursing hat is obviously the mental and physical health needs of younger versus older women, will be different and I suppose…" (Mel).

"So I think we really need to consider older women because I think they have been stigmatised, they have been – they hold that stigma, hugely. They don't – they, in some of the county councils or corporation or, the city council housing areas they don't – there might be liaison officers from TCC but they don't go to them, they feel as if they don't fit in" (Liz).

The need to respond sensitively and appropriately to women who are caught in a trap of sexual exchange for drugs came through in the key stakeholders' interviews—recognising that the issue was prevalent in both communities but not having a clear strategy to respond effectively.

"She told me about her being engaged in – in sex work and said that really, she wasn't comfortable, she was very afraid but that her partner had a debt, and she was trying to pay it off and so on and so forth. And I think – I mean I know that you have Ruhama and services like that, but I think there's a huge need I suppose to – to make sure that we're not seeing women in the same lens that we see men in" (Mel).

"You've young women being used…and what are we doing about it. I think it's, again you're looking at women around cocaine, sexual exploitation… you know, they're – they've been in environments where they have to perhaps favour sexual favours for men, men calling to the house in the morning time, the trauma of that" (Liz).

"There would be, girls that would be – women that if they can't rock up with the money, they would need to provide sex or 'I'll bring a third party in to have sex with you'. Well, that's my experience, and that's all quite tender, for – you have to as a worker I suppose build up a trust and be professional enough that you get somebody that's going to trust you with stuff like that because, that's a big – the families probably wouldn't know that that's going on, do you know what I mean? There's

huge – and then you've got, taking risks – risky behaviour there… multiple partners, being videoed, all that. It's just – yeah" (Jude).

One key stakeholder shared a harrowing story which demonstrated how women are being manipulated into sex transactions with no way out.

"there's one particular case where a woman owes money for crack cocaine and she's going to owe money every week because she's dependent on crack cocaine. And – and as a way of paying her debt she's getting – people are knocking up to the house in the morning before her children go to school, so you're talking six/seven o'clock in the morning, with another man and she has to perform sexual acts on the man that the dealer brings. And that's happening most, like, mornings, Wednesday/Thursday mornings to a particular cohort of women and that's something that's not really overly sort of talked about. There was also a case of a young girl and she was asked to hold an amount of drugs for a gang out there and – so that she would be in debt, you know? And then she wasn't able to repay it so then she had to have sex with men then to repay this debt, but that was a forced manipulated way of making her in to sex work, you know?" (Tara).

But I suppose the second piece around a gang actually targeting a young woman that they think would make them good money as – as a sex worker- and trapping her into a false sense of debt and the long-term implication of that is definitely nothing I've – like, it's like nothing I ever heard before" (Tara).

Interlinked with sex work was coercive control of partners.

"Sometimes if – like that particular girl I was talking about, if her partner finds out 1) that she's out, there's huge issues around that. He'll have her robbing for him, he'll have her back maybe working in – in sex work, maybe around domestic violence if she tries to stay away from him. So, there's all these things to – I suppose the threat of violence is quite real for a lot of them" (Sam).

There was a perceived surge in level of domestic violence across both communities.

"… you know, emotional abuse. A lot of domestic violence, huge amounts of domestic violence and, again, if women are beaten down like that, their capacity often to – to come to services is reduced unless they have someone within the community they can trust, that they will go to" (Fran).

"*– I mean we talk about domestic violence in society but put that – put that up ten notches once there's a drug dependency piece involved in that …"* (Liz).

There was an urgent and desperate call from key stakeholders to respond effectively to the needs of women enduring trauma in the community. They spoke of the need to root out this insidious scourge on women.

"And generally, in my experience women have been hurt a lot and they have, been let down and their trust is broken, and they have, more than likely experienced some form of abuse, whether it be sexual or violent or coercive control or whatever and therefore they require a different approach. They need to be met differently and they need different interventions" (Frankie).

"But in real life nobody is going to ever come forward because this –these horrendous things happen every week so you can imagine the shame and the guilt and the … everything else that goes along with it. So I mean if we ever did get any, like, by the time someone contacts you you're going to be so traumatised that, particularly that young girl in the community, but I think it's something that – to keep on the radar and to keep talking about because it's such a breach of – of human rights, you know" (Ali).

"But again, we need to be progressive in our thinking and develop new ways and new models or working with women because women don't just come with one specific issue, i.e., domestic violence" (Eva).

Services for women experiencing domestic violence were wholly inadequate. Eva shares her story of trying to elicit effective strategies from professionals potentially coming in contact with a woman in need:

"But there's – there's no response [laughs] it's like this big jigsaw piece and there's DV [domestic violence]services responsible for everywhere else and then there's a big glaring hole in the map of D10[Dublin postcode] where no services go into. I was dropping the kids to school, talking to home/school liaison officers, talking to the principals, talking to the public health nurses, to me own GP, trying to suss out where – 'if someone presented, a woman like me, I was being assaulted or abused or experiencing coercive withdrawal and you as a first responder identified where' – where – 'what would you do? Where would you go? What would you – who would

you refer me to?' And they all said they didn't know, so I was, like [laughs] 'what do you mean you don't know?' 'Yeah we wouldn't know where to send her, we wouldn't know what to do. You know what we'd do? We'd send a report into Tusla, child protection". (Eva).

APPROACHES TO SUCCESSFULLY ENGAGING WOMEN

There was a recognition that treatment initiation needed to be gentle and focused on basic needs if services were going to engage women successfully.

> *"we just brought women in with a very low level of expectation, it was just generally about their – their presentation, their attendance, they got some food. By 11am they were able to sit down with us and have breakfast and engage on a very informal basis and we focused specifically on themes and conversations that were universal, a bit more engaging and a little less deficit based"* (Jamie).

> *"we need to start slow if we are to have any chance these women are in bits coming through the door. They are not ready to hear about CBT or ACRA or whatever we are doing*"(Sam).

Moreover, key stakeholders spoke of the need for engagement to be adaptive to the women's needs at the time of presentation. Knowing and accepting that the support they offer may be taken on an incremental basis, and nonetheless being aware that acceptance is key to future engagements.

> *"… the original programme was a group programme on a Friday for three hours where the women come in, sit down, have a general conversation and something to eat. They could have a shower if they wanted it, they could wash their clothes if they wanted …So for us – success for us was that they come in the door, whether it be fifteen minutes or an hour when the step into a group. That for us is a major success because we had then ten women that would be in a group, not using for three hours that they probably would have been using if they hadn't have been in group"* (Sam).

> *"So that woman that you sort of welcomed in, you've allowed her come in and you have a simple but accommodating session as best you can with her child in the room, you have to keep things quite superficial but you can at least support her. That woman might well then tell a friend or tell somebody that she knows that it's okay to go in"* (Les).

Similarly, participants cited the need to provide additional supports outside of service and 'usual' hours to create optimal conditions to engage women who are not in a position to engage with current services. The need to make spaces and information accessible was seen as key.

> *"So we're just trying to get into the community and embed and even have conversations with our head office around, like, social media, can we get on a local social media platform like Facebook or things like that and it's looking at okay our – our policies and procedures mightn't allow us to but how do we amend them that we can become accessible …"* (Miriam)

> *"… to those people. Because a parent that's really struggling with a baby that's up through the night that is really struggling might go onto Facebook and click a link or, do you know, at two o'clock in the morning when there's nobody in an office that she can ring at that time. So it's about being more open to different possibilities of people connecting to us*" (Miriam).

> *"I think basically again making connections with, we're talking about young women and mothers and women generally in the community, I think we're talking about, community groups getting together, open up their – their centres, having drop-ins, they're all doing this, having coffee mornings"* (Fran).

At a fundamental level working with women required basic respect and value.

> *"That they're actually worth – they all work in their own little ways. All these, like, Smart, that has bits of CBT, MI, CRA, they all – they're all – even Reduce the Use, all these programmes all work but the biggest thing is making people feel that they have value, that actually that they're worth it. That – that's what works. –Nothing – nothing you try or do so, they have to feel themselves that they're worth it and once you make them feel that well then whatever you do you'll find the best tool to use with that individual whatever they can manage to – and that could be harm reduction stuff"* (Sam).

> *"You know, and I know that's one word that's bandied about a lot at the moment but it's about being kind and respectful and it happens at the – as somebody walks in the door, you know it's back to very basics I think kindness, respect, humanity ….. treating that person as a human being that is going through a very difficult time and*

just a bit of care and a nice cup of tea or sit there and say nothing, take a breath" (Liz).

Unsurprisingly, building trust by focusing on assets rather than deficits was seen as crucial when engaging the women.

If I had all of them people in me life telling me how bad I was [laughs] as a parent, like you know what I mean? Even though that's not their role in there but that's what comes across to the parent themselves and even the way they refer to the parent as 'oh and how would Mum feel about that? (Sam).

"we focused specifically on themes and conversations that were universal, a bit more engaging and a little less deficit based so it wasn't – it wasn't always about 'what are you struggling with? What are you doing badly? What's going wrong with your drug use?' It wasn't all about their fears, it was more about 'what's it been like to be a woman in JADD? What's it like to be a woman in the community? What shared experiences do we have?' and we tried to focus on building some sort of therapeutic alliance with them with very informal expectations on them (Celine).

"What we found is it mightn't be foundationally relevant because it's not going to be based on all the evidence, we're only going to get all the evidence when we build the trust in the therapeutic I suppose relationship or alliance, maybe not therapeutic is the right word, but a trusting relationship with that service user. That when they do engage in that case management structure that we have all the areas that need to be I suppose resolved or what barriers are really in place. That I don't think is going to happen if we push it too early" (Jamie).

Likewise, being transparent and building trust with the women regarding the type of information shared with Tulsa and the rationale was core to supporting women accessing and maintaining supports.

"So they understand from very early on, 'this is the type of information that we would have to share if we were worried', 'we'll tell you before we share it, we'll tell you why we're worried, it is the only way to keep everyone involved" (Jolene).

"I think the Signs of Safety framework is probably hopefully assisting with that in terms of, being very clear with parents and services around the parents about what Tusla's concerns are and maybe how they can be mitigated" (Simone).

"So I think if we all work together and collaborate and have joint meetings to support these women I think is the core piece because everybody's clear in what's being done as well as the women that we're working with" (Miriam).

BARRIERS TO TREATMENT

The perceived fear of losing children as a barrier to treatment for the women as a dominant theme in the key stakeholder's narratives. When it came to women who were parents child protection was a transparent barrier to seeking treatment. Key stakeholders acknowledge this as a genuine fear with immediate and direct consequences.

"Fear of what's going to happen next in relation to who's going to look after their children, who's going to provide their children with what they need. Oftentimes once women begin to engage with a community service or any type of addiction service if there is children there can be an escalation of Tusla, statutory involvement in the case also, so fear of I suppose the unknown of where other services can intervene"… (Eva).

"And we'd often even say to the women that it's – it's much better for them if the, if, say, social services or whatever, family support workers, know that they're engaging with the service and know that they're trying to do something. But, that fear is always going to be there. It's a huge fear, it's a genuine fear…I'd often – years ago I probably would have often recommended to somebody 'look', 'if they're going to go after a court case put them into voluntary care, at least then you're still in control'. Even now I'm not sure about that anymore because I see very few getting them back" (Sam).

"But it also impacts on I suppose external factors such as Tusla becoming involved, which adds a huge layer of pressure to parents even though it comes from a supportive place I – it's really scary and I know that sometimes parents think 'if Tusla are involved that means my children are going into care'…. and sometimes they think that about Barnardos as well" (Jolene).

"… if they present in an addiction service there'll be – there'll be a report going into Tusla, even if it's done on a very gentle and respectful way, which in my experience it always is but it still goes in and I think in particular in Ballyfermot, Ballyfermot has the highest concentration of children in residential care in – in I think in Ireland. So, like, they have a whole really negative experience of social workers and of they come

and they take the children, so I think for a woman to present to an addiction service and outline this is what's going on when her children are in the house I think that fear of Tusla is – is one major thing that stops them from presenting" (Ali).

Others suggested that this was maybe based on historical issues and perhaps was slightly outdated. Participants highlighted the active role that addiction services have in dispelling this information.

"I know the Tusla thing and I'm not saying that that isn't an issue but it's – it's so perceived that if you go in and seek help that immediately children are going to be taken off you" (Les).

"I think there's a fear and a stigma of accessing treatment and 'if I am to admit that I'm using drugs what implications will that have for me and what implications will that have for my children?' So I think there's a real old school fear that if I admit to using drugs, you known the social worker is going to come and – there's still there real fear that 'social workers will take my children away'….So it's trying to break down that idea and looking at the social worker as a supportive point of view but it's very much a very old school thought that is still a thing" (Jade).

"Fear of what's going to happen next in relation to who's going to look after their children, who's going to provide their children with what they need. Oftentimes once women begin to engage with a community service or any type of addiction service if there is children there can be an escalation of Tusla, statutory involvement in the case also, so fear of I suppose the unknown of where other services can intervene …"

One key stakeholder illustrates successful strategies employed to help negate these fears for women by discussing these fears and communicating the parameters for reporting between agencies.

"And the idea was, and the goal was, to slowly introduce more conversation – to slowly introduce more conversations around what their fears are specifically around treatment and rehabilitation. So what we done then was we started to explore what were their fears around treatment.-…So I sat in for one weekend just to explore what case management is, theoretically what it is and in real life what it often looks like, the good and the bad and that. And we done a workshop nearly on what their fears were around that, again without hearing one iota of their own drug use. -So we

didn't explore or investigate any of their drug use or want to know anything, just what the – the parameters of their understanding of case management. And then another few hours spent on confidentiality, what was I suppose what was mandatory reporting – we done weeks of these conversations…. I suppose that came about from them understanding that not every issue is a mandatory reporting obligation, not everything that they discuss automatically means negative consequences regarding some sort of case management triggered response. But that took a long time to get to that place." (Jamie).

A high number of key stakeholders noted how the responsibility of childcare most often rested with mothers.

"So I just checked back through our Annual Report in 2020 and actually 46% of our cases open to us in 2020 were lone mothers. So the biggest percentage of – of I suppose cohort of parents that we're working with are actually single mums. And 15% are parents living apart , co-parenting so just shows you that – it shows you the sort of – the – the lack of support maybe, even in the statistics that some of the mums I suppose don't have that we're working with" (Jolene).

"Time, so if – if there's kids in school or kids at preschool or kids have to be dropped and picked up and the whole lot. And, like, a guy can come in here, say, into our particular service and I don't mean this as any disrespect to any of the lads that can come in, but they don't have any worries about any of that. –They don't have worries about cooking dinners or the whole lot. The vast majority are either living on their own, living at home with parents, even if they are living with partners they don't have those concerns, they don't have those worries. The – the majority of women coming here have those concerns, have those worries" (Sam).

"I think a man can, make a decision 'I'm going [to treatment] on the 5th January' and that's it, he just walks and he goes into treatment. But with women I think, there's huge variables that need to be taken into consideration in terms of, childcare" (Celine).

"*I see this play out in domestic violence as well because I think we have to factor in the whole gendered piece … in relation to where women are left holding the bag all the time in relation to Tusla when it comes to addiction and when it comes to them being victims of domestic violence. The man isn't held to account on any of those*

forums, they're not held to account in case conferences, care plans, interventions, assessments" (Eva).

There was a noted increase in women presenting to services for support who had children with special needs. The perception was that these women were left to struggle with no access to support. Childcare was a significant barrier for women accessing services.

"*an awful lot of women that I've experienced over the last few years coming into the service, a lot of them have children that have special needs, you know? I've worked with women over the years as well, that they're fulltime 24-hour carers for their children because their children's needs are so severe"* (Sam).

"Parents are doing round the clock 24 hour care with their kids depending – and that's not depending on the severity or not, that's just the way it is at the minute. Because there is no support services out there and it's been like that since last March and there's nobody advocating on their [speaker's emphasis] behalf to get something set up for these children. But [name redacted] hasn't been able to move outside the house since March [COVID-Outbreak] because she's no support services, no respite, no nothing …No supports from family. … so she can't even get to meet other than a Zoom" (Celine).

"… we would have a lot of parents who the children may have gotten an Assessment of Need completed I don't know three or four years ago, they're handed the paperwork and then that's it. So there's – there's no follow-up response, there's no coordinated care plan for that child so, there's – there's extra challenges for those children and it's really hard for those parents …" (Jolene).

"a lot of women have children – children that have special needs and they're on waiting lists. There's a lot of children with autism that are waiting to be assessed and they're waiting to get supports in – in early years and they've no real help from family or from anyone else with – with their children who really, really need them and they can't even really get an assessment. So that was one thing that was really, really hard for the women as well as managing drug use" (Ali).

It was suggested that some women did not identify with the services. The stigma associated with the service acted as a barrier to access.

"And I suppose they wouldn't identify themselves – I suppose because there's certain places that are known and really well known I suppose different agencies that are really well known and it might be, 'oh well this is for people who are', 'starting out in their recovery', whereas parents would see themselves as 'I'm – I'm not identifying with that. I'm not identifying with that guy that I saw on the road' that is in whatever way" (Gene).

"I suppose some of the drug services, particularly in Ballyfermot, some of the women don't really identify them because they're places where their dad might have went to, their dad might have been an injecting opiate user whereas they're drinking cocaine and alcohol – [laughs] they're drinking alcohol and using drugs" (Simone).

"… at – at the weekend and they don't – they don't see themselves as that cohort of person who uses drugs. So they're – they're not inclined to present. And I don't think they identify with the services that are, in existence and we're putting a lot of resources and, services will say they've changed their treatment models and they may well have but you know, the branding hasn't changed. A lot of the young women we work with, their parents went to them services so they'll say 'no, my Mam was in Star when she was strung out, I'm not going up there', do you know what I mean? – They don't identify as being junkies or any of that stuff, that old negativity stuff but they can say 'yeah, this is problematic for me', do you know what I mean?" (Lou).

AREAS FOR SERVICE IMPROVEMENT

Key stakeholders spoke critically about the broader addiction services and how disparaging these have become. The shift towards 'corporate' models of care and the focus on outcomes, which was seen to have removed and dehumanised individuals in need of treatment. Moreover, the notion that women receiving treatment had no autonomy over their care, echoed by the women.

"I think that we're very different and yet I think all women with addiction, and men for that matter, I think there's a sense sometimes that they're all seen as, needing a care plan, maybe they need needle exchange, maybe they need to see, the doctor, maybe – maybe I'm coming from the HSE set in-house as well, maybe they need the – the counsellor, maybe they need to see the pharmacist but – but I think sometimes that – that the human sometimes is lost in that. That was really damning of our

service and I suppose the reason why I mention it is because it's that dehumanising experience and people didn't feel that they had, any autonomy I suppose in their care – I think – I think there – as you know there are particular cultures within services. I think, it's been a very medical model, very medicalised, it's – it's been, from our service point of view, it's all about harm reduction – but where's the women!" (Mel) .

"But when you have it too heavily focused on governance, on privatised way of thinking, so even how we account for how human work in these communities now in Tallaght we're – we're adopting this privatised model of outcomes and inputs and matrix … and all of a sudden the human complexities of people's lives are disappearing and this much more corporate speak is being imposed on a community that doesn't respond to corporate speaking" (Ronnie).

"So I think there was, going back to that word genuineness, there was a genuineness, there was a need and there was a togetherness, right? That togetherness isn't there now because money came into it, services got in to all the – the areas, if you look at Tallaght the amount of community development that's – that's up here, the amount that's pumped in yet we don't – I would think that we don't need all these treatment centres" (Jude).

The need to build competencies around addiction in non-addiction service staff was a key theme in the key stakeholder interviews. Of particular note the inexperience of some Social Workers and how this plays out in a woman's care was seen as a real issue for change. Stakeholders spoke of the inability of some junior colleagues to respond with empathy to the needs of the women and children in their care. This inability was assumed to be due to a lack of exposure and the need for more comprehensive training on drug and alcohol issues.

"in the family end of social work there's an awful lot of young inexperienced …girls …… who have no [speaker's emphasis] idea, absolutely no comprehension of what it's actually like for somebody in certain situations. And, I've seen some absolutely brilliant social workers and I've seen some absolutely dreadful social workers …… but there's no consistency....I just think it's – it's a very mixed bag. You can be really lucky and get a very good social worker, you can be really unlucky but I think a lot of it too is that, they just have far too many cases for the amount of – and an awful lot of the inexperienced just out of college social workers end up in, at the I suppose at the coal face with – with the welfare concerns and the abuse concerns and all that, unfortunately. And then I think a lot of them, the really good ones, if they get half a

chance they'll – they'll find a job that's without the same amount of pressure and concerns where they feel that they can actually do a good job" (Jamie).

"You know, so it' like – it' like Tusla need a lot of education around addiction and in terms of them getting that, you see because of – like, I mean we have one girl here, right, she started here last August and she's had six social workers involved in her family" (Celine).

"I suppose a lot of it the workers would work it through the women in our programme and – and no disrespect young women, they're very young and they're being put into situations, especially out of college, to deal with women who are in deep, deep chaos and are coming through traumatic events and – and they're all 'Mam needs to do this' and 'Mam needs to do that'. It's patronising, it's condescending. – there needs to be a level of understanding of what pain and – what these women are dealing with daily. And I don't know how that balance is between child welfare and the welfare of the mother or the parent, but I think the woman needs to be seen as separate to her children in one respect... – to me you're introducing the social workers, they're too young, too inexperienced, they don't understand who they're working – and they're trying to fit everyone into a little box, 'this is what and this is what works and this is what we say works' and they're looking at some of the women and they're living in chaos, they're living in a house with no furniture. It's devastation and these young people coming in don't understand that, they've no lived experience, they're too young" (Bernie).

Key stakeholders highlight the constant loop that women with co-occurring mental health issues and drug use found themselves in when seeking help. The notion that addiction services would not deal with women with a mental health issue and vice versa mental health would not assist women with addiction issues was a dominant theme in the study. Accessing health services was difficult and left the women in 'limbo'.

"… and I think they're blocked sometimes from accessing them because of their drug use, the mental health say it's the addiction and the addiction say it's mental health" (Ali).

"Yeah. The other thing as well is that again the people who present to an ED, haven't had a diagnosis so they wouldn't be seen anyway or in primary healthcare if they don't have a diagnosis they won't be seen, so you have to go through a process of

getting a diagnosis before you're actually dealt with. But that doesn't facilitate the person in crisis for the first time that has not had a diagnosis because they've not been in crisis, first time. And because addiction would keep them away from that, all the rest, all the complexities around substance misuse then keeps them away from getting a diagnosis in the first place" (Liz).

"I think there's a big issue still in terms of if women have dual diagnosis …Okay…. in relation to mental health and addiction, for example. That doesn't seem to have been sorted out and they seem to get bounced between the two and sometimes end up with, not in either service or getting properly helped by either service – you know, difficulty accessing mental health services sometimes when you also have an addiction issue" (Jamie).

"Absolutely huge yeah and, like that, as well some of the women that I work with have a dual diagnosis that they might have, like you know, there might be addiction but they also have a mental health diagnosis and then the mental health services won't work with women who have an addiction and then it's, like, yeah. It's just – I feel like they feel they're in limbo" (Simone).

In addition, participants expressed concern around the unmet sexual health needs of the women, particularly those that were exposed to risks associated with sex work.

"there is – there's, and maybe I'm bringing my sexual health hat to the table but I think the sexual health side of things I think can be lost in – I don't – I don't hear it reflected in treatment and rehab discussions that often" (Mel).

"I think, access to the clinics, STIs, all of those, how difficult that is for women. As well again if there's a partner he could be the one pushing her into this environment as well, which often happens too" (Liz).

Similarly, participants expressed concern at how outreach services had changed through the years and appeared to have lost the connection with the community. Connecting with women in their homes was seen as a beneficial way to reduce stigma and reach a population that would otherwise not engage. Identifying key community members to assist with engaging harder to reach women was viewed as an untapped resource.

"Because, like that, it goes back to the fear and the stigma so if a person is actually coming to you [speaker's emphasis], to your home and explaining it takes the scariness out of it a little bit for women and being 'look , we're here to support you. We're not here to judge you', like, and , I think breaking down those barriers. But, like that, the outreach piece has been huge. Huge in women accessing those services" (Jade).

"Yeah, again it's the reaching into the places where they are, do you know what I mean, because women are somewhere so, young women. So, what are the environments they're in? And if they're not in services are, they in stuff that we don't think of as services, connected but not getting needs met do you know what I mean?" (Tony).

"Yeah. Like, I mean, like, I used to go to the youth project, they had some young men that were, like, 16, 17, 18 who were really chaotic and there'd been a couple of murders amongst the group at the time. It was really fucking hostile so instead of me, for ages, instead of me talking to any of them about their drug use I asked – I got permission from the youth service for me to go along on some of their summer – summer project trips… I went go-karting, and I went clay pigeon shooting and the lads knew I was the drugs worker from next door, but I never ever mentioned drugs to them. I went and was fucking crashing into the back of them in go-karting and … and then all of a sudden, they start coming to me and that – a group developed a year later, you know what I mean? So, it's – it's even, like, everyone's working in silos now in these communities, do you know what I mean, nobody's actually doing that connection piece" (Ronnie).

There was a sense that once a woman became a parent, the needs of the child superseded her needs. While there was no disputing that the needs of the children were a priority, the women's needs were lost to their parental status.

"This is – when the Children First came into place in, what, 2017 I remember at the time saying it in these structures that we're missing a part of this and it's – it's the mother and it's – we're just – obviously the Children First is, for that very reason, called Children First but what we're finding is we're completely ignoring and removing the needs of the mother (Alex).

"For the parents I think the biggest need is – I think there's a lack of that sort of nurturing – there's a lack of a nurturing person in their life that can meet their [speaker's emphasis] emotional needs. So what – what – I suppose what we see is that while the children are often not getting their emotional needs met consistently the parents aren't either and haven't had that experience, the mums I should say….Because, it wouldn't be an effective intervention if we offer children 20 weeks of individual work and actually didn't do any work with the parent because they're the most important person in the children's lives" (Jolene).

Importantly key stakeholders acknowledged that not all women who are in need of treatment have children and these women may have other complex needs.

"What about the women who do not have kids, we are so fixed on the women that have, we often forget about these"

"No, all women have childcare needs, there are women with complex needs, addiction, mental health, just no kids".

While key stakeholders were enthusiastic about residential services that allowed a mother to enter with her child, the limitation for women with no available places or more than one dependent child was a likely barrier.

"So I suppose there's often childcare issues, which although Coolmine is there and there is that option many of the women that I – I work with, the Mams, they've got five and six kids. That isn't an option to go into Ashleigh House with five and six kids so it's looking at those pieces as well" (Gene).

"there's Ashleigh House, but that's one place and how many women?" (Celine).

"if I've a child of five or six and I need to go in for residential treatment, 1) I can't do it, there's nowhere for me. 2) I then have to get somebody to look after my child and if the family relationships have broken down, where do I go? How do I get that help and support if, I end up having to then put them into voluntary care?" (Sam).

Similarly, childcare was cited as a major barrier to women accessing support. The inability to access childcare in order to attend services was a key frustration.

"*Like, a few years ago, you were able to ring up a childcare, especially a community childcare facility and if we had someone coming in for one to ones and there was someone coming in for something as simple as acupuncture or counselling and you were able to get the child minded while they attended for those services and you ring up one of the local ones and being able to organise it for an hour, two hours a week or whatever that case may be. You can't do that anymore"* (Jolene).

"That's absolutely – and childcare, that there's absolutely – the constraints on them and the stipulations and everything else that goes in the childcare facilities makes it really difficult for us to get somebody and then, you have these – they then say that you can – there's a list of childminders within your local area who are available. Like, it doesn't work that way, it doesn't, you can't – I'm not going to just ring up somebody and just ask them to mind my child when I go and then try to organise payment and all this stuff" (Sam).

" I've had experience of people going on for six, sometimes nearly 12, months onto treatment and they can't cope when they come back because the relevant supports are not in place for them, they don't have a crèche facility to be able to access daytime community services or the kids might only be in school until 1.40 and most Community Employment schemes don't end till two o'clock…now she can no longer attend!" (Celine).

"*So there's a huge gap in childcare, it's very hard to get a child into a service here unless it's the likes of An Cosan, which is Tusla funded and if you have a social worker they can send a referral letter and I think the public health nurses have referral pathways there as well. And obviously Barnardos, we have the – the preschool and I always use my – my internal referral pathways for families when I can but there's not enough, so childcare is a huge issue"* (Jolene).

The need to go outside the current system to identify childcare resources was key to reducing barriers for women accessing treatment.

"Childcare is critical for these mums to access day programmes or whatever it is that they need for their addiction plan. We have an improvement service now in the sense that there's an NCS, so the National Childcare Scheme is targeted and will fund women who have children who are in that welfare need. So I would consider a mum who has an addiction a welfare need and you just make an application through us and once we can identify a crèche place, which hasn't been a difficulty yet, once we

identify a crèche place we can support that and it can be funded. And that's a gap that I've been screaming about for quite a while and it's really a newish development, so it sort of came across my path going back to maybe October last year" (Rita).

"… in Australia, so Tusla funded a number of childcare places for – for children and if there was concerns about a child Tusla would pay, the equivalent over there would pay, for the child to go to crèche and then that would be increased visibility for the child but also respite for the parent to, work on their – it's so hard from them to attend appointments and to be present when they're really stressed" (Jolene).

At the core of all key stakeholders' suggestions for change was the need to address the holistic needs of women—the need for services to take a biopsychosocial approach.

"There's absolutely no service or approach that I'm aware of that's holistic that you can, you can address all of those issues within the one place or at the one time or, some kind of an interagency approach to it" (Frankie).

"Not necessarily – maybe just a – a holistic wellness centre or something, not call it a drug treatment centre. But where – like a big one where you could have childcare there, you could do holistic, you could link in with a GP there, there would be a nurse there and where you could come and do respite as well if you're just a woman – not just, if you're a woman that uses crack and you have two children that you can go in and just have a rest and a proper meals for a few days and not necessarily having to stop your drug use" (Ali).

"more often than not we see a multitude of different issues or factors or complex needs at play and we need to implement – like what I was saying about additional residential treatment beds or – we need to change our – our way of working with women in a more holistic fashion. So she can enter a residential safe refuge, treatment centre, whatever you want to call it but 'we're going to deal with all of your issues, we're not just going to deal with DV [domestic violence] here and then', boom, 'send you over to an addiction service'. It's not – you can't decompartmentalise all of these …… parts of somebody, it's totally a waste of time, a waste of resources, it's unrealistic and you can't chop and carve a woman up like that [laughs] into so many different parts" (Eva).

Likewise, the experience was when a woman who uses drugs seeks help for domestic violence, she would not necessarily get access, or in seeking help, she may be an additional risk.

> *"There's – particularly for women who use drugs it's very hard, impossible! to get a woman who's either homeless or a woman who is using drugs into a domestic violence refuge"* (Ali).

> *"And, exploiting a woman in that regard and also it can play out too in the – in the project setting where the – the male perpetrator will feel quite insecure if the woman's getting help, and that can put her at risk because she's going in for her key working session or her counselling or her group work. That that in itself can put the woman at further risk, …"* (Les).

Key stakeholders spoke of how services were disjointed and fragmented. Specifically, how the current case-management and interagency framework was not fit for purpose.

> *"there was no major collaboration or dialogue until we started this process so that was – it was quite – disjointed is the word I'd use so you had one experience at the prescribing doctor had, you'd have one experience that the GP in the community had that might be prescribing Lyrica or another type of medication, Tusla had one experience of what was going on, and the community drug service had a different experience. So there – there wasn't much connection there"* (Alex).

> *"While Tusla know one part of the story, the County Council know a small part of it, we know a little bit. So we're finding that with women quite often that the case management structure is so fragmented that different parts of the table know – only know a little bit about it …… and what we find is we can't – we were quite conflicted and we have an ethical decision to make continuously about what's more important here"* (Alex).

> *"I suppose I suppose I sometimes feel that there isn't a sort of a seamless transition or a seamless connection for the client ….. with services because, and it's not unique to Ballyfermot, but quite often we find that the client, gets, dropped between two stools, (dual diagnosis is) constantly coming up, where – and – and in fact I think that there are some – there are some links a little bit tenuous between we'll say the Task Force in Ballyfermot and mental health services in primary care*" (Mel) .

"from a service point of view, I think we could work a hell of a lot better with each other, I think, instead of fighting for little bits of each other's service to actually have a look at what is available in the community and how women can actually tap into that to get that result, do you know what I mean? And having the steps along the way for them to be able to do that" (Celine).

There was a collective recognition that services and the workforce would need to change if they were to meet the needs of the women presenting for services effectively.

"So what we provide sometimes doesn't match the needs of what the women need when they are actually coming into services, you know. It has to be more practical, more intense, more supportive instead of stigma and child protection and, that's – because that's the route that they end up going down when they come into services is that. That's always the point that scares them so it keeps them out there in their addiction for five or ten years" (Celine).

"… we're hoping to bridge up a little bit and get a domestic violence worker in Ballyfermot even just to do clinics with Saoirse. So we're in talks with victims around that at the minute and if that works, like, that'll be the start of – of things changing as well so yeah" (Ali).

"I'd like a domestic violence service for women – women that use drugs because quite a few do. And I'd like maybe another programme in Ashleigh House that people can go in and have childcare and detox and do subsequent rehab and – and provide aftercare support as well I know more broadly speaking Ballyfermot definitely needs a domestic violence specialist or specialism, it just isn't here very locally" (Miriam).

"So considering what the issues are being experienced we haven't got a domestic violence outreach person or direct referral person within this community. But I think there's some scope to looking at that so that's a really good thing" (Les).

So I think it's – I think – I think from an organisation it's about being open to looking at our culture and not – to looking at our culture, to who we are, what we do, how – how are we doing and are we doing it consistently, you know? (Liz).

SUPPORTING PATHWAYS TO RECOVERY FOR WOMEN

Key stakeholders noted the lack of visibility of recovery supports to engage women. Practitioners shared their successes with engaging women with non-treatment related activities recognising the need to engage on another level and providing women with social outlets.

> *"I think we'd 1,200 up at the café last year every Wednesday night creating a space to have a recovery café that no matter who you were or what you were you could come in, speak to a staff member, speak to a recovery coach, get involved in the activities that was going on. They could step from one room into another room and there was an NA meeting and the whole social aspect, that connection aspect of that that has helped so many people in the Tallaght community to actually go from the clinics and go into a recovery sphere that they can actually learn how to become manageable within their own lives"* (Celine).

> *"I think, like, a social night or something, you know like, a café or an event of sorts that's not necessarily drug treatment but just as a way of bringing women in and bringing them together that there's no pressure to do a big assessment or referrals or even to talk about stuff like that. But just having an event on, that women would go to such as holistic and, you know? Maybe a bit more fun but something that would – that would make them present and come in and – and put no pressure on them whatsoever"* (Ali).

Key stakeholders highlighted the need for women-specific services. There was a recognised period of initial treatment where services should be women only – with the view to transitioning to mainstream treatment.

> *"I would probably set up a community project for women. I really would, as a starting point that there is somewhere for women only to go and to not – to just – to not have to deal with all the complexities around gender and how they experience men and how they think men see them and they can just go and just talk about the different traumatic events that they've had and, like, I – I know as a woman that I speak to other women about certain female experiences like motherhood, parenting, about ageing, whatever it is that I just wouldn't speak to men about"* (Frankie).

> *"So I think there needs to be the option of a women's only service for – for women and then they can look at, once they get a little more confident or a little bit – feel a*

little bit more, yeah, ready then they could maybe go to other projects that's mixed gender" (Les).

"I – I think you bring them back because the natural place is for men and women to be together …… you know, I think conversations won't happen unless you separate both men and women for a period – a necessary period. I think it's really important and more and more I see the importance of the separation of the genders in terms of working, if you again if you really want to get to core issues" (Liz).

"And with women specific treatment services within the community I find would be really important and more resources going into drug services to – to be able to work with people in more of a humane informal, not informal but in a much more broader sense that we can start building trust and relationships with a generation of drug users who've had negative experiences for sometimes over 20 years" (Jamie).

There was a recognition that treatment goals that were set were unrealistic and decreased the woman's autonomy and control in her life.

"I believe unrealistic treatment goals maybe based on – on –another drug treatment service and – and a woman, a mother, female participant it can quite often be an external service who creates the treatment outcome objective" (Alex).
"So somebody coming into recovery after 30 years of addiction, they're not going to say 'I want to be a hairdresser' or a fireman or whatever, they don't know what they want to be, you know. So putting that pressure on somebody coming in at the start of 'okay, you need to be goal setting and you need to be telling us what you want to do when you go on here', they're only probably a month drug free and they can't – they don't even know their arse from their elbow, never mind what they want to do in a year's time, you know" (Celine).

"I suppose sometimes I feel, particularly with the Tusla cases where the parent isn't ready sometimes, we have to offer the service and they don't turn up and then we offer and then we offer and then we offer, and they don't turn up and unfortunately our information that we feed back to Tusla then is the parent didn't engage. I think it's really important in that that we actually say that this isn't the right time for the parent to engage in this work and this is what we think they need instead" (Jolene).

Key stakeholders cited the need to make a timely intervention and facilitate women seeking recovery when they are ready and most motivated.

> "*I – I think if somebody comes to me today and says 'I can't do this anymore', that – I should be able to say to them 'right, come in here tomorrow and let's get this started', If somebody says that they're ready and they want to come off a clinic or they want to stop using drugs or they want to make a difference in their life they should be given the opportunity to do that and they shouldn't have to wait on waiting lists or wait nine months to get into Cuan Dara [residential detoxification] or now I think it's something like a ten month waiting list or something in Ashleigh and there's over a year's waiting list in Cuan Dara.* (Celine).

> *"… I suppose it's really disheartening for women, if you've made the step admitting that they want to, go into treatment and to know then you have to wait a number of years or whatever… or months depending on where you're going, so much can change in a week, never mind in a couple of years, do you know? So I think sometimes you need to catch people when they're ready … and they've lost a little bit in the sense of waiting lists"* (Jade).

> *"I think it's so important to empower the people we work with when they're ready at that step that 'yes, I'm accepting and I'm going to go into treatment' that we allow them to do that and not put blocks and barriers up. But that has been the case in the past is that there's barriers there for them to get access to the – the treatment that they want and need"* (Miriam).

They shared their vision for recovery-based community services. Shared spaces brought together a range of biopsychosocial services. Spaces that are free of stigma would support a range of women and their families in real-time.

> *"I'd love this place where, like, if the bottom floor was a stabilisation programme, the middle floor was a detox programme and top floor was the drug free programme. That all you have to do is just move up a couple of stairs and there you are, you're in the next phase of it, you know what I mean? Whereas if it was altogether in one service that people didn't have to go looking or waiting lists or filling in referral forms or 'and you have to do four counselling sessions with him down there and you need to go back to your doctor and …' you should be able to do all of this within one setting – If somebody wants to address any part of their addiction why can't they just*

go to one place? Why should they have to travel all over Dublin to get the services that they need?" (Celine).

"So it's a very broad range of programme delivery, we attempt to integrate it as much as possible so the concept being of a one stop shop for a young person – The idea being that these services can be wrapped around without the endless referral on and referral on and referral on of children. Where you can walk in the door but when you're walking in as a 22 year old young woman you could be going in to, go into the crèche to drop your child in, you could be going in to go to your youth work group, you could be going in to, have a chat with, we do alternative therapies, you could be going to reiki, do you know what I mean? You could be doing anything but – or you could be going to see your, your work – to work on your drugs and alcohol or your counselling appointment. So there's – there's definitely the anonymous piece connected with that and I think that's easier for young people to connect with, so for young women" (Lou).

"So – and if there's something that could be done it's around strength and – say, a women's network somewhere locally and stuff like that, we don't have a women's network here in Ballyfermot. There's networks of women but not a formalised network, I think that would be a really good use of resources. There's also somewhere buried in the community, like in every community, really strong female leaders and it's to try and identify them and ask their input and that requires a bit of a resource, so that might be renting out rooms or it might be promotional leaflets, I'm not sure what shape that would take. But to try and identify those women and – and pull them to the fore somehow. I mean it's a bit of a community development stuff going on there. I think Ballyfermot is such a strong community and there's a real sense of community development but perhaps it's going back to a little bit more of that community development workers out on the streets, out of hours outreach and stuff" (Les).

The value of the peer influence was emphasised by the key stakeholders.

"That sense of, I can do this, you know? And – and how they were supporting one another, there's nothing like that that camaraderie, where – where women, even if they're out with their girlfriends, that piece where you just feel that support, I think that's what some of these – these women need [speaker's emphasis]" (Mel).

"I suppose the support groups, the peer support groups, there's a huge need for that. I think women, not just women but people in general, whether it's – get huge support from their peers and from seeing, like, I can say things 20 times to them but if somebody within their own group, within their own peers and they see – they see themselves and they see it happening and they know that they can do it. That's, twice the value of something that I can say to them" (Sam).

"And another way I was thinking recently when we can go back to face to face is actually to get some parents who are – who are doing well and who are able and who are comfortable to actually maybe come with me to those type of meetings and actually chat to the other mums and say 'oh I did it and I had these worries and – but we did this and we did that' and just ease the – the pressure for them and the worry I suppose about engaging with Barnardos" (Jolene).

Key stakeholders spoke explicitly about the benefits of Recovery Coaches (RC), i.e. peers who are in recovery from drug and alcohol use, supporting their peers in early recovery. RC was seen as having a deep understanding of their community and the resources available to support women. The visibility of having RC in services was seen as a motivator for women in services.

"They know the services, they know their own local communities, they know the women that are struggling, they know the women that are behind closed doors that are struggling as well and having that resource within a community and that in a number of communities that they could be even a support together and creating the spaces for coffee mornings or mother and toddler groups or whatever it may be. They're meeting women in the fellowships that we wouldn't be aware of that have never crossed a service's door, like you know what I mean, but they'd have access to them, you know?' (Celine).

"…putting a recovery coach in the clinic, even once a week just to show people that recovery can be an option for them even if, like, recovery is only coming down 5ml, it's not to make everyone drug free… with the hope of even just having a recovery coach coming to speak to them when they come to the end of their CE just to show them that this is something that could be possible, you know? And I mean it works so

well so I'm hoping to link back in with Paul around that in the new year because I think – I think it would really change the lives of women that participate in the services in Ballyfermot, you know? (Ali)

SUMMARY OF FINDINGS

- High levels of traumatic life events were highlighted by key stakeholders as central to problematic drug and alcohol trajectories for women presenting in services.
- Key stakeholders discussed the ongoing sexual exploitation and control of women in these communities.
- The need for treatment initiation to be gentle if services were going to engage women was emphasised.
- Services were disjointed and did not work together as effectively as they could.
- The perceived fear of losing children as a barrier to treatment for the women was a dominant theme in the key stakeholder's narratives.
- Lack of access to childcare services was cited as the most significant barrier for women accessing treatment.
- Women did not have adequate access to the necessary support services (domestic violence, mental health, primary care).
- There was a noted increase in women with children with special needs.
- A high number of key stakeholders noted how the responsibility of childcare most often rested with the mothers.
- There is an urgent need for the development of gender-sensitive treatment approaches that support women's particular needs around maternity services, childcare and domestic violence.
- Key stakeholders highlight the constant loop that women with co-occurring mental health issues and drug use found themselves in when seeking help.
- The need to build competencies around addiction in non-addiction service staff was a key theme in the stakeholder interviews.
- Participants shared their vision for recovery-based community services. Shared spaces brought together a range of biopsychosocial services.
- Peer-led support was seen as particularly successful when attempting to engage women.

CHAPTER 5: FINDINGS FROM THE COMMUNITY CONSULTATION

INTRODUCTION

To ensure that we facilitated an open consultative process of participation in the study, we built a mechanism whereby all staff, Task Force members and referral agents from across both communities (regardless of whether they are selected for an interview) were invites to attend an online consultation session. The session lasted for two hours and was facilitated remotely via Zoom.

The consultation participants were asked three questions:

> (1) With women's treatment needs in mind, what in your experience works in your community?
>
> (2) With women's treatment needs in mind, what in your experience does not work in your community?
>
> (3) In order to ensure all women who, need treatment in your community access it, what do we need to do differently?

A total of 28 participants attended the online session. Participants were broken into small groups and asked to answer each of the questions. Each group was appointed a moderator to take notes and feedback to the wider group. Moderators and participants were randomly reassigned for each question. Below is a copy of the moderators' notes, which document the key points raised in each of these groups.

WHAT HAS HELPED WOMEN ACCESSING TREATMENT?

- Greater access treatment residential and community services.
- Additional supports that are available for women during school hours (for example community crèches and/or funded childcare places).

- A greater level of awareness around what services are on offer as a result of a larger social media presence. Thus helping to dispel the misinformation that dates back to when services were opiate focused. This can also impact positively on the levels of shame that women can feel around accessing services for substance issues.
- The availability of the Mother and Child Unit in Ashleigh House has made it possible for women who refuse to, or simply cannot leave their children, to access residential treatment.

WHAT HAS HINDERED WOMEN IN ACCESSING TREATMENT?

- Most women in addiction are using multiple substances i.e. polydrug use. The threshold for residential treatment is too high – most require 50mls of methadone and clear urine from cocaine, tablets, and other street drugs. The waiting lists for residential detox and subsequent rehabilitation are too long- 6 months minimum.
- Lack of childcare supports for women seeking treatment. Coolmine Ashleigh House is the only residential treatment centre with childcare available to women in Ireland.
- In some areas there is a reported lack of support from prescribing doctors for women to access treatment. This inhibits recovery as all treatment referrals require the support of a prescribing GP. Anecdotal reports from women in the community suggest that they generally do not feel that engaging in recovery with their doctor is an option. Doctors are only prescribing drug therapy, access to counselling and other reduction-based abstinence approaches. It is also nearly impossible for a woman to access community benzodiazepine detox from GP's in one area. This frustrates many key stakeholders in the area as women require detoxification from street tablets before they can access residential treatment.
- Waiting lists for mental health supports results in women using higher levels of illicit drugs to manage their mental health challenges.
- Domestic violence and control from partners are a block to women accessing treatment. There is need for a low threshold women's refuge as women who use

substances are often refused a place in a refuge due to their drug use leaving them trapped in an abusive relationship.

WHAT MIGHT BE DONE DIFFERENTLY TO BETTER SUPPORT WOMEN ACCESSING TREATMENT?

- A proactive low threshold outreach service for women who use crack cocaine. Mothers using crack cocaine need to be treated as a cohort in their own right and require early interventions and supports before their crack cocaine use accelerates.
- Another residential treatment centre like Ashleigh House in Coolmine with adequate childcare facilities.
- Drug education and prevention programmes starting with 13-14 year-old age groups.
- A low threshold domestic violence refuge for women who use drugs and alcohol.
- Community detox should be available to women (and men) in the community through their prescribing doctors.
- Recovery coaches in clinics, making recovery an option for women in Ballyfermot & Tallaght.
- A review of residential treatment criteria which reflects the polydrug use that most women seeking treatment are trying to detox from.
- A respite for women with children who have high support needs.
- Gender specific support groups – peer led groups.

CHAPTER 6: FINDINGS FROM THE ONLINE SUBMISSION

INTRODUCTION

To ensure that we facilitated an open consultative process of participation in the study we also built in a mechanism whereby women attending drug treatment services in the two areas, staff, Task Force members and referral agents from across both communities (regardless of whether they are selected for an interview) were given the opportunity to make an online submission. The link to an anonymous survey space was embedded in an email and sent to all staff, Task Force members and referral agents via Task Force networks. In addition, a Social Media (Twitter, Facebook and Instagram) campaign was driven by the research team to capture the experience of women in both communities.

All submissions were anonymous. Participants were asked three questions:

> (1) With women's treatment needs in mind, what in your experience works in your community?
>
> (2) With women's treatment needs in mind, what in your experience does not work in your community?
>
> (3) In order to ensure all women who, need treatment in your community access it, what do we need to do differently?

Each question had an open space (which was limited to 500 words per question, i.e., each submission has a maximum of 1500 words). The submissions were completely anonymous. The purpose of the online submission was threefold: (i) to enable interviewed participants to express a concern/issue anonymously, (ii) allow participants (particularly, but not limited to, those who had not been interviewed) an opportunity to voice their experience that would not have otherwise been captured, (iii) to maximise the chances of capturing women's experience that are not connected with other treatment users or services in either community.

A total of 25 individuals made a submission. Of these, two were from women seeking treatment; one was from a woman in long-term recovery, the remaining 22 were made by treatment and service providers. In addition, nine participants chose to offer additional comments. Below is a brief synopsis of submissions. (Submissions are included in the unmodified form in appendix 1).

WHAT IN YOUR OPINION HAS WORKED TO HELP WOMEN ACCESS TREATMENT FOR DRUG AND ALCOHOL USE IN BALLYFERMOT AND TALLAGHT?

When asked what worked when engaging women in treatment services in both communities, submissions highlighted the existence of several quality services in Ballyfermot and Tallaght. It was generally suggested that these services place a strong emphasis on the complex needs of women who use illicit substances or alcohol. Peers and professionals had actively ensured that women's needs have been placed and kept on policy and practice agendas. Moreover, these agencies prioritised women, children and families in terms of their specific treatment needs. Services in both Ballyfermot and Tallaght operate trauma-informed, non-judgmental, compassionate services based on local knowledge and individual need. In addition to meeting the treatment needs of women accessing services, staff are also advocating for and referring women to other complementary services, such as General Practice or child protection services. It was suggested that peer-led interventions in particular were critical success factors in women's engagement with treatment services. The need for an increase in gender-sensitive services was a common and oft cited theme in the submissions, while highlighting that such services are not often available. Most submissions highlighted that gender-sensitive programmes and interventions have been particularly effective in encouraging women to access services, while also reducing loss-to-follow-up.

WHAT IN YOUR OPINION HAS NOT WORKED TO HELP WOMEN TO ACCESS TREATMENT FOR DRUG AND ALCOHOL USE IN BALLYFERMOT AND TALLAGHT?

When addressing what did not work when encouraging women to access treatment, participants noted that the stigma and shame associated with illicit drug use and crime, sex work, homelessness disproportionally affects women. Submissions highlighted women's

fears about losing custody of their children as a significant barrier to access, while childcare issues were as frequently mentioned. Moreover, the lack of parental support was seen as disadvantaging the women, particularly those with less family support.

Some submissions emphasised that the attitudes of some services providers, which may be perceived by women to be judgmental and punitive, are a significant barrier to access to treatment. This is then compounded by inadequate service provision for women experiencing domestic violence and lack of joined-up or integrated service provision. The visibility of women in treatment services was also highlighted not least as services can be seen to be opioid-centric, while failing to depict women with non-opioid addictions or with different ethnicities or age profiles.

The dearth of pathways to treatment, in particular residential treatment, was overwhelmingly represented in the submissions with stakeholders calling for an expansion of child-friendly residential treatment and care.

Finally, several submissions mentioned weaknesses in the current case-management system, expressly the need to link women entering detoxification to adequate inpatient aftercare.

WHAT NEEDS TO BE DONE DIFFERENTLY TO HELP WOMEN ACCESS TREATMENT FOR DRUG AND ALCOHOL USE IN BALLYFERMOT AND TALLAGHT?

The submissions acknowledged that many of the suggestions for change were already beginning to take place including increased availability of childcare and women-only group supports. However, the need for expansion of these facilities was raised and longer-term political and funding commitment. There was a particularly clear call for the expansion of childcare and family-friendly residential treatment and care services.

The need to continually train, upskill, and supervise service providers to respond adequately to women's needs was frequently cited- as was the need for creative thinking and adaptable outreach to engage women in services. The greater involvement of peer networks, peers support and peer outreach in accessing and making contact with women in less visible

situations was mooted. Harm reduction approaches were considered critically important in outreach services, while the reorientation of gender and age-based drug treatments need was acknowledged as a crucial change. Improving community-based treatments will ensure the increased engagement of women in services, it was claimed.

ADDITIONAL COMMENTS

Submissions frequently referred to the need for improved mental health supports for women accessing treatment for illicit substance or alcohol use. The impact of poverty and structural inequality disproportionally affects women in terms of physical and mental health, while violence against these women is commonplace. Repeated exposure to vicarious trauma and acute deprivation also impacts people working in treatment and support services and there is a need to take a more systemic approach to service development and self care.

Finally, submissions frequently referred to the need to continually review treatment plans so that women receive interventions that are appropriate to changing need.

CHAPTER 7: DISCUSSION OF FINDINGS

The main goal of this study was to enhance the understanding of women accessing appropriate treatment for their substance use. The study's narrative approach has facilitated a detailed exploration of the events and circumstances leading women into substance use, as well as their experiences of treatment services. Although the section of the research that focused on women's experience of treatment is multifaceted, the women interviewed were united in their belief that access to services was restricted for gender-specific reasons. All the women interviewed invariably reported complex and sometimes traumatic life experiences, often still ongoing and compounded by abuse, violence, and loss. As indicated by the international evidence reported in Chapter 1 and reinforced by this study, women's treatment needs are distinct from their male counterparts, both in terms of causes and consequences. It therefore follows that the services, strategies, and interventions aimed at engaging women in treatment must be distinct from mainstream services. This study has further indicated, again reflect in the international evidence, that services and interventions must be age and 'stage' appropriate while simultaneously recognising that prompt access to treatment is paramount if ongoing cycles of addiction and dependence are to be prevented.

A considerable proportion of women, particularly those who have experienced traumatic life events and are struggling with addiction and, in the majority of cases, mental health issues, need an interim trauma-informed model of treatment that provides a supportive environment as well as a range of specific supports. The aim of this model of treatment should be to maximise the prospect of a successful transition to mainstream recovery services and supports.

The women's interviews indicated that parenthood, and its associated responsibilities, strongly influenced the treatment-seeking behaviours of mothers who use drugs. A lack of child care provision within substance use services limited access to support for mothers as the literature suggested.[25, 35-37, 39, 58] While stigma and fear were a key barrier in treatment

access for the women interviewed, participants with children voiced specific fears regarding the loss of custody of their children if they engaged with substance use services. This also corroborates findings from the national,[39, 58] and international literature [24, 30, 33, 34, 36, 37, 48, 56]. The perceived risk of losing custody of their children is often traumatic for women[36, 116] and may increase substance use and criminal activity.[117]

Tulsa, the Child and Family Agency is the dedicated State agency responsible for improving wellbeing and outcomes for children and as such, a discussion of findings related to the service is warranted here. Results from the women's and key stakeholders' interviews suggest variability in their interactions with social workers. Tusla's 2019 Parent Survey suggests positive relations with their clients though clients noted that high levels of turnover among social workers had negative effects on their progress.[118] Key stakeholders further suggested room for improvement in the relationship between social workers from Tulsa and the substance use services. Tusla's Meitheal approach is a coordination process to support families which do not meet the criteria for social work involvement.[119] This approach may improve coordination and cooperation between substance use services and Tusla's social work department.[119] The Meitheal programme and outcome study recognised the importance that maternal wellbeing plays in the overall family dynamic and highlighted positive outcomes for the model.[120] These reports are not focused on women who use drugs. However, Hanson et al. [121] has demonstrated that close cooperation between child protection services and substance use treatment providers in the implementation of a family recovery model can result in a high percentage of children (81%) remaining safe and in parental care.

This study clearly demonstrated that women who use drugs in Tallaght and Ballyfermot display a complex array of needs across a variety of domains. These include adversity such as stigmatisation and domestic violence. One response suggested by both the women interviewed, and key service providers and stakeholders was provision of women specific services. Women only services are designed to meet female-specific needs and often provide additional supports that accommodate the particular needs of women.[108] Women

specific services may provide primary health care, child care, a family-friendly environment, housing support and transportation support in addition to substance use treatment.[108] The need for expanded access to childcare in residential and other treatment services is paramount and was repeatedly raised in the literature and by the vast majority of participants in this study. The integration of substance use-oriented harm reduction[73] and parenting supports[112, 113] in women-only environments have been achieved in Ireland. International literature both corroborates the need for women only services[13, 36, 76] and their effectiveness.[109, 110, 122] The data collected in this study calls for the provision of holistic and integrated services for women. In lieu of integrated service provision, there is a demonstrated need for greater cooperation and communication between services.

Many women indicated that they did not know where to access appropriate support for substance use when needed. This informational gap between service providers and service users has been demonstrated in the international literature.[23, 36, 69, 77] The women interviewed reported that family and friends were their main source of information about treatment services. Public health care providers are in key positions to increase the awareness of substance use services among their patients. However, this opportunity needs to be better utilized.[34, 36, 104] Key stakeholders appear aware of this informational gap and are actively trying to increase service awareness in their community as well as provide low threshold services to encourage the engagement of women who use drugs. Building trust between substance use services and the community they serve is vital to supporting women access to even low threshold services. [23, 101] These findings suggest a need for appropriate and effective community outreach programmes to increase service awareness.

Importantly, models of treatment that aim to support recovery should provide for a number of young people in any one treatment setting; they need to be time-lined and support a clear pathway to recovery. Participants spoke of how their peers and family members 'modelled' recovery. Th women reported that they were happy to engage with peers. Peer-led recovery supports are an emerging evidence-based model with enormous potential.

Additionally, the women interviewed reported a range of pressing issues beyond their substance use that are likely to pose risks to their future and their ability to achieve and sustain recovery including parenting children with special needs, traumatic life events, and mental health problems. Women need early psychological support interventions before moving to mainstream treatment services.

Women in this study, while recognising a number of gains, particularly in the early stages of treatment, were mainly negative about the experience of long-term methadone maintenance. In the main, both the service providers and the women noted the lack of autonomy women had in their clinical regime. At best they played a passive role that offered little opportunity to exercise agency in relation to their ongoing treatment.

The results highlight that women who use drugs are not a homogenous population. They vary in age, the substance used and family status. Both the women interviewed, and key service providers and stakeholders highlighted that women of different age groups may find it difficult to identify with each other and require substance use services that address their specific needs, barriers and life experiences. This corroborates what was found in the initial SWAT study.[104] International literature supports that people of different ages vary in treatment seeking,[123, 124] and require appropriately specialised treatment provision.[125, 126]

CHAPTER 8: CONCLUSION

There was a genuine enthusiasm for the research amongst participants. The benefits of evaluation of services were clear and consistent. The services are willing and wanting to engage with women to better address their treatment and recovery needs.The two Task Force areas, Ballyfermot and Tallaght, offer an eager perspective and supportive environment which if adequately nurtured will ensure the continued development of better services for women in their communities.

In the main scientific research and evaluation have not played a significant role in influencing the development of addiction treatment services for women nationally or internationally. The consequence of this is large disparities in the development, management and monitoring of national treatment systems. The current study seeks to rectify this by providing much-needed data on women's experience of accessing treatment.

By initiating and undertaking the research Ballyfermot and Tallaght Local Drug & Alcohol Task Forces are leading their peers by responding to national policy and further developing evidenced based practices. The current study is aligned directly with national policy addressing actions set out in the National Drugs Strategy to improve access to services for women.

STRENGTHS

The research included the perspectives of a range of stakeholders: women, practitioners, policy makers and community representatives. There is a dearth of literature on Irish women and their rationale for accessing treatment. Thus, eliciting these views from this cohort is a key strength of the study.

LIMITATIONS

Nonetheless, the research is not without its limitations. All data are self-reported and therefore open to bias. The data were collected during the COVID-19 outbreak and as a result there were limits on travel and personal movements which impacted on accessing

and interviewing participants face to face. The study included women connected in some way with services. Based on the experience of the women included in the study one can assume that there is a hidden cohort of women in both communities in need of accessing treatment that have not come forward. We did not manage to include these women in the research. This is the biggest limitation of the study. Homelessness as a barrier to women accessing treatment came up in the online submissions and the Service Provider/Key informant interviews but was not a factor for the women interviewed. One plausible reason is that women with immediate homeless needs are more likely to present at services in the City Centre, particularly during the COVID-19 pandemic.

FUTURE DIRECTIONS

Future research should focus on accessing this hidden cohort of women with unmet treatment needs. Moreover, gender-specific factors influencing recovery merit particular attention at policy and service levels if women's treatment needs are to be appropriately met. Understanding how gender can shape, define, and influence both men and women is crucial to supporting sustainable recovery pathways. In Ireland, we currently examine recovery through the narrow lens of treatment outcome data, with an overreliance on abstinence. Recovery is a far more helpful metric, one that encompasses more than abstaining from substances. As such, recovery allows us to understand the journey from a range of outcomes (for example health, relationships, well-being, education, employment, and self-care), including the individual, the community and society. Of particular importance is evaluating ways to build community capital, i.e. collecting robust data that will inform the development of new and existing services and supports for women initiating and sustaining recovery.

CHAPTER 9: RECOMMENDATIONS

This chapter will draw on the available international literature, coupled with the findings from this study, to inform recommendations for both policy and programming. The findings have national relevance and will require leadership and political will to improve addiction recovery services for women. While the Ballyfermot and Tallaght Local Drug and Alcohol Task Forces have demonstrated particular commitment to women, both in initiating this study and in their development of the SWAAT project, recommendations are intended to inform wider policy and practice at national Task Force level.

This study's findings suggest that women frequently rely on peer and family networks, and 'word of mouth' for information about available services. It is significant that many of the women who participated in this study expressed reluctance and even fear around seeking help and support when they felt they needed it or in a time of crisis in their lives. At a minimum, promotion of information about service availability must be more accessible, in conjunction with provider reassurance that help-seeking for addiction is a positive and supportive step rather than a punitive one. The importance of services being trauma informed and gender specific was raised consistently by both the women and key stakeholders and cannot be underestimated. The women and key stakeholders were unanimous in their recommendation of childcare and family support for women accessing services. The development and expansion of pathways to services, education and employment for women were identified as being central to women sustaining recovery.

The recommendations are outlined in detail below.

RECOMMENDATIONS	ACTOR/ DRIVER *National/ Local*	TIMEFRAME *Short (0-6 months) Medium (7-12 months) Long (13-36 months)*
RECOMMENDATION 1: DEVELOP AN ADEQUATE TRAUMA INFORMED RESPONSE FOR WOMEN WHO USE DRUGS. Overwhelmingly the study's women and key stakeholders highlighted high levels of traumatic life events in the women's lives, which played a significant role in the trajectory of their drug use and ability to engage with services. Moreover, there was an acknowledgement of vicarious trauma amongst staff responding to the current needs of women presenting to services, with little to no self-care systems for vulnerable staff members. In order to address these issues there is a need to develop a comprehensive trauma-informed response.		
1.1 Provide trauma awareness training and ongoing support for all staff and volunteers across services.	Local	Long-term
1.2 Ensure all staff (and volunteers) are trauma informed and are competent to integrate this into all interactions.	Local	Medium-term
1.3 Ensure line managers and senior members of staff are provided with additional support to help monitor and assess vicarious trauma in staff.	Local	Medium-term
1.4 Ensure all staff (and volunteers) have a self-care plan.	Local	Medium-term
1.5 Line managers and other senior members of staff need to be offered similar supports, with a trauma informed specialist, particularly non clinical staff who are less likely to have regular supervision.	Local	Medium-term

1.6 Develop a robust data collection system to establish and record trauma. Documentation of prevalence and severity of trauma will better place services to respond effectively. In addition to ongoing review and evaluation, the data will allow services to provide appropriate treatment.	National	Long-term
1.7 Record women's levels of adverse childhood experiences.	National	Long-term
1.8 Record staff/ volunteers levels of vicarious trauma (ProQOL).	National	Long-term
RECOMMENDATION 2: ESTABLISH GENDER TRANSFORMATIVE, INTEGRATED TREATMENT AND SUPPORT SERVICES FOR WOMEN WHO USE DRUGS The women interviewed reported a range of pressing issues beyond substance use and mental health problems that are likely to pose risks to their future and their ability to secure and sustain recovery. By the time women reach treatment, they are often in crisis and have several complex needs outside of their substance use. Specific populations of women consistently report significant barriers to treatment access. Further, stakeholders identified various sub-populations of women who attend their services such as women who are pregnant, have children, have co-occurring mental health difficulties, experience domestic violence, are homeless, or engage in sex work. In order to address these issues and improve outcomes for women the literature and the findings of this study recommend gender-sensitive approaches in safe, supported surroundings.		
2.1 Develop interim models of care. Interim models of gender-sensitive care may be the most appropriate option for women with high and complex needs, who need a supportive environment to develop the skills and confidence to aid recovery.	National	Long-term
2.2 The planning of appropriate pathways to treatment needs to be initiated early and reviewed regularly in consultation with women.	National	Long-term
2.3 Gender-sensitive evidence-based training .Develop an evidence-based, gender-specific training suite for staff across addiction and support services based on the needs of specific populations.	National	Long-term

2.4 Develop a strong outreach focus to bring in women who are not connected to services and make supporting their needs a priority. Key to this is the identification of local partners from within the community, including peers in recovery.	Local	Medium-term
2.5 Explore opportunities to integrate outreach into existing services and staff roles.	Local	Short-term
RECOMMENDATION 3: ESTABLISH A WORKING GROUP BETWEEN BALLYFERMOT AND TALLAGHT LOCAL DRUG AND ALCOHOL TASK FORCES AND THE CHILD AND FAMILY AGENCY (TUSLA) The perceived fear of losing custody of one's child, societal and self-stigmatisation, and negative experiences with healthcare providers reinforces barriers to access. Both Ballyfermot and Tallaght Task Forces and the child and family agency (Tusla) should establish a working group. Mentoring early career social workers and addiction staff would provide intensive key knowledge exchange and support. The mentee should have access to a senior social worker, a senior addiction practitioner and a recovery coach who would induct the early career social worker into the local context and equip them with the necessary knowledge and support.		
3.1 Develop appropriate training for staff and to operate more closely aligned referral pathways.	Local	Short-term
3.2 Develop a guidance and support mechanism for frontline addiction and family support services staff to integrate referral pathways and to enable 'early intervention for both woman and children at risk.	Local	Short-term
3.3 Develop a communication strategy that sets out a plan to raise awareness among women regarding available services to support them and their children in getting their needs met. This awareness campaign should involve various communication approaches (such as social media campaigns, adverts on community radio, recovery cafés, open fellowship forums).	Local	Short-term
3.4 Develop an interdisciplinary mentoring scheme: a mentoring scheme for early-career social workers and addiction staff entering communities and areas with high prevalence of addiction.	Local	Short-term

3.5 Provide senior social workers, addiction practitioners and recovery coaches with specific training to help them support junior colleagues.	Local	Short-term
RECOMMENDATION 4: DEVELOP PATHWAYS FOR WOMEN TO SUSTAIN RECOVERY While the aim of recovery is apparent in Ireland, policies, language and the concept of recovery are far less visible. Early intervention involves assisting women, particularly young women who want to change or are in the early stages of recovery. Recovery Community Centres (RCCs) are intended to be recovery hubs facilitating "one-stop shopping" in the accrual of recovery capital (e.g., recovery coaching; employment/educational linkages). RCCs can allow communities an opportunity to reimagine a space and transform that space into 'other' services and supports on days that it may be underutilised. RCCs allow communities to collaborate with experts to deliver skills to populations that generally go unserved, particularly in that space. Moreover, RCCs can create a space for all community members, one that is free of stigma and labels. Creating spaces free from stigma and not branded as drug and alcohol services are vital to engaging young people who are maybe using drugs or alcohol in a harmful or hazardous way. RCC's could also develop pathways to support women to escape abusive relationships (reducing negative social capital) and to engage with positive groups, including mutual aid groups (positive social capital) and access community resources (positive community capital).		
4.1 Development of peer-led components of service delivery. Training and employing recovery coaches to deliver programmes and offer one-to-one support.	Local	Medium-term
4.2 Create visibility and showcase peer recovery which are proven approaches for reducing stigma.	Local	Medium-term
4.3 Refocus service provision by building and resourcing a 'community of services'. Developing RCCs adds to the existing tiers of formal treatment and mutual-help organisations.	Local	Medium-term
4.4 Audit local spaces across respective communities to understand where and when potential spaces can be opened up. Reimagining how these spaces may be utilised to engage members of the community has enormous potential.	Local	Short-term

4.5 Develop parent-friendly services including recovery services for women who may also be parents and who may not ordinarily present to recovery-based activities. This would include the development of spaces and activities for children (sports, drama, science camps, workshops) in parallel to the women's treatment.	Local	Short-term
4.6 Develop a series of pop up cafes and social events run by peers in recovery to showcase recovery and engage women in need of support.	Local	Short-term
4.7 Community engagement- work with those in their recovery and the wider community to teach and develop skills to help individuals gain or retain long-term employment.	Local	Medium-term
4.8 Community training opportunities- conduct an audit of local businesses, training schemes, enterprises, partnerships to identify training opportunities and upskill community development programmes.	Local	Medium-term
4.9 Create community capital asset building- conduct an audit of local clubs, societies, faith-based groups, SMART Recovery Groups and fellowships and open up community spaces to showcase these and to engage women in their broader community.	Local	Medium-term
4.10 Create recovery spaces with holistic services, clubs, activities and workshops that are non drug-related is a unique way to engage women across the community in a non-stigmatising way.	Local	Medium-term

RECOMMENDATION 5: EXPAND PATHWAYS TO EDUCATION AND TRAINING FOR WOMEN Participation in education and training is critical to ensuring that women transition to secure work. Successful entry into a highly competitive labour market is strongly dependent on the acquisition of the appropriate mix of academic credentials, training and employability skills. This study's women recognised and strongly emphasised the importance of education and training, with several depicting education as critical to finding a 'way out' of addiction. Moreover, some women were forced to choose between maintaining financial support for their family and educational advancement.		
5.1 Partnered communication strategy including social media campaign, open cafes, dissemination pack for peers and outreach workers.	Local	Medium-term
5.2 'Match-making' women with relevant financial support and an education plan.	Local	Medium-term
5.3 Aftercare plans for all women that continue to include education and training pathways that are adequately resourced.	Local	Medium-term
RECOMMEDATION 6: SUPPORT WOMEN TO REBUILD AND SUSTAIN HEALTHY FAMILY RELATIONSHIPS This study has documented the lack of family support for some women. Most of the resources available correctly concentrate on supporting parents to respond to their children effectively. Several key stakeholders highlighted the unmet needs of the women as children themselves. Thus, developing support for women and their family members to maintain connections and rebuild relationships is hugely beneficial for initiating and sustaining recovery. In part, because fractured family relationships and family environments characterised by conflict are factors known to precipitate addiction, work with families is frequently neglected or not prioritised.		
6.1 Develop a programme to strengthen family relationships	Local	Medium-term

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APPENDIX

Submission	What in your opinion has worked to help women access treatment for drug and alcohol use in Ballyfermot and Tallaght?
1	*The presence of a number of high-quality services in the Ballyfermot and Tallaght areas with a strong focus on the needs of women among workers, professional and peer, has ensured that women's issues have been placed on and kept on the agenda for both practice and policy. The provision of services in these agencies have prioritised the needs of women, children and families in terms of treatment and support.*
2	*here in Ballyfermot, we offer a nonjudgmental approach to offering treatment to all service users. we understand the many challenges for women accessing treatment and on entering Ballyfermot Advance Project this is the first step for many of the women. Treatment can be anything from reducing their use to accessing appropriate services to their needs. Many women do not go further than engaging with key working and getting some balance into their life. I can only speak for Ballyfermot and I am only working here a year and find some women are more open to treatment when Tusla are involved. I have a lot of experience of working with Tusla and this helps put the clients at ease. Offering treatment in any shape or form is so important to women be it holistic or intervention tools such as CRA or Solution Focused Brief Therapy.*
3	*More funding available to meet the needs of childcare for women looking to access treatment. More residential beds where a woman can bring her child. Further to this I feel female specific aftercare services with a wide range of supports available. Addiction specific community-based midwife would be great and to work in collaboration with other services in the community*
4	*Having access to Childcare, working on self-worth and being around other women has worked to help women access treatment. From my experience the main thing that has helped is supporting them with being a parent.*
5	*Local services such as Star project*

6	*Fusion in Ballyfermot was a great support for me.* *Others in recovery.*
7	*Knowledge of supports services available and services they offer, a lot of women I have signposted where unaware of how to get help, or taught the services offered support to a different profile of drug user only,*
8	*Services Family members, peers.*
9	*One of the main supports to women accessing treatment both internally in our community-based service JADD or accessing Tier 4 services is more trauma informed methods of working with service users. To work cohesively in line with their shared experiences and their personal barriers in place to accessing their preferred treatment goals. Most of the women attending our service in need of stabilization treatment are also engaging in often complex multi-agency arrangements with TUSLA, Housing, mental health, Probation, social workers and many other agencies. Their fear and hesitance to engaging openly and transparently in a case management structure is naturally high. This is often due to the consequences of different agencies through Housing arrangements, Child Protection Legislation and or legal ramifications for housing if for example a woman's house is taken over by Crack using gangs. The JADD project through a focused Crack Cocaine Program actively engaged this cohort and worked with them on safer subjects around health, harm reduction, safety and gave food and addressed their primary needs in the majority of the discussion. Over 11 months 10 of the 15 women, through introducing more topics of case management, confidentiality, treatment goals are now in preparation for treatment. Any future treatment strategies for women must acknowledge their natural resistance to transparent and open case managed plans as it will inevitably trigger mandatory reporting or actions. The process will take longer as Children First obligations and any other legal obligation must be facilitated to be processed effectively, while work can be introduced towards a clear treatment outcome.*

10	*Access to a range of services at both lower and higher thresholds. If they haven't worked well with one service down to personal preference, other attendees or relationship with professionals there is another that they can try.*
11	*The facilities for woman with children. the family help the service provides.*
12	*One-to-one key-work and clear referral pathways to services.*
13	*Women been able to access childcare facilitates has really helped. Having specific women's programs when children are in school or at childcare.*
14	*Available services with qualified staff when needed, peer support groups, information on available pathways to treatment options, 1-1 supports from qualified staff offering evidence-based supports.*
15	*Childcare supports within addiction services for women with substance use problems. For example, Ballyfermot STAR & JADD project have extensive contact with women with addiction problems.*
16	*professional support in accessing appropriate services. Advocacy, building relationships with client's Appropriate interventions. Access to services out of the average hours 9/5 hours Protective factor children been taken into care.*
17	*professionals support in accessing the appropriate service professional ability to structure times that suit individual. The relationship with service user and client Advocacy The potential risk of children being taking into care from Tulsa can be a protective factor to get women engaged in treatment. Having an on-site clinic gives accesses to' hard to reach' clients' doctors that encourage treatment, however when it comes to stabilization it seems they will only make referral when there is reoccurring injury due to IV use*
18	*Peer support has helped woman engage in services. Service providers continue to contact woman in target group.*
19	*There are many addiction services in Ballyfermot & Tallaght who work tirelessly with women, in particular the CE programme. Ballyfermot Star & JAAD have facilities with*

	childcare on site and I think this is hugely beneficial. Other programs which are helpful are gender specific groups and crack cocaine specific groups.
20	*Having good communication. providing a space for women to go to. Making sure they [the women] understand that our service is judgmental. Confidentiality is at the highest standers.*
21	*We have a social prescriber in our GP practice who has been invaluable in linking all patients up with these supports. Patients have found Dominic's in Tallaght, which is quite helpful.*
22	*Referrals from stabilisation programs, access to childcare. Staff who are trauma informed and sensitive to the unique needs of women with multiple issues that need to be addressed in conjunction with their addiction.*
23	*Peers, like coaches, and fellowship.*
24	*Whilst there are no women specific drug and alcohol services in Tallaght that I am aware of there are general principles that will attract women into services. Services whose staff are compassionate, non-judgmental and open-minded increase the chances of attracting women into treatment, particularly women with children who may be fearful of being reported to social services because they have an addiction problem.*
25	*Services that can help & support women with children.*

Submission	What in your opinion has not worked to help women to access treatment for drug and alcohol use in Ballyfermot and Tallaght?
1	*In Ballyfermot and Tallaght, as across the city, the barriers and gaps in a range of areas impacts on women's uptake of services. In the first place, the fear, stigma and shame attached to becoming involved in illicit drug use and associated activities and fall out (crime, sex work, homelessness) is in the main greater for women and girls. There is much evidence to suggest and confirm that women's experiences of drug use are different to those of men and that the fall out is greater for women. Secondly, for women with children, the fear is often accentuated with regard to the possibility of losing children to the care of others. Visibility may also be a considerable issue and women may take longer to present to services and when they do, it may be due to a range of issues including health needs, pregnancy or referral by a range of agencies. Thirdly, childcare is often a deterrent to women attending services for assessment, counselling, key working, case management etc. The lack of on-site short-term (drop in) and longer term (crèche) care means that many women are at a disadvantage and women with less family support may find themselves unable to access or uptake services. Fourthly, across all areas, the attitudes and responses of services may be perceived as judgmental and punitive by women, especially where there is concern about the welfare of children or child protection issues. Fifthly, some services, across all areas, may not be sufficiently trauma informed. Women's experiences of trauma, in childhood or across their lives, is closely entwined with their addiction, drug and alcohol use, involvement in crime. In addition, relationships with partners (male or female) may be coercive, controlling, physically and or sexually violent and women may be reluctant to reveal this to services or partners/others may actively prevent them from using services.*
2	*Fear of Tusla and lack of childcare support.*
3	*The lack of residential beds, long waiting lists. The fear of social work involvement*

4	*A lot of women are not aware of the services being provided, women's negative feelings around drug use and being a parent.*
5	*At the moment COVID is the main one. Before that the services worked very well*
6	*Woman with young kids maybe*
7	*The stigma attached to local services and the fear of been seen entering leaving or while in the service, has prevented many women from engaging with services, Women with small children also have a fear of social work becoming involved with them by accessing services*
8	*The perception that the current drug and alcohol services are opiate services, women, young women particularly can associate current services as places their parents attended for support with opiate addiction No alcohol or cocaine specific services. The challenge identifying when recreational drug use moves to more problematic drug use*
9	*Through many Case Management experiences supporting women accessing treatment several factors are rooted in the problem. There is no clear pathway into treatment for a woman who is the primary carer of a child. There will need to be some level of family support plan with relatives where often there is fractured and complex history. There are difficulties ensuring long term post treatment planning as quiet often the community infrastructure is not there to support their goals. If a client detoxes there is not a clear pathway to a drug free residential service. Case Management structures are often deficit based and not with a clear agreement of a drug treatment goal in line with the service user's capacity. This may involve agreeing a community-based treatment to become drug free, where there are signs in previous treatment history that it is not a viable plan. This may have been agreed with TUSLA and other agencies without a coherent basis for this plan. The combination of poly drug use within care plans in treatment are also in need of review with the impact upon outcomes. If a service user presents with Crack Cocaine use as their primary issue, there is often an equally problematic opiate dependence and or tablet and alcohol use. This pattern of stimulants and depressants use will inevitably lead to challenges in delivering community-based*

	treatments as they are either impacted by intense crack use or effected the following day coming down off the drug. This has knock on effects with engaging in assessment appropriately and delivering treatments effectively.
11	*In terms of residential treatment, the waiting lists and lack of beds is a huge issue. Someone may decide they are ready to access treatment and prepare for it and by the time a bed is available their circumstances have changed, and it is not possible any longer. Children are also a huge factor in influencing residential treatment for women. Often, the women we work with don't have a strong family support network to help care for their children while they go to treatment or the thoughts of missing them and not seeing them enough can be a barrier. Some [residential treatment] centres don't allow children to visit for at least 6 weeks while others allow it immediately but may not be the appropriate centre for their needs. In terms of local addiction day services, there are a number of factors which may be a barrier to women attending. This can be down to individual counsellor they attended previously and personality clashes. There is also a stigma around some of the services, maybe their parents who were opiate users years ago attended there or just neighbors they know, and they don't recognise their alcohol, benzo or cocaine use to be as problematic or want to be seen in the same light as people who attend there. The individual may have another worker who they want to support them with accessing treatment locally however, this support may be confused by the drugs services as the individual not attending on their own initiative. Often women who access our service support struggle to remember appointments whether it is medical, mental health, for their children etc. and this is a key element of support we offer whether it is a reminder or a lift to it. This is a voluntary and requested support however, sometimes it is difficult to bridge the gap between drugs services and other community services to do this piece.*
12	*I think it has worked and I cannot personally find any fault with the service provided*
13	*Not enough emphasis on supporting holistic issues for women (e.g., having mental health issues and drug/alcohol issues can mean not receiving support from services not prepared to deal with dual diagnosis). Women with children or dependents putting their*

	issues last on the never-never and this not being picked up enough by services who focus then only on the issues presented. Need for services to really understand the level of fear for mothers around the possible or imagined involvement of social services and the amount of calculation that women can make on these issues before presenting their needs.
14	*Not providing women with childcare, not providing women with a choice of a gender specific worker as some women may only prefer to work with another women.*
15	*9-5 services no after hours in certain areas, childcare options when attending 1-1 supports or day services support, community awareness of what supports are available to women, lack of community detox supports as most women cannot attend residential services even were places available. Stigma and shame attached for women and fear of social service involvement or risk of children been taken into care.*
16	*There is an 'attitude' within the HSE addiction services, and to an extent, the Drug & Alcohol Task Forces, that they are not responsible for supporting children of women with addiction problems, which immediately blocks a pathway to treatment for these women.*
17	*COVID 19 To long of a waiting list Availability of Beds not enough beds. The process to accessing treatment is too long*
18	*Due to COVID 19 restrictions on residential and day programmes. Fear of Tulsa - kids will be taken, access to Childcare, attitudes and stigma that women face from professionals due to their drug use. Services not shifting their model of work. We do not only need medical intervention we need therapeutic interventions in a Trauma informed manner from services across the board. Waiting list not enough beds[residential services], mixed groups, women afraid to speak and have a different set of needs compared to men.*
19	*woman cannot access childcare. Services need to advertise more. Organizations need to have a wide range of services.*
20	*The lack of collaboration between the community voluntary sector and the statutory services. In particular, the fact that many women in addiction are except from accessing statutory mental health services due to their addiction. The lack of childcare support*

	prevents women seeking treatment. The cap on how many years a woman can spend on a Community employment scheme is also a barrier. The lack of residential/stabilization beds for women. The unwillingness of GP's and local health providers to provide community detox and naloxone. The lack of recovery options and the overprescribing of methadone to women in the area. Poly drug use locks women out of statutory services. Fear of social work involvement associated with help seeking.
21	*Childcare. Lack of motivation. stigma.*
22	*More inpatient detox beds would be helpful. More difficult to access inpatient beds with COIVID [restrictions]*
23	*Lack of access to childcare. Lack of understanding of the complex needs and responsibilities of women with addiction issues. Poor levels of support for women dealing with Tusla for access to their children.*
24	*Lack of women specific services particularly in the HSE Addiction services and also a lack of expertise in women's health.*
25	*The lack of available treatment for women with children, in other words women with children seldom get the proper treatment for their addiction because there aren't any residential treatments available where women can take kids with them. Coolmine Ashleigh House is the only residential treatment centre available to women with children. The problem is the availability of spaces to those mothers. It's this kind of service that women with kids really need. And more should be done to help with these issues.*

Submission	What needs to be done differently to help women access treatment for drug and alcohol use in Ballyfermot and Tallaght?
1	*Many of the things that are suggested below are taking place and yet it is crucial to add to and supplement these activities. Keeping the issue on the agenda in the longer term is crucial. These same issues have been raised since the late 1980s and although it is accepted that women's concerns are important much has not changed for women who use drugs in the interim. Keeping women's issues, health needs, concerns and preferences on the agenda. Childcare to facilitate access to services. Constantly training, supervising and supporting already well-trained workers to provide adequate services for women. To encourage thinking 'outside the box' in terms of outreach to and engaging women in services or going to the women with services (phone, zoom, outreach). Involving (employing) peer networks, peers, support, and outreach in accessing and making contact with women in less visible situations and 'on the street' - begging, sex work and in private homes. Harm reduction strategies are crucial in outreaching to women. Opportunities for women across a spectrum of needs and where they are at.*
2	*To open women up to treatment we need to do more information workshops and have visits from external agencies to meet and greet the service users.*
3	*The stigma around women in addiction needs to change, and more recognition that women cannot access residential treatment as they as they are seen as the primary carer for the family. family support and more female specific training for workers working with women in the community*
4	*Promotion of the services offered women who have being through treatment mentoring women.*
5	*More services and less focus on class A women are reaching for Xanax and Solpadine which evolve into hard. Intervention is needed at the beginning*
6	*I got the help and support I needed in Ballyfermot*

7	*Services may need to undergo a rebranding to fit with the current drug trends provide an outreach service to people's homes until people are comfortable to engage within the services appointments could take place in cafe shops initially*
8	*Rebranding of current services Acknowledge the important role of youth services to provide some of these services Work with young mother and young women's groups in the community in non-drug and alcohol services*
9	*Gender and age-based drug treatments need to be designed to acknowledge the differences between genders and the trajectories their drug using career is at. This will address the difference between a woman aged 21 with problematic Powder Cocaine use with recent history of employment and social capital to a woman aged 45 with a 30-year drug I.V drug career and Crack use with children living in her home. Better models of community-based treatments need to ensure trauma informed methods of delivering services. With increasing complex poly drug use and the impact on women's experiences through violence and prostitution as well as ongoing community intimidation women are often likely to present to services struggling to manage their behaviours often due to recent experiences. This will need to be changed to remove the risk of service users being removed from community service due to trauma-based actions.*
10	*A service which is targeted at primarily recreational, alcohol or cocaine use would be helpful for the younger age group or for individuals who don't feel their drug use is as problematic as opiate users.*
11	*I think more information in the area about the service and more information, so women feel there not the only one with a problem and instead of hiding their situation feel free and ok to source help*
12	*For the most I think we do well. Would love to see all our services have a good understanding and be able to deal with people as holistically as possible. Aware this is often contrary to national policies. Think through needs assessment and outreach we could be reaching a lot of women who are not presenting for a many reason including those above.*

13	*All services need to work together to bridge the gap so that women's needs are been meet.*
14	*Availability of services in the evening or at weekends, childcare options when attending services even if it's for an hour or two (sessional hours), a non-CE day programme for women only, (reduce the use, relapse prevention etc.) services need to match what the service user requires and have more options available*
15	*Remote clinics/one to one space rather than a drop-in service. Drop-in services can carry a stigma and make people avoid going.*
16	*Genuine and effective representation should be made twice yearly for these women to treatment providers, however, should be made through a third party. I suggest a third party as I have witnessed very capable female service users being 'parked' onto so called subcommittees and being overwhelmed by these committees which often include strong personalities, with often strong moral views on women who use substances.*
17	*Policy and procedures need to be changed due to shift in drug trends. Earlier interventions. Develop contact between Tusla and the addiction services. Proactive professionals working in community's More staff more communication between services.*
18	*There needs to be a shift in views and policy it is not only a heroin using society, we are now crack, cocaine and polydrug using society and yet our policy is reflecting the Heroin epidemic' at that time that was a good policy, but society has changes and policy needs to reflect these changes. Develop Practices between Tulsa and addiction services. 'we are required to report but then the report goes nowhere, and the case is closed, this is having an impact on relationship with clients in addiction services. More community developed needed in disadvantages areas as these seem to be the areas that are getting hit the hardest meaning the women are facing even more struggles than the average person. People on these committees need to be seeing the 'realities' that these people and communities are faced with. More women only programs with particular interventions designed to meet their needs. More safety and skills-based groups.*

	Increase the access to childcare or after school activities to enable women to attend appointments External case managers
19	*More childcare and family support*
20	*Community and statutory services need to be involved in shared care planning. Women in addiction need access to vital mental health supports. Women need to be heard by prescribers in relation to community detox and or detoxification from their methadone. Gender specific treatment programs with childcare is the only way to support women. An improvement in the waiting lists for child supports such as Barnardos or Jigsaw. A realization that the profile of women in addiction is changing from opiate users who a prescribed methadone to poly drug using women who are consuming cocaine, alcohol, and tablets. The harms associated with cocaine/crack cocaine addiction such as sexual drugs for sex transactions needs to be highlighted as the stigma and shame associated further drives women underground.*
21	*To get the word out for women to know each service in their area.*
22	*Social prescribing Within GP practices great to link patients with Alcohol/drug supports. More resources needed for this*
23	*Support with family reunification should be part of a woman long term care plan. Care plans need to be spanned out over a longer period of time. A treatment centre with places for children.*
24	*We need women specific services for women who need or desire these services. We also need to look at ways in which we engage with social services who often rely on urine testing to determine parental outcomes. This is not helped by the embedded culture of urine testing in OST services. Women's health is quite nuancing, and services need to be skilled up to deal with this demand.*
25	*Residential services for mothers need to be made readily available. Women are more likely to not seek treatment because they don't want to leave their children behind.*

Submission	Is there anything you would like to add?
1	*"Poverty and structural inequality affect women, thereby leading to the reality of women bearing the brunt of a range of issues in terms of health, mental health and a whole range of issues, theirs, their children's, partner's and families'. Gender-based inequality and violence are witnessed as experiences of women every day in services. With regard to workers' experiences and witnessing of these social realities the impact of vicarious trauma among professional and peer workers also needs to be acknowledged".*
2	*"I think a lot more women have accessed treatment over the years I think more mother and child treatment in Dublin would allow women to access treatment".*
3	*Just more information without sourcing it in the area and letting woman know the trust they will have and services in the area*
4	*"While there are lots of services in Tallaght and Ballyfermot available for women to attend there is a need for more outreach to women who can't attend for different reasons and more supports need in the home or through outreach in different locations such as Family Resource Centres or community centres. Some services have a tradition of holding on to Service users even when another service may be more appropriate or beneficial to the woman, this needs to be addressed".*
5	*I would suggest that there should be a percentage of childcare places within each Drug & Alcohol Task Force area to facilitate more women to access treatment supports.*
6	*"Many young women across Ballyfermot are not in support of vital mental health support despite the recent suicide cluster in which 8 women died by suicide in a 10-week period. The rising reported 'sex for drugs' transactions for women using crack cocaine see a dealer presenting to women's door once per week with another male whom she is expected to preform sexual acts on to pay off her drug debt. Her children are in the house at this time. The shame and guilt associated with this in my experience results in the women consuming more of the substance to cope with this ongoing trauma. These women rarely speak about this as the fear of social work*

	involvement, judgement, and shame further marginalizes and silences these women. I hope these women experiences will be included in this research so they can be supported to speak out and be supported to access appropriate treatment".
7	*"Women deserve better. Their needs and barriers to recovery are different to that of men's. More of these studies please! More focus groups, more involvement of women with research. I would love to see more treatment centres like Ashleigh House nationwide with overall longer term care plans. Better access to housing, to legal aid, to therapy. Addiction services should look at advocating and supporting women more when dealing with Tusla. An important aspect of a mother's recovery is reunification with her children. Stop telling women they can't have this. It sends so many back out using again".*
8	*"Open more services to women, especially women with children. In the whole of Ireland there is only 1 treatment centre that caters for mothers & their children that is Coolmine's Ashleigh House. Unfortunately, they are also limited to the numbers of mothers with children that they can cater for. This is very sad, I've seen first-hand the benefits for both mothers & children when they can stay together, it's an amazing thing to see & more could & should be done to support this".*
9	*"Involve more peers in the treatment delivery. Recovery coaches are doing amazing work with fantastic outcomes".*