Faculty of Health Sciences
Centre for International Health

Alcohol, tobacco and other drug concerns of newly arrived 'CaLD' (culturally and linguistically diverse) women in Perth

Susan Kaye Lee

This thesis is presented for the Degree of
Doctor of International Health
of
Curtin University of Technology

December 2008

Declaration

To the best of my knowledge and belief this thesis contains no material previously published by any other person except where due acknowledgment has been made.

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university.

Signature: …….

Date: ……...

Table of Contents

Tables and Figures

Acknowledgements

In writing this thesis I have been the recipient of many acts of generosity and support. A warm thanks to the staff of Womens Health Services, the staff at the Centre for International Health at Curtin University of Technology, and the many service providers, interpreters, bilingual workers and newly arrived women who were involved with the project. A special thanks to the women involved with the Consumer Reference Group for their contribution to this project.

I am deeply indebted to Dr. Sandra Thompson and Professor Steve Allsop for their time, expertise and advice. Their guidance and encouragement made some very rough drafts into something far more readable.

I would also like to thank Alicia Lynch for her enormous help with the physical activity pilot project and its evaluation, Joette Loh who undertook the one year evaluation of the consumer reference group, Nadia Loncar whose hard work made the *Once a Leader, Always a Leader* project possible, Ingrid Stotesbury for the copyright free drawings she created for the CaLD Women's AOD project and to Jenny Lalor for her support and advice in using SPSS. Thank you also to Alli Bateson for her assistance in formatting the final document.

I would also like to acknowledge the funding organisation that made this project possible:

- Curtin University of Technology
- The Australian Postgraduate Award
- Office of Multicultural Interests
- West Australian Network of Alcohol and Other Drug Agencies

Finally, I would like to thank my husband and children who have been infinitely patient, especially when I needed to use the computer the same time that they did. Thank you for your love and support.

Abstract

Alcohol, Tobacco & Other Drug Concerns of Newly Arrived Women in Perth

Womens Health Services (WHS) in Perth provides medical services, counselling, information, community talks and workshops, referral, and outreach to women in Western Australia. WHS works with women from over sixty different nationalities, including many newly arrived migrants and refugees. New arrivals access a wide range of WHS programs, but at the time the current study was developed few ethnic women attend the alcohol and other drug (AOD) services offered by the organisation. To address this a needs assessment was conducted with newly arrived women (0 to 5 years in Australia). The needs assessment examined the use of alcohol and other drugs by newly arrived women, the barriers that prevent women from accessing alcohol and other drug (AOD) services and explored the types of services and programs newly arrived women wanted.

Method

The needs assessment used both qualitative and quantitative methods. Twenty two service providers working with newly arrived migrant and humanitarian entrant women were either interviewed individually or attended a focus group. The views and experiences of 26 newly arrived women from a variety of culturally and linguistic backgrounds were also collected through one-on-one interviews (n=6) and through focus groups (n=5). The information gathered from these interviews and discussions informed the design of a questionnaire that was administered to 268 newly arrived women. All women participating in the project were 18 years of age or more, Australian citizens, permanent Australian residents or in the process of being granted permanent residency and had lived in Australia 5 years or less.

Findings Regarding Tobacco and Alcohol Use

Australian cultural attitudes had had an impact on newly arrived women's alcohol and other drug use. Some impacts were positive, for example, increasing restrictions and the decrease in acceptability of smoking in public places along with strong educational messages about the risk of smoking had influenced some women to quit

since coming to Australia. Unfortunately, not all Australian cultural attitudes had a positive impact on newly arrived women. Just under one third of the women (31.7%) who drank alcohol were drinking more alcohol since coming to Australia. Reasons for drinking more alcohol were varied and included alcohol being cheaper in Perth than in their own countries, socialising with Australians who drank alcohol, and using alcohol as a way of coping with stress. However, it is important to note that only a very small percentage of the newly arrived women participating in the needs assessment drank at levels considered risky or high risk for either short term or longer term harm. The vast majority of respondents surveyed did not smoke (n = 207; 77.2%) and did not use alcohol (n=201; 76.1%), often due to cultural or religious reasons.

Other Results

Other findings of the needs assessment included:

- Over 21% of newly arrived women responding to the survey had been put in fear by some one under the influence of alcohol and/ or drugs. Nearly 17% of women responding to the survey had been verbally abused by some one under the influence of alcohol and/ or drugs.
- More than one third of the women responding to the survey indicated that they wanted information and support on family violence.
- Over 40% of the women responding to the survey wanted information and support for depression.
- Forty women (14.9%) responding to the survey wanted support for husbands or children that were drinking too much alcohol.

A surprising finding was the high level of interest in women's only exercise classes and opportunities to participate in other types of physical activity Two thirds of questionnaire respondents said that exercise was a priority for them. Subsequent feedback sessions with newly arrived women about the results of the needs assessment confirmed the need for opportunities to participate in a variety of physical activities in a safe, affordable, women only environment where childcare was available.

Understandings of Alcohol and Other Drug Services

Participants in the study appeared to have a poor understanding of what AOD services were, different types of treatments and models that could be used, who was entitled to access them (not just the alcohol or other drug user), the associated costs and fees, and whether or not the police would become involved. There was a significant lack of understanding by service providers working with newly arrived women about eligibility to access alcohol and drug services and what assistance and support these agencies could provide either to women using alcohol and other drugs or to family and friends impacted by another's drug use. Few service providers asked their clients any questions about alcohol or other drug use on a regular basis.

The findings from the needs assessment have been used to improve programs and services with newly arrived women at WHS. These have included the addition of a specific alcohol and other drugs program for women from culturally and linguistically diverse backgrounds with a focus on prevention activities as well as opportunities for newly arrived women to participate in a variety of physical activity classes.

Abbreviations Used in This Document

AOD	Alcohol and other drugs
CaLD	Culturally and Linguistically Diverse
CEO	Chief Executive Officer
DAO	Drug and Alcohol Office
DIAC	Department of Immigration and Citizenship
DSR	Department of Sport and Recreation
GP	General Practitioner (family doctor)
IDU	Injecting drug user
MWAS	Multicultural Women's Advocacy Service: a domestic violence program for women from culturally and linguistically diverse backgrounds at Womens Health Services
NAATI	National Accreditation Authority for Translators and Interpreters, Ltd.
TAFE	Technical and Further Education
TIS	Translating and Interpreting Service
WA	Western Australia
WANADA	West Australian Network of Alcohol and Other Drug Agencies
WHCH	Women's Health Care House
WHS	Womens Health Services

Chapter One

Introduction

Womens Health Services (WHS) is a non-government women's health organisation located in the centre of Perth in Western Australia. Each year WHS staff have over 50,000 client contacts with women from over 60 nationalities as well as Indigenous women and women born in Australia. I started working at WHS as their Community Development Program Manager early in 2003. Prior to this I had worked in a variety of organisations involved in health promotion, especially with migrants and refugees. I soon realised that although women from ethnic backgrounds accessed many programs and services at WHS, the alcohol and other drug services were not well attended by ethnic women despite WHS being located close to ethnically diverse neighbourhoods. In addition, there was little discussion about alcohol and other drug issues amongst service providers working with migrant and refugee groups at networking and service co-ordination meetings I was attending. Intrigued as to why this was, I gained the support of WHS to explore what were, if any, the alcohol and drug issues facing women from culturally and linguistically diverse communities. This question became a research project that was a joint endeavour between Curtin University of Technology and Womens Health Services.

As the idea for the project developed, I realised that looking at the alcohol, tobacco, medication and other drug issues and concerns of all migrant and refugee women was a huge topic, beyond the scope of a single doctorate. A way of narrowing the topic and still collecting useful information for WHS and other organisations was to look at alcohol and other drug issues only amongst newly arrived women. My academic and professional work in health promotion and community development, led me to a focus on prevention and what women themselves perceived as the issues, how they could be addressed, and the barriers women faced in accessing services, rather than a focus on treatment alone.

1.1 About Womens Health Services

Women's Health Care Association established Womens Health Care House (WHCH) in 1977. The purpose of the association is to: *"To create opportunities for women to improve their own, their families and their communities' health and wellbeing"* (WHS Strategic Plan 2008-2010 2008). The primary aim of WHCH was to provide quality health care to socially disadvantaged women in Western Australia.

In 1989 the Board and staff identified that an increasing number of women who were accessing WHCH had significant issues related to alcohol and other drug use. The outcome of defining this need and lobbying Government was the funding of Perth Womens Centre in 1990, an alcohol and other drug service to specifically meet the needs of both women who use drugs and their families. In 2005 Womens Health Care House and Perth Womens Centre changed their names to Womens Health Services (WHS). This name change was intended to reflect the holistic and integrated approach of the association in providing services to women.

At the time the research project took place services offered by WHS included:

- Primary health care services provided by female GPs and nurses;
- A support program for women with a chronic mental illness and their families;
- A support and counselling program for women using alcohol and other drugs while pregnant or parenting;
- A post natal depression program;
- A support program for Aboriginal grandparents and their families;
- Domestic violence counselling and advocacy services;
- A domestic violence and advocacy service specifically for ethnic women;
- Alcohol and other drug programs for women and their families;
- Community development and health promotion programs;
- Therapeutic programs and general counselling services for women; and,
- A mediation service that assisted women who were survivors of domestic violence with property settlement.

1.2 Aims and Objectives of the Research

The final project negotiated by myself, Womens Health Services, and Curtin University was a needs assessment. This needs assessment examined newly arrived women's patterns of alcohol and other drug use, use and perceptions of health services including alcohol and other drug services and the types of services and programs newly arrived women wanted. The majority of the data collection was carried out in 2006 and 2007. The main objective of this research project was formally worded as:

To identify concerns and issues regarding alcohol and other drugs (AOD) experienced by culturally and linguistically diverse (CaLD) women in Perth who had been in Australia 5 years or less, and to identify potential solutions to these common concerns and issues.

The research project also had a number of sub-objectives. These included:

1. To explore and document common AOD concerns and issues of newly-arrived women as identified by these women and the service providers working with them.

2. To explore with newly arrived women and the service providers working with them what underlying factors contribute to the AOD concerns and issues of these women.

3. To explore and document what newly arrived women and service providers working with them recommend to address the AOD concerns and issues facing this group of women.

4. To explore the extent to which issues raised by new arrivals and service providers in interviews and focus groups exist in the broader community of newly arrived women

5. To develop, pilot and evaluate a health promotion program to improve women's knowledge and skills around identified AOD concerns and problems.

The resulting needs assessment is described in the following chapters starting with a review of relevant literature and followed by a chapter looking at some of the methodological issues in conducting research with migrants and refugee groups. After this chapter there is a more detailed elaboration of the methods used in this research project followed by chapters reporting on the results of the needs assessment. Chapter Eight describes some of the outcomes of the project including the pilot programs that have resulted from the research. Recommendations as well as future areas for research in this area are discussed in Chapter Nine.

Chapter Two

Literature Review

2.1 Introduction

This chapter examines the literature around culturally and linguistically diverse women and drug use. As the overall aim of the project was to gather information to inform appropriate interventions, special attention is paid to alcohol and other drug prevention programs that have been conducted for this group of women. The many methodological issues in cross cultural research are not considered in this chapter as they are discussed in Chapter Three. This literature review starts with information on how the review was approached and some definitions of commonly used words and terms. It then examines a range of theories and models that have proved useful for looking at alcohol and other drug use in immigrant populations, especially with regard to prevention programs and their development, and then the factors that influence alcohol and other drug use amongst women migrants and refugees. This includes issues around women and drug use as well as the influence of culture, migration, settlement and past traumatic experiences. Specific prevention programs are then considered starting with mainstream alcohol and other drug prevention programs and the impact, if any, these programs have had on CaLD women. Finally, AOD prevention programs that were specifically designed for women from CaLD backgrounds are considered.

2.2 Method

Literature was identified through databases of published literature. These included Medline, Science Direct and ProQuest using various combinations of the words: ethnicity, health, alcohol, alcohol and other drugs, drugs, medication, tobacco, smoking, health promotion, migrants, refugees, women, CaLD, and culturally and linguistically diverse, and acculturation. The literature search was limited to studies from 1996 onwards. Articles that looked at models and theories regarding drug use amongst immigrant populations or that examined methodological issues involving cross cultural research were included even if published before 1996.

Overall, there is a paucity of published literature in Australia and internationally about ethnicity and issues regarding drug use and treatment (Ames & Rebhun 1996, Chen et al. 2000, Reid, Crofts & Beyer 2001). The lack of literature is especially apparent regarding ethnicity and issues around women's drug use including prevention and treatment programs aimed at women. For this reason it was important to include grey literature, including unpublished program reports. This grey literature was often difficult to locate and time consuming to obtain. I relied heavily on searches through the internet and my professional networks to obtain copies of reports and articles. A more complete discussion and limitations of the use of grey literature is in section 3.2.1

2.2.1 Criteria

There were several criteria used in determining which research to include in this literature review. The first of these was that the study looked at tobacco, alcohol, over-the-counter or prescription medication, and/or illicit drugs. The study also needed to have been conducted with or include women as a substantial proportion of participants, or alternatively the authors to have made particular reference to gender issues in their report. Participants in the study also needed to be from an ethnic background(s) different to that of the host population and to have come to the host country either as migrants or humanitarian entrants. Particular efforts were made to source Australian studies as these were likely to be of greater relevance. Studies that had a study population of adults or young people near the age of 18 were included. Literature that looked at AOD prevention programs or activities and/ or explored the types of problems that migrant or refugee entrants experienced that put them at risk for tobacco, alcohol and other drug use was also included.

2.3 Definitions

A number of terms used through out this project are defined below.

Culture is an organised set of understandings and behaviours shared among members of a group (Ames & Rebhun 1996). These understandings and behaviours can include formal and informal structures within the group, specific vocabulary, customs, beliefs, social rules and folklore (Ames & Rebhun 1996). Small groups of

people such as those in a worksite can have a culture as can much larger groups of people in a region or a country (Ames & Rebhun 1996). Common differences between cultures include the relative significance of past or future events, the relative importance of traditional values, the differing obligations towards family members and the role of women to name but a few. In relation to drug use, cultural influences determine how drugs are used, under what circumstances they are used and the expected benefits of use. Culture also influences what drugs are deemed acceptable and for whom, how to behave when using a particular drug, and sanctions against what is deemed inappropriate use (Ames & Rebhun 1996, MacAndrew & Edgerton 1969).

Ethnicity is a complex construct as it can be defined using race, the colour of a person's skin, country of origin, language spoken, membership of a religious group, ancestry or a mix of these and other characteristics (Bradby 2003). Chapter Three contains a more complete discussion of ethnicity and how it is used in cross cultural research.

For the purposes of this project, the term **culturally and linguistically diverse (CaLD)** has been defined by the Womens Health Service's Consumer Reference Group and refers to where the language spoken at home is a language other than Australian English and/ or where the cultural and social customs are different from the range of Australian cultural and social customs. This term excludes Aboriginal and Torres Strait Islander backgrounds. This definition was worded with specific reference to Australian English and Australian cultural and social customs due to the number of African entrants currently arriving in Australia who speak English as their primary language. These new arrivals would not be considered CaLD if having a language other than English was the criteria for being of CaLD backgrounds. A number of the women in the Reference Group recognised that people could grow up speaking English but be proud of their background of another heritage and culture.

A **Migrant** is someone who leaves their country of origin voluntarily to settle in a new country.

A **Refugee** often has little choice in leaving their country of origin. The United Nations Convention and Protocol Relating to the Status of Refugees (1951) and the associated 1967 Protocol Article 1A(2) defines a refugee as a person who:

> *"... owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it."*

Resettlement is the final option or 'durable solution' which the United Nations advocates for refugees. Since the end of World War II some six million migrants have come to Australia and of these some 600,000 have been refugees or other humanitarian entrants (Bernstein 2002)

New Arrival – This project used the same time frame to define a new arrival as the Department of Immigration and Citizenship (DIAC), five years or less in Australia (Department of Immigration and Citizenship, 2008)

The following definition of **health promotion** comes from Howat and colleagues (2003) and incorporates many of the newer aspects of health promotion:

> ***"****Health promotion can be regarded as a combination of educational, organisational, economic and political actions designed with consumer participation, to enable individuals, groups and whole communities to increase control over, and to improve their health through attitudinal, behavioural, social and environmental changes"* (Howat et al. 2003).

Traumatic Events are defined by the American Psychiatric Association (1994) as an event that either threatens death, serious injury or harms in some other way one's own or another's physical integrity. The person's response to this event(s) involves intense fear, horror and/ or helplessness. Traumatic events common to the refugee experience include: (Kaplan 1998)

- Witnessing mass murder;
- Witnessing of death squads; etc
- Disappearances of family and friends
- Forced marches
- Extreme deprivation – poverty, unsanitary conditions, lack of access to health care
- Persistent and long-term political repression, deprivation of human rights, and harassment
- Removal of shelter, forced displacement from home
- Perilous flight or escape
- Separation from family members; and,
- Refugee camp experiences –prolonged squalor, malnutrition, lack of protection

Torture is defined by the United Nation's Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) as:

> *"...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in or incidental to lawful sanctions."*

Some of the most common forms of torture include (Kaplan, 1998):

- Severe beatings by fists, boots or objects
- Deprivation of sleep
- Use of psychotropic drugs
- Burning with cigarettes and other hot objects or corrosive liquids
- Isolation and solitary detention
- Sexual violence and rape (of men, women and children)

- Sham executions
- Witnessing the torture of others, including loved ones; and/or
- Abuse of family members

The Victorian Foundation for Survivors of Torture estimates that 25% to 70% of humanitarian entrant clients have been tortured or severely traumatised. However, these figures vary from year to year and depend on the humanitarian intake countries at any particular moment (Kaplan 1998).

A **Community** is an intermediate size group with "sufficient social interaction, structure and permanence" to allow individuals to identify as belonging to this group (Ragin et al. 2008). How people define community often depends on whether people are speaking in the abstract or are referring to a particular community such as their own community (Ragin et al. 2008). This is one of the reasons that communities can be defined in a number of ways. People can define the community they belong to as people with whom they share similar experiences, interests, activities or religious beliefs. Communities can also be thought of geographically or by location. A community can also be defined as family, friends and neighbours. A community can also be defined in terms of profession, occupation or workplace or a combination of all of these different ways such as professionals working in a particular geographic area (Ragin et al. 2008).

In talking about refugee communities, it is important to note that these communities are often made up of individuals who are together in one place by circumstances rather than design. Individuals may not have common socio-economic backgrounds, interests, professions, religion or even language. These communities can be demographically skewed with more women and children as other family members, especially men, may be missing and the elderly may have died. For these reasons these communities can be quite dynamic in terms of their membership and can often be highly politicised (Dona 2007)

For the purposes of this document, the use of the word **drug** will not just refer to illicit drugs but rather to a broad range of drugs including tobacco, alcohol, prescribed medication, over-the-counter medication and illicit drugs. The exception

will be when a specific drug is being discussed and this will be clearly stated. The term **alcohol and other drugs (AOD)** will also be used but again refers to tobacco, alcohol, prescribed medication, over-the-counter medication and illicit drugs.

2.4 Theories and Models incorporating Gender, Ethnicity and Alcohol and Other Drug Use

There are a number of models that have been proposed to explain alcohol and other drug use amongst immigrant population groups. One of the most popular models is the acculturation model. This model proposes that over time migrant populations take on the behaviour patterns, attitudes, beliefs and customs of the host population they have entered. However, this dropping and adding of cultural traits takes place at different rates for different migrant groups and even at different rates for different sub-groups within the same migrant population (Gilbert 1991, Caetano 1994). Acculturation takes place over a number of years and is often talked about as taking place over generations. The acculturation model offers a fairly simplistic explanation of changes in patterns of alcohol and other drug use seen in migrant groups after their arrival in a host country. Gilbert (1991) and later Caetano (1994) offered critiques of this model in their respective examinations of alcohol use amongst minority women in the United States. These studies showed that the acculturation model is too simplistic and that there were a range of other influences at work. Gilbert's (1991) work is of particular interest as Gilbert highlights gender differences in the acculturation process with regards to alcohol consumption. Using data with Mexican American women as an example, Gilbert pointed out that many women who had migrated from Mexico were likely to be abstainers because of strong cultural norms against women drinking. However, their daughters were less likely to be abstainers and their grand daughters were more likely to have an alcohol consumption pattern similar to those of other US women. Furthermore, the drinking patterns of women of Mexican descent were positively correlated with education, income and employment unlike the drinking patterns of men of Mexican descent. As an example of how gender, income, and employment interact with drinking behaviour, Gilbert discussed the fact that professional Mexican-American women consumed more alcohol than blue collar women or home makers. Gilbert concluded that higher levels of education

and income as well as professional employment interacted to give these Mexican American women more opportunities to drink alcohol. These drinking opportunities most often occurred where the drinking of alcohol by a woman was considered normal and thus resulted in higher levels of alcohol consumption amongst this professional group of Latinas. In addition, Gilbert drew on other research that showed that US born Mexican-American women had higher expectations about the positive social benefits of drinking alcohol such as the reduction of tension and increased social pleasure than women born outside of the US.

Gilbert's evidence showed that acculturation was only one of many influences on the drinking pattern of an immigrant group. Other influences included gender, income, employment and changes in norms and attitudes towards alcohol consumption. Given the often complex and dynamic interaction between these factors, Gilbert then looked at the implications for prevention activities for specific sub-groups amongst Mexican-American women. For example Mexican-born parents may have expected that their daughters would not drink due to traditional cultural prohibitions on women consuming alcohol. Given the more permissive norms of mainstream US culture, these parents may have been unaware of the pressure their daughters' face to drink from their peer group and mass media. Gilbert argued that because of this cultural conflict, young Latinas may not have had good role models of safe and moderate alcohol use. However, as Gilbert pointed out, alcohol use was only one of many tensions that these first generation women faced as they negotiated the often conflicting norms and values handed down to them by their parents, in contrast to those of the larger society. Alcohol and other drug issues needed to be included as one of a number of potential conflict issues that these young women faced and not addressed in isolation by prevention programs. Gilbert concluded that prevention programs needed to be sensitive to the issues faced by different generations, different subgroups within a group, and individuals with different levels of acculturation and the factors impacting on the acculturation process in order to be helpful to immigrant women.

The acculturative stress model is another model that has been used to explain hazardous use of alcohol and other drugs amongst migrants and refugees. This model explains hazardous use as a response to the stresses of acculturation. This model is

particular popular amongst Australian practitioners working with refugee groups to explain their drug use (Sowey 2005). Caetano (1994) offered a critique of the acculturative stress model using the initial findings of a 1984 US survey of black and Hispanic women compared to white women. The initial data were then compared with a follow-up study conducted 8 years later. The sample sizes used in the comparisons were large with over 1000 in each group. Caetano's study itself is not of particular relevance to the current project because of the different population groups it examined. However, Caetano's discussions on the factors influencing acculturation with regards to drinking behaviours are thought provoking. Caetano argued that although acculturation could be stressful, the process of adopting cultural traits was gradual and took place over years, and it may not be the only factor in leading to drug use. Caetano argued that many supporters of the acculturative stress model often did not assess the levels of stress amongst minority groups they were studying, rather they assumed the processes of acculturation, including the discrimination people often experienced increased stress to a point that led to drug use.

Using an acculturation scale, Caetano demonstrated that Hispanic women who were more highly acculturated were more likely to drink than those who were less acculturated. This effect of acculturation on drinking and heavier drinking among Hispanic women was independent of age, income, education and being born in the US. Like Gilbert, Caetano surmised that more opportunities to drink alcohol, changes in attitudes and norms about women's drinking, an increase in disposable income, changes in employment, and increased educational opportunities were factors that lead to a increase in women's alcohol consumption rather than just stress related to acculturation. As Caetano pointed out, not all people deal with change and stress with the adoption of unhealthy coping strategies. Explaining drug use patterns in immigrant groups as the adoption of unhealthy coping strategies to stress limits the understanding of both positive and negative coping strategies immigrant groups use as well as other factors that impact on drug use. Caetano argued that the acculturative stress model was too simplistic a model as it relied on the stereotype of a decadent Western culture being so stressful for migrants and refugees that they used alcohol and other drugs in order to cope. However, this explanation did not fit Caetano's data or many service providers' experiences. Instead, Caetano argued that drug use patterns reflect an inter play of cultural, historical and socio-economic factors.

The last model to be examined is that of Ames & Rebhun (1996). These two researchers wrote a comprehensive literature review on the interaction of gender, ethnicity and occupational culture on drinking behaviour and then proposed a model that incorporated these variables. This model can be used to explain other drug use behaviour as well apart from alcohol which was the focus of their paper. As Ames and Rebhun pointed out, it was (and continues to be) difficult to generalise and compare findings of studies in this area as there were no common consensus on which variables to include, how to describe the variables, and the way these variables should be measured. For example, the different ways that ethnicity was described varies from study to study. The use of different variables and their measures was also due to the complexity of the interactions between the variables of gender, ethnicity, occupation and alcohol consumption. Ames and Rebhun argued that this disparate use of variables and their measures in studies was not a reflection of poor study design but rather a reflection that research on women, alcohol consumption, ethnicity and occupation was still in the preliminary stages and was mainly exploratory.

Ames and Rebhun were among the few researchers in this area to note that cultures change over time, that larger cultures are composed of different subcultures and that individuals can exhibit traits from two or more cultures. Individuals also experienced acculturation as well if they were a minority group within a larger more dominant culture. Themes explored by Ames and Rebhun and incorporated into their model of women and drinking behaviour were that drinking norms in most cultures are different for men and women and that abstinence rates or conservative drinking are more common amongst women with recent immigration, lower levels of education and lower household incomes, and less acculturation. Women who worked outside the home and who were more highly acculturated tended to drink more. However, Ames and Rebhun were cognisant of the fact that cultural norms outside of the workplace could influence alcohol consumption patterns. Developing a model that incorporated all of these aspects was difficult. The model proposed by Ames and Rebhun was a far more comprehensive and complex than the acculturation model or the stress acculturation model as it took into account multiple variables and their interaction, including individual and family drinking patterns, drinking patterns of a woman's cultural group (recognising that these cultural values and practices were

gendered and change with time), and the norms of a woman's occupational or workplace subculture (that were also gender specific). Although this model did not include factors known to influence drug use such as age and environmental factors such as alcohol availability, it remains as one of the more useful models to help researchers and practitioners understand drug use amongst migrant and refugee groups.

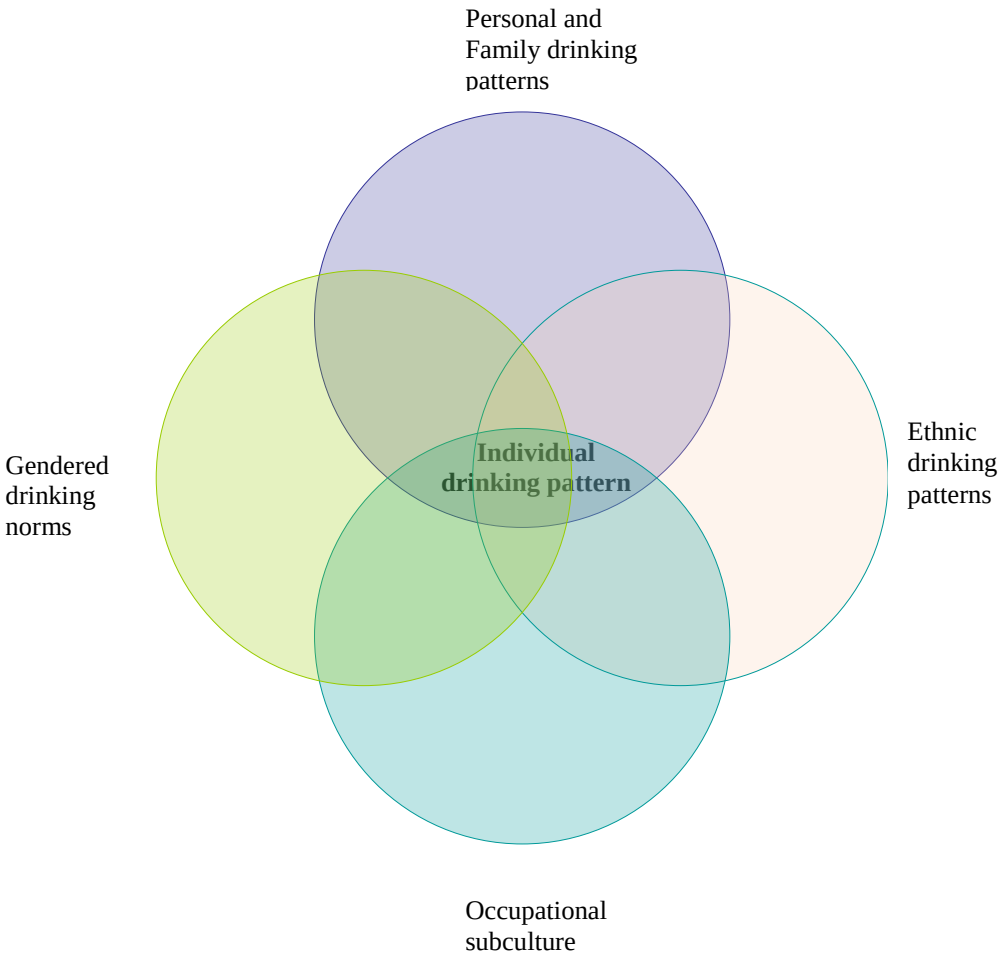


Figure One: Model of interactions of influences on women's drinking by Ames & Rebhun 1996

2.4.1 Summary of Models

It is difficult to look at a single characteristic such as drug use in isolation as there is a myriad of interacting factors that influences that use. Mainstream health promotion models do not incorporate the effects of gender, ethnicity, and culture although these factors can be incorporated into the models if necessary. The acculturation and the stress acculturation models are popular with service providers working with migrant and refugee groups because these models incorporate the effects of culture and are easy to understand. However, these models ignore other known influences on AOD use such as socio-economic factors, availability of alcohol and other drugs, and acceptability of use. More complex models such as that by Ames and Rebhun incorporate factors such as gender and drug use and culture. However, these models still struggle to include all the known factors that influence drug use amongst culturally and linguistically diverse women. As Ames and Rebhun emphasize, the lack of agreement about which factors to include, how to describe them and how to measure them is a sign of the exploratory nature of the research in this area.

2.5 Factors Influencing Alcohol and Other Drug Use amongst Women Migrants and Refugees

2.5.1 Women and Drug Use

There are physiological differences in how drugs affect women compared to men (Dale & Marsh 2000). Many of these differences are due to the fact that women have smaller frames, a higher percentage of body fat, less lean muscle mass, and less body water than men of a similar weight. Some drugs are also influenced by female sex hormones so that the effects of a drug can vary during different phases of the menstrual cycle, in pregnancy, and/or menopause (Epstein, Fischer-Elber & Al-Otaiba 2007, National Centre for Education and Training on Addiction (NCETA) Consortium 2004). Alcohol is one of the most well studied drugs in terms of gender and physiology and can be used to illustrate some of the physiological differences and the resulting health problems between men and women.

Women's smaller frames, higher percentage of body fat, less lean muscle mass and less body water compared to men of a similar weight are particularly important where alcohol is concerned as alcohol is water soluble and little or no alcohol enters fatty tissue. Thus, in general, women will have a higher blood alcohol concentration

for the same volume of alcohol consumed compared to men (National Centre for Education and Training on Addiction (NCETA) Consortium 2004). Women also have lower levels of enzymes that breakdown alcohol in the stomach than men of the same weight. Therefore women metabolise alcohol less efficiently than men (Epstein et al, 2007). The combination of these physiological differences is that women tend to develop physical health problems related to alcohol use sooner at lower levels of consumption compared to men (Dale & Marsh 2000, Epstein, Fischer-Elber & Al-Otaiba 2007, National Centre for Education and Training on Addiction (NCETA) Consortium 2004; Tsianakas & Rice 2005). Women with alcohol problems are more likely to die from circulatory disorders and cirrhosis of the liver than their male counter parts (Tsianakas & Rice 2005). Heavy alcohol use in women can also lead to a variety of specific women's health problems such as menstrual problems or health problems more commonly associated with women such as osteoporosis and breast cancer (Epstein, Fischer-Elber & Al-Otaiba 2007, National Centre for Education and Training on Addiction (NCETA) Consortium 2004). As women age they are more physiologically susceptible to the negative consequences of alcohol consumption. This is due to the drop in lean muscle mass, a decreased rate in metabolising alcohol due to less efficient hepatic and renal function, and a decrease in the effectiveness of the blood brain barrier (Epstein, Fischer-Elber & Al-Otaiba 2007). The use of prescription drugs amongst women as they age also increases. Thus, there is a greater possibility of adverse reactions between medications and alcohol so that even low levels of alcohol use can be problematic (Epstein, Fischer-Elber & Al-Otaiba 2007).

Problematic alcohol use is also associated with mental health problems differently in women than in men. For example, women who use alcohol hazardously are more likely to experience depression and anxiety compared to men (Tsianakas & Rice 2005). Women who drink hazardously are also more likely to attempt suicide and die from suicide than their male counterparts (Dale & Marsh 2000, Tsianakas & Rice 2005). These mental health issues are often related to traumatic experiences, an issue which is discussed in more detail later in this chapter in section 2.5.6.

There are numerous health risks associated with drug use in pregnancy ranging from miscarriage to foetal deformities to infant death (Dale & Marsh 2000). The consequences of drug use in pregnancy are dependent on a number of factors

including the type and amount of drug(s) being used, concurrent use of drugs, route(s) of administration, when the drugs were used during the pregnancy, general maternal health, and quality and use of antenatal care (National Centre for Education and Training on Addiction (NCETA) Consortium 2004). These health risks have been best documented with the most commonly used drugs of alcohol and tobacco and alcohol can again be used here as an example of the impact of drug use during pregnancy (National Centre for Education and Training on Addiction (NCETA) Consortium, 2004). Alcohol use during pregnancy can increase the risk of miscarriage and still birth as well as premature birth and low birth weight and size (National Centre for Education and Training on Addiction (NCETA) Consortium 2004). There are a wide range of effects on the foetus as result of prenatal exposure to alcohol. These range from small decreases in cognition to Foetal Alcohol Syndrome (FAS), a term that describes a range of physical, mental, behavioural and/or learning disabilities due to foetal alcohol exposure (National Centre for Education and Training on Addiction (NCETA) Consortium 2004). Severe developmental disability and the cranio-facially abnormalities that are the classic markers of FAS are associated with high alcohol use (above 42 standard drinks per week) through out pregnancy (National Centre for Education and Training on Addiction (NCETA) Consortium 2004).

Because of the health consequences of maternal drug use, pregnant women can be stigmatised for any drug use, especially illicit drug use. Even for women who are not pregnant, women's role as mothers and care givers often means that women who use experience more shame, guilt and stigma compared to men (Dale & Marsh 2000, Tsianakas & Rice 2005). The barriers of stigma, depression and fear of removal of children in a woman's care, means that women are often reluctant to seek help and consequently enter treatment programs at half the rate that men do (Dale & Marsh 2000, National Centre for Education and Training on Addiction (NCETA) Consortium 2004, Tsianakas & Rice 2005).

In addition to the barriers posed by stigma, guilt, shame and fear, women must also overcome other barriers in seeking treatment. Historically, AOD service delivery in Western countries has largely been developed on the basis of research with Caucasian males and has particular relevance for them, with possibly limited

relevance for others (Sterk 1999, Whiteside-Mansell, Crone & Conners 1999). Information and services have then been transferred to other populations such as women. However, the inclusion of other populations into the original model of service delivery has often taken place with little specific research, consultation or adaptation. Thus, information and services may not be entirely appropriate for women and/ or ethnic populations (Sterk 1999, Whiteside-Mansell, Crone & Conners 1999). Women's AOD issues, barriers to treatment and strategies to address these issues are often quite different to those of their male counterparts. For example, women may be reluctant to seek treatment for fear of losing their children to social services or estranged partners. Women may also find it difficult to seek treatment due to lack of childcare and/ or domestic violence issues. The following section examines some of the known factors influencing women's drug use and issues women face around either their own use or that of a family member. This is followed by a discussion on the impact of culture on women's drug use.

Influences on Women's Drug Use

Drug use in both men and women is influenced by a variety of factors. The Australian study by Jonas and colleagues (2000) demonstrated this well as the researchers investigated different patterns of alcohol use by women of different ages using data from the Australian Longitudinal Study on Women's Health. Currently known as the Women's Health Australia (WHA) study, this research is tracking the health and well-being of female participants over a twenty year period. The researchers described data from the first year of the study, 1996, and the patterns of alcohol consumption and factors influencing that consumption amongst younger women in the study aged 18 to 23 years. Specific findings of Jonas and colleagues' research were that women who did not drink were more likely to be married, to report having home duties as their occupation, were pregnant, had lower levels of education and job status, were non-smokers and were born in a non-English speaking country. High risk drinkers and hazardous drinkers had these characteristics reversed.

As the researchers in this study noted, there were complex interactions of factors that influenced women's drinking behaviours and not all these influences had been well documented amongst young Australian women. Using the longitudinal data gained from the WHA study researchers would now be able to examine some of these

influences on women's alcohol consumption and see how these patterns changed as women aged and experienced lifestyle changes. This study and others that have analysed and reported on the WHA alcohol data will help researchers and practitioners better understand the influences on women's drinking behaviour. Such information can be used to plan and conduct health promotion activities to reduce problematic alcohol consumption amongst different age groups of women.

As mentioned previously, women who have problematic drug use experience gender specific issues around their AOD use and barriers to accessing services. These issues are well illustrated in two evaluation studies of AOD treatment programs for women. The first study documented the development and evaluation of an alcohol and drug treatment program for women users and their children in the US (Whiteside-Mansell, Crone & Conners 1999). The program was designed to be a "one-stop shop" staffed by a team of multidisciplinary workers. Despite using this model, the evaluation of the program identified many of the barriers and difficulties faced by women who were pregnant and/ or parenting in accessing AOD and other social services. These barriers included a lack of child care, transport, social support, and safe drug-free housing. Other issues that impacted on service provision with this group included the high percentage of clients who were dealing with legal issues related to their drug use and/ or child protective services whilst participating in the treatment program. Women presented with complex personal histories of their own sexual, physical and emotional abuse as well as family histories of alcohol and drug use including the use of alcohol and other drugs by previous or current partners. The study documented physical health problems of both mothers and infants during pregnancy, birth and the post partum period including issues related to infant growth and development. The evaluation found that both staff and the program needed to be flexible to respond to opportunities as well as to the changing needs of clients and changing community resources. The experience of staff was that individualised treatment plans were less effective than treatment plans that included both the mother and her child. Integrating the care of the mother and her children provided better outcomes for both the woman and her family. The study was an excellent reminder of the complexity of the issues faced by women users who are pregnant and/ or parenting. Examining issues in isolation lessens the opportunity of providing effective treatment and support services to these women and their families.

A study by Osorio, McCusker & Salazar (2002) also evaluated a treatment program. The program was based in the United Kingdom and found similar issues to those faced by women with problematic drug use described by Whiteside-Mansell, Crone & Conners (1999) in the US. These issues included the importance of having a safe environment where women can access services, the difficulties women faced in leaving the house because of lack of child care and/or domestic violence issues, and the difficulties women had in knowing where to go to access AOD services. The study had broad aims and used both process and outcome evaluation methods were used to determine the level of accessibility, quality of service, sensitivity to women's needs, and women's satisfaction with this UK based women's only service. Overall, participants made health and social gains and expressed satisfaction with the women-only environment provided to them. An unexpected finding of the evaluation was the women's enthusiastic use of complementary therapies such as massage. The authors felt this was due to women finding the complementary therapies useful in dealing with anxiety and depression, conditions that many women felt were the underlying causes of their drug use. The evaluation study had a small sample size and engaged more readily with women using alcohol only rather than with women using illicit drugs. Despite these limitations, the study illustrates the difficulties of engaging with women using alcohol and other drugs and the complexity of the issues that women users face in accessing services. The study provides a useful overview of many of the gender specific issues of women who use drugs such as their need for child care, safety from violent partners, the need for information about services, the importance of women's only space where women feel safe free from the sexual harassment that many women experience in mixed treatment services, and the desire to deal with other issues such as depression and anxiety that women feel are related to their drug use issues.

Another aspect of women and drug use was illustrated in the Dublin based ethnographic study by Murphy-Lawless (2002). This research explored the role of women as carers in supporting one or more family members and/ or friends using heroin. The study aimed to gain a better understanding of how women thought about the dilemmas they faced in supporting and interacting with heroin users in their family and community, and was undertaken to make recommendations to improve

policies and support structures for these women and their families. This study highlighted the multiple roles women play in the family and the community, especially in marginalised communities with high rates of unemployment, social problems and limited access to services. In the numerous interviews with women, it was clear that despite husbands, fathers and other male family members playing a supportive role, in most families women remained the principle doers of "family work" and this often included dealing with issues relating to the care and support of the drug user such as supporting the family member(s) through drug treatment options and after care as well as supporting family and friends in prison. The caring role often included caring for grandchildren and other extended family member's children due to parental drug use and supporting other family members that were coming to terms with the family member's drug use. Murphy-Lawless (2002) demonstrated that women's roles were put under pressure negotiating the many needs and issues in response to drug use in their families and communities. Women coping with one or more drug users in the family felt a strong sense of parental failure, stigma at having a drug user in the family, devastation, grief, anger and denial. An interesting aspect of this research was how Murphy-Lawless linked women's individual experiences of supporting family members and friends to how they became involved in support groups in the community. Some of these support groups turned into more formal community based projects. The study provided insights into why individual women were motivated and how they organised themselves effectively to respond to drug issues in their community. The women often developed very local solutions to local issues. Often these solutions meant building the capacity of the community to deal with core issues such as unemployment, lack of education, unsuitable housing, and lack of recreation facilities. However, the support of local authorities and government departments was necessary to make this work sustainable.

2.5.2 Summary of Women and Drug Use

Drug use, in both men and women, is influenced by environmental factors such as physical access, socio-demographic characteristics including occupation, influences related to family, peer groups and cultural norms, motivation for drug use and beliefs, attitudes and expectations of drug use, physical health, and the impact of life events such as traumatic experiences. Women with problematic drug use experience gender specific barriers to accessing services including lack of child care, lack of transport, lack of social support, sexual harassment, and lack of safe, affordable housing for themselves and their children. Domestic violence issues may also hamper women's access to services. Women who use drugs are also more likely to be engaged with child protective services than their male counterparts. Often women involved in AOD treatment services present with complex personal histories of their own sexual, physical and emotional abuse as well as a family history of alcohol and drug use, including the use of alcohol and other drugs by previous or current partners. Service providers may need to assist women with physical health problems related to pregnancy and the post partum period along with health issues women's infants may have related to maternal AOD use. Women are also impacted by drug use in their network of family and friends. They are more likely to take on caring roles of helping family members through drug treatment and after care, supporting family and friends in prison, and caring for children of parents who are using.

2.5.3 Women, Drug Use and the Influence of Culture

Culture is an important influence on all aspects of women's behaviour regarding alcohol, tobacco and other drugs. Culture is also a highly gendered and in many cultures there are strong cultural proscriptions around women's drug use. These cultural values include strong parental attitudes and religious prohibitions against AOD use even with legal drugs like tobacco and alcohol. Often research reveals glimpses of gender differences influenced by culture and the impact these have on drug use. The study by Rissel and colleagues (2001) is a good example of this. This study examined tobacco use amongst Arabic and Vietnamese young people. The 1998 Sydney based study collected both qualitative and quantitative information among Vietnamese and Arabic youth aged between 15 and 17 years, as well as conducting key informant interviews with Arabic and Vietnamese health workers.

Although the participants were not 18 years, it was of interest to read about their attitudes towards tobacco use and compare these with those of adult key informants interviewed as part of the study. The study was undertaken because the lower rates of smoking by non-English speaking background youth were often reported in the literature but not adequately explained. This made effective smoking prevention programs difficult to develop for this group of young people. The study found that students from all of the focus groups were well aware of the negative health effects of smoking but the image of smoking was an important factor in choosing to smoke for many of the students. Both young people and adult key informants were very aware of the gender differences in tobacco use in their respective communities. Smoking by men was seen as far more acceptable, especially by the Vietnamese community. Smoking by males was considered a sign of manliness, whilst smoking by females amongst the Vietnamese community was often associated with prostitution. Participants in the study felt that Arabic-speaking women were less likely to smoke until they were married. However, participants in focus groups and interviews reported young women being influenced by peer pressure to smoke as well as using smoking as a way of controlling weight or coping if they were not doing well at school. Arabic speaking girls identified a stronger cultural influence on their behaviour, describing boys as having more freedom than girls. Both young people and the adult participants in the study saw parental influence as important, especially parental disapproval and disciplinary action if youth were caught smoking. Vietnamese parents often viewed cigarettes as a gateway drug that led to other drug use such as cannabis or heroin or even involvement in criminal activity and for this reason parents were may be more likely to change their smoking behaviour in order to be a good role model for their children. Rissel and colleagues (2001) concluded that as children from these groups acculturated they were likely to increase their rate of smoking to more closely match the rate of their English speaking peers. The reported experiences of young people trying to balance the norms of their peer group with the often vastly different expectations of their parents is not unusual as this happens in mainstream Australian and Indigenous families as well. However, the experiences reported by these young people were those of young people living in a much more “divided world”, trying to conform to mainstream Australian culture outside the home and their parents’ culture inside the home (Rissel et al. 2001).

Another NSW study with secondary school students also gives some insight into the cultural factors that influence drug use. Chen and colleagues (2000) looked at data from four surveys of NSW secondary students in 1983, 1986, 1989, and 1992. Students were classified according to what language they spoke at home and then these languages were grouped into broad regional areas e.g. SE Asia. Data were stratified by age and sex to look at the prevalence of tobacco, alcohol and illicit drug use over time use amongst these adolescents speaking a language other than English at home. Like Rissel and colleagues (2001), these authors concluded that in most cases drug use was lower among youth speaking a language other than English at home compared with youth speaking English and that this pattern continued over time. However, one of the methodological concerns with this study and one that the authors themselves pointed out, was that the ethnicity data was aggregated into broader categories. For example, students from Spanish, Greek, Italian, Macedonia, and Maltese backgrounds were all classified as Southern European in order to obtain meaningful numbers for data analysis. Some of the findings, therefore, may not have been applicable to all ethnicity groups in the broader category classification and other potential findings concerning specific ethnic groups would have been masked. Like Rissel and colleagues (2001), Chen and colleagues (2000) speculated that a contributing factor to lower drug use amongst students who spoke a language other than English at home was explicit family rules about drug use and their enforcement. Chen and colleagues concluded that parental expectation about non drug use and strong family values may have provided some protection against drug use for youth speaking a language other than English at home. They pointed out that it was these cultural values that could be considered a protective factor rather than ethnicity per se.

Religion can be an important element of ethnic identity and one that has been associated with reduced mortality and morbidity (Brady & Williams 2006). A study by Bradby & Williams (2006), carried out in Glasgow, examined the influence of religion on alcohol and drug use. This study examined the level of tobacco, alcohol and other drug use for Asian and non-Asian men and women aged 18-20 years in 1996 compared to their previous levels of reported use at age 14-15 years and with use in their parents' generation. Data were examined by the self-identified religion of the participant (e.g. Muslim, Sikh, Hindu, Christian). The study also considered the

importance of religion as a reason for abstinence and any differences between religious and cultural groups at 14 to 15 years compared to when participants were 18 to 20 years. The findings showed that Sikh and Hindu women's drinking increased sizeably from low levels at age 14 to 15 years compared to when they were 18 to 20 years. These levels were not as high as those of Christian women but were significantly higher than that of Muslim women aged 18 to 20 years. In general, women from Pakistan, India and Bangladesh, regardless of their religion, had low levels of consumption at age 14 to 15 years and these levels were sustained to early adult life. Amongst Muslim women, 81% reported their religion as the motivating factor in not drinking alcohol. The analysis showed that religion was a key factor but not the only one in determining whether a young person would use alcohol and other drugs. The authors argued that religion reinforces the broader ethno-cultural proscriptions against drug use especially amongst women and that women's abstinence and moderate use of drugs is in keeping with the general concern with a woman's reputation and being the keepers of the family honour. The authors argued that young women's behaviour is more closely scrutinised and regulated by the community as a whole and this requires women's abstinence from alcohol, tobacco and drugs. However, when alcohol and drug use is compared between those born in the UK and those born overseas, participants born in the UK were much more likely to have smoked, and drank alcohol despite religious prohibitions to the contrary. This may be due to the fact, that the there appeared to be no measure of the level of engagement with religious practices of the young people studied. Active engagement in religious practices and events organised through a church, mosque or temple are more likely to offer protective factors against hazardous use of alcohol and drugs rather than nominal affiliation with a religion. Despite this weakness, this study 's findings agree with other studies such as those by Rissel and colleagues (2001) and Chen and colleagues (2000), that familial, religious and cultural influences can contribute to low levels of alcohol and/ or drug use or to total abstinence.

Although these familial, religious and cultural protective factors can help minimise problematic drug use amongst women and their families, these same factors can make it difficult for women and their families to access services when in need. Family, community, religious and cultural attitudes and barriers to accessing services were explored in the study by Reid and colleagues (2001). The study, Drugs in a

Multicultural Community - An Assessment of Involvement, examined illicit drug use only and came from extensive research conducted in 1998-1999 in Victoria. The study was undertaken to better understand the cultural attitudes, experiences and expectations of various ethnic communities in this Australian state. The study included a literature review of both international and Australian literature on ethnic communities that were coping with drug use and compared the concepts and themes from the literature to qualitative research undertaken with various ethnic communities in Victoria. The qualitative research comprised 25 key informant interviews, and two ethnic community leaders' information forums and fifteen focus group discussions with eight ethnic community groups. Participants in the interviews and focus groups did not identify themselves as using illicit drugs. The communities that were chosen varied in size and settlement periods in Australia.

The research found similar themes from focus groups and interviews reported in the Australian and international literature. There were a range of reactions individually, by the family and by the community as a whole around illicit drug use including shame, denial, stigma, and embarrassment. Parents of drug users often felt a sense of failure. In this respect the reactions these researchers found to drug use were very similar to other individual's, families' and group's reactions, irrespective of their cultural background. Most users and their significant others are often wary of seeking help outside of their family or community because of a sense of failure, shame or embarrassment. However, for the families from the cultural backgrounds in this study, the stigma was much more widespread. Families and communities as a whole often felt that the use of illicits by one of their own tarnished the family's and/or community's honour. These feelings and reactions were major obstacles to admitting a problem existed and in seeking information and treatment. Community members often first sought help from workers who spoke their language such as a GP, religious leader, or a social welfare worker.

Participants in focus groups and interviews reported that community members were often confused and/ or uncertain about what drug treatment services did and could offer. However, this is not unique to members of ethnic communities as many other community members have only vague notions of what drug treatment services are available and how to access them. The additional barriers posed by language and

culture such as the cultural appropriateness of talking to a stranger rather than a family or clan member about personal issues, often means that assistance is only sought outside of the family or community in a crisis. Participants in the study reported that the reluctance to speak to professionals outside of the community was changing.

Participants in the study reported that when ethnic community members did access drug treatment services, they encountered long waiting lists and a lack of flexibility and sensitivity to cultural issues which impacted on treatment. Families often felt excluded from the process. Focus groups and interview participants perceived that the drug treatment models used were designed for middle class Caucasians and did not look at issues in a holistic manner. Drug services were not connected with other services offered within and by ethnic communities so that welfare issues were often poorly addressed. Participants reported a need for a community wide approach where everyone received education drug use issues and related services and not just those in need. Participants also expressed that communities often felt excluded in the process and there was a desire by ethnic communities to be involved in planning strategies and designing programs around drug prevention and treatment.

This Australian study by Reid and colleagues (2001) highlighted the similarities in the barriers faced by different ethnic communities and their members with regards to accessing AOD services. Despite different cultures, languages, religious beliefs and differing amounts of time within Australia, the barriers described by participants were remarkably similar. Although service providers need to be cognisant of the differences between and within ethnic groups, this study highlighted that many of the barriers to accessing appropriate services are similar across disparate cultural and language groups. The choice to focus only on illicit drugs in the study was somewhat puzzling. Alcohol causes far more drug related harm, is far more commonly used, and often alcohol and illicits are used concurrently. Including questions on alcohol and gaining information on alcohol use in these communities would have strengthened this study and would have contributed greatly to this area of research.

Similar findings concerning the barriers to accessing services were found in the study by Dar and colleagues 2002. These researchers carried out a retrospective case note

study of 200 consecutive patients assessed at a Community Drug Team during an 18 month period from January 1996 to June 1997 in the London Borough of Ealing. The Community Drug Team noted that the number of "Asian" clients that presented to the service had increased from 2% in 1990 to 26% in 1997. This report included an excellent discussion on ethnicity; the impact ethnicity had on patterns of drug use, and possible explanations for the low number of "Asian" women seen by the Community Drug Team.

Dar and colleagues (2002) defined "Asian" as people from India, Bangladesh and Pakistan but acknowledged that these groups were not homogenous and had differing attitudes towards drug use. This was one of the few studies where the authors noted the difficulties of using alcohol and drug research from other countries as the composition of ethnic groups varies from country to country and the definition of terms varies. For example, the authors noted that Asian-Americans refer mainly to people of Korean, Taiwanese, or Chinese ancestry compared to the UK where "Asian" primarily refers to ethnic groups coming from the Indian subcontinent. Each of the groups described as "Asian" have different patterns of use from one another as well as from other non-Asian groups.

The authors acknowledge that women in general are under-represented in drug treatment services and ethnic women even more so. In their retrospective case sample, 29% of the "white" sample was women while only 10% of the "Asian" sample consisted of women. Rather than ignoring this low percentage, the authors discussed possible reasons, offering two possible explanations. The first explanation was that of lower drug use by "Asian women" and the second explanation was women's reluctance to seek treatment. A number of reasons were proffered for the possible reluctance of women to seek treatment, including bringing shame and loss of face upon herself and all others in her kinship network, the perceived lack of understanding by staff (perceptions that AOD services were run for and by "whites"), and the fear of confidentiality being broken. However, these speculations were not backed by evidence gained through the study. The authors concluded that the under-representation of Asian women in their sample needed further exploration even though the reasons for the low number of women engaged in treatment appeared to be reasonable.

Sargent and colleagues (2001) studied injecting drug use by 15 to 24 year old young people from Vietnamese, Cambodian or Lao cultural backgrounds in Cabramatta, New South Wales and showed how the influence of culture can lead to very unsafe practices. The authors felt that there was a strong anti-injecting sentiment amongst these cultural groups, which made it even more difficult for the young people from these cultures to access services and to identify as Injecting Drug Users (IDUs). This in turn meant that health promotion strategies and disease prevention initiatives for other IDUs were not accessed by this group. The authors concluded that alternative and more appropriate strategies were needed. The research was conducted using semi-structured interviews with two female ethnographers and a female bilingual peer worker. These researchers interviewed 38 young men and 14 young women who had injected at least once in the past month. Their findings showed this particular population of IDUs had a mean age of initiation into injecting of 17 years compared to the general populations of IDUs of 18 and 19 years. At the time of first injection, 10% and 39% respectively of the young people did not know that HIV and Hepatitis C could be transmitted by sharing syringes. Over half (52%) had injected in public places in the month preceding the interview, environments that promoted furtive and risk-laden injecting practices (Sargent et al. 2002). The illustrative quotes included in the article reveal a startling and tragic lack of knowledge with regards to safe injecting practices, harm minimisation, and HIV and Hepatitis C transmission in this group of young people. Although the information that has been gathered is excellent, given that this study was also designed to develop a pilot peer education training program, the study could have been strengthened by asking these young people what types of services and ways to access information they would find the most appropriate. It appears as if the authors had already decided upon a number of strategies such as medically supervised injecting rooms, but did not ask the target group whether these strategies would be accepted and utilised. Nor did they appear to differentiate between strategies that young women would find useful compared to young men.

2.5.4 Summary of Women, Drug Use and the Influence of Culture

These studies are illustrative of how gender, culture and attitudes towards drug use can interact in complex ways. Some of these interactions are protective against drug

use in that women are often deterred from drug use by strong cultural and parental attitudes against use of either legal or illegal drugs. Religion can reinforce these broader ethno-cultural proscriptions against tobacco, alcohol and other drugs, especially for women. However, as women acculturate, their drug use patterns more closely approximate mainstream patterns of consumption. The impact that acculturation has on drug use is often not mentioned nor measured in AOD studies with individuals and groups from CaLD backgrounds.

Individual users, their families, and the community groups to which they belong demonstrate a wide range of reactions to women's drug use. These reactions can include shame, loss of face, denial, stigma, and embarrassment. Individuals, parents, other family members and communities as a whole can feel a sense of failure at the perceived loss of honour. These attitudes and the behaviours influenced by them can place drug users at greater risk as well as placing significant barriers for users to accessing services. Individuals and their families may be reluctant to seek help from AOD agencies fearing a breach of confidentiality as well as the perception that AOD service are run for and by "whites".

2.5.5 Migration, Settlement Issues and Drug Use

Another set of influences to be considered on culturally linguistically diverse women's drug use is the impact of migration and settlement experiences. A number of qualitative studies with refugee groups have looked at this issue, primarily focusing on youth. These studies are generally reported in the grey literature and usually have very small sample sizes. Gender issues are rarely mentioned, let alone discussed in detail.

A study by Kalunta-Crumpton (2003) illustrated particularly well issues related to migration and settlement that impact on drug use and the barriers faced by migrants in trying to access AOD services. Kalunta-Crumpton's (2003) research looked at the social problems faced by Italian and Portuguese migrants in the UK accessing a drug treatment program. The paper drew on data from a larger study that used a sample of 226 client files at a drug project in the United Kingdom as well as open-ended questionnaire interviews with staff at the project. Thirty Italian clients' files and 57 Portuguese clients' files were examined and compared to 82 "white" clients' files

(those who were English, Scottish and Welsh). Kalunta-Crumpton argued through her paper that although these migrants were not physically different than other "white" groups in the UK, the unfamiliarity of these Italian and Portuguese migrants with the British system, their settlement difficulties including lack of appropriate housing and stable employment, lack of English, and lack of family networks complicated their drug use issues. The Portuguese and Italian clients who accessed the drug treatment program experienced social isolation as they generally had enjoyed a strong extended family system in their country of origin. This family system meant that they could rely on family members for various types of support. Once in the UK, however, this system of support was minimal. In response to this isolation migrants would often associate only with other drug users from their same culture. This resulted in further isolation from the mainstream culture and increased difficulties in breaking the drug using cycle. It also led to risky behaviours such as needle sharing.

The findings of the study also showed that lack of English made these migrants vulnerable to exploitation in the workplace, working long hours for cash in hand and being unaware of their entitlements. Language difficulties contributed to wariness of accessing drug treatment services and many of the migrants had experienced difficulties in accessing GPs. Kalunta-Crumpton noted that often Portuguese and Italian clients self referred, and similar to Anglo Celtic clients often sought assistance not for their drug use issues but assistance with practical needs such as housing. However, the Portuguese and Italian clients also sought assistance with migration issues and assistance with employment as they often faced difficulties in finding work due to discrimination and lack of English.

This study illustrates many issues that migrants face and how these issues interact with drug use issues in complex ways. Kalunta-Crumpton calls the Italian and Portuguese migrants "invisible" as they looked like other people of British ancestry and were often counted in statistics as "white". This points out the inherent risks of using a race based system for keeping client statistics e.g. white, Asian, black as these migrants and their needs became invisible. The lack of gender specification was one of the main flaws of the study. Nowhere are the number of male or female clients mentioned and there was no discussion about whether women presented with

the same or different issues to men. The lack of discussion around gender meant that women become just as invisible as the very migrants Kalunta-Crumpton wrote about.

The new and emerging African communities in Australia have many similar issues regarding settlement and language difficulties as discussed by Kalunta-Crumpton. However, the vast majority of these new arrivals have experienced forced migration versus migration by choice, as they have come to Australia as humanitarian entrants. The article by Sowey (2005) summarised a number of grey literature reports and consultations with new and emerging African communities in New South Wales and put them into context with each other and the published literature. Ideally these individual consultations and papers would be reviewed, however, given the difficulties in accessing these, Sowey's article was a useful substitute. Sowey (2005) noted that African community leaders, community members and youth had identified problematic alcohol and drug use issues in their communities. Participants in the various consultations cited a number of inter-related causes for problematic drug use ranging from stress and anxiety leading to problematic use of alcohol (especially in men) to the lack of drug and alcohol prevention programs to address problems faced by youth such as lack of access to sport and recreational programs, discrimination and lack of understanding of medicines to name but a few issues. Sowey concluded that the appearance of hazardous drug use in some new and emerging African communities after only several years in Australia was of particular concern as the literature identified these trends usually after considerably more time was spent in the host country. Sowey's article provided a useful overview as to why refugee youth might be at particular risk for drug use. However, there was no mention of protective factors this group possessed such as strong religious and/or cultural prohibitions against smoking, alcohol and other drug use. The influence of gender on drug use was also not discussed. Sowey's report provides a useful background paper to those interested in alcohol and other drug issues amongst African refugee groups in Australia, and a foundation to encourage more critical reviews and research in this area.

2.5.6 Post Traumatic Stress Disorder and Past Traumatic Events

More attention is now being paid to the link between Post Traumatic Stress Disorder (PTSD) and problematic drug use amongst women (Stewart 2007). PTSD is a type of anxiety problem that can develop as a result of being directly exposed to an event that threatens death and/ or threatens or causes serious injury or harms in some other way to oneself or another (American Psychiatric Association, 1994). Traumatic events can include experiences related to assault, war, natural disasters, domestic violence, sexual assault, abuse, and severe accidents such as car crashes. The person's response to the event(s) involves intense fear, horror and/ or helplessness (American Psychiatric Association, 1994). In order for a diagnosis of PTSD to be made a person needs to have symptoms that relate to the re-experiencing of the event (for example intrusive thoughts and flashbacks), avoid stimuli associated with the trauma (for example avoiding people and places associated with the trauma), and experience symptoms of increased arousal such as hyper vigilance and increased irritability (American Psychiatric Association, 1994). These symptoms need to be present for more than one month and cause considerable distress or disturbance to a person's ability to function in daily life in order for a diagnosis of PTSD to be made (American Psychiatric Association, 1994). Symptoms associated with PTSD can include headaches, depression, panic attacks, digestive problems including stomach pain and eating disorders, generalised pain in limbs and back and sleeping problems.

Complex PTSD is a term used to describe PTSD that is the result of multiple traumas occurring over time and not caused by a single incident (Marsh, 2008). Examples of trauma that can result in complex PTSD include prolonged childhood sexual abuse or trauma resulting from escaping armed conflict (Marsh, 2008). Risk factors for developing complex PTSD include the age at which the traumas occurred (younger ages being more vulnerable), the duration of the trauma, whether the trauma is inflicted by someone in a position of trust such as a parent, and whether the trauma was intentional for example sexual assault versus trauma resulting from a natural disaster (Marsh, 2008). In PTSD resulting from an isolated traumatic incident, there is often a set of behavioural responses to a reminder of the trauma whereas in cases of complex PTSD there is often a more widespread impact on the child's or young person's development and ability to cope with normal life events (Marsh, 2008). Thus, it is not unusual in adulthood for people who have complex PTSD to get a

range of other psychological problems including depression, dissociation, somatisation, anxiety, suicidality, impulsivity, antisocial behaviours and problematic AOD use (Towers 2008, Marsh 2008).

There is a great deal of literature that looks at trauma, PTSD and drug use (Marsh 2008, Stewart 2007, Towers 2008). AOD disorders often co-occur with PTSD with up to one in every three to four clients in AOD treatment services having co-occurring PTSD (Marsh, 2008). Physical trauma is particularly associated with a high rate of AOD use, especially in women (Marsh 2008, Towers 2008). Even if PTSD is not present, the link between other mental health issues, AOD problems and past traumatic experiences persists. Researchers have found an association between other mental health issues such as depression, AOD use and traumatic events occurring in childhood such as physical, sexual or emotional abuse (Koehn & Hardy 2007. In adulthood traumatic experiences such as sexual assault and intimate partner violence are also associated with both depression and AOD use (Koehn & Hardy 2007).

Women have higher rates of PTSD and other associated mental health problems when compared with men (Olff et al. 2007, Marsh 2008) This may be due to the fact that compared to men, women are more likely to experience the types of events that carry a higher risk of precipitating PTSD such as chronic interpersonal violence such as domestic violence and child sexual abuse and/ or other types of interpersonal assault such as rape (Kaysen et al. 2007, Olff et al. 2007). In addition, women may be more likely to develop PTSD and other types of anxiety disorders as well as major depression due to female physiology (Olff et al. 2007). Women appear to perceive threats more readily than men and are more likely to categorise these threats as being beyond their personal control (Olff et al. 2007). Women are also more likely than men to report acute emotional responses to events such as intense fear, helplessness, horror, panic and anxiety and tend to use more passive coping strategies (Olff et al. 2007). This may be the result of socialisation as men are often taught to cope more actively with problems whilst women are socialised to use more passive coping strategies. However, there may be a physiological component to these choices which has been strengthened through evolution. Using more passive coping strategies under extremely stressful situations may have maximised the survival of women and their

off-spring. For example, being able to partially disassociate from the memories surrounding childbirth may have originally enhanced women's survival and therefore their infants' survival (Olff et al. 2007). Remaining quiet and still with a threat close by may have enhanced survival of mother and children rather than trying to flee with infants and toddlers.

Women's role in society and societal expectations of women can also influence women's experiences of PTSD and related AOD use. Women (and men) who have PTSD and other related mental health issues often experience poor functioning in most aspects of their lives (Towers 2008). Issues can range from finding and maintaining employment and stable accommodation to having positive relationships with family and friends. Co-occurring AOD problems can often aggravate poor functionality as problematic AOD use can negatively impact relationships, employment, and self-esteem as well as adding legal difficulties (Koehn & Hardy 2007). Such issues have far reaching consequences for women and the children in their care. Women with co-occurring disorders may feel compelled to stay in violent relationships in order to house herself and her children. These women will often experience poverty which can impact a woman's ability to access services even if services are free (Koehn & Hardy 2007). Although the cost of getting to services and child care whilst attending services may be minimal, the opportunity cost can be quite high. Time is taken away from possible employment and caring for her children. Many mothers fear that their children will be apprehended if she is seen as not coping by accessing mental health services and/ or AOD services (Koehn & Hardy 2007).

The combination of mental health problems and co-occurring AOD problems can severely impact on a woman's ability to seek and participate in treatment for her mental health and/ or AOD use issues. For example, women may have difficulty in concentrating during counselling sessions or group therapy, remembering appointments, and following instructions (Koehn & Hardy 2007). Women's caring roles for children, partners, and other family members with mental or physical disability or ill health, may also limit women's access and participation in treatment. Caring for others also impacts on the ways women can positively care for themselves such as through exercise, getting enough sleep, eating well and having time for them

selves. Women may instead return to less positive coping strategies such as smoking and consuming alcohol (Koehn & Hardy 2007). Women who are experiencing co-occurring mental health and AOD difficulties may not receive support from their partners and families to get treatment, especially for AOD use, due to the stigma associated with being a woman with an AOD problem (Koehn & Hardy 2007). Women's partners can often be AOD users themselves and may have introduced/ supported problematic use in their female partners. Thus, partners may be particularly unsupportive of women seeking treatment (Koehn & Hardy 2007).

Depression and PTSD and AOD use problems are influenced by social, physiological, psychological and environmental factors and/or complex interactions of all of the above to impact on women's mental health and AOD use (Koehn & Hardy 2007). The link between PTSD and drug use in women, especially alcohol use, is still being explored and more research is needed about gender specific causes, prevention and treatment (Koehn & Hardy 2007). However, two main models have been put forward to explain this link. In the first model, drug use precedes PTSD which develops because in order to support her drug use a woman places herself in risky situations and/ or because of a woman's drug use, a woman's judgment of risk is poor which results in traumatic experiences (Stewart 2007). This model may be somewhat simplistic as recent studies have shown that trauma experiences especially at a young age can impair the development of the ability to assess risks and benefits of potentially dangerous situations, actions or individuals (Smith, Davis & Fricker-Elhai 2004). Thus, the use of alcohol and other drugs may be a result of a woman not perceiving the use of drugs in general as problematic or the use of drugs in a particular situation as problematic.

In the second model, PTSD symptoms precede drug use and drug use is seen as way to cope with or medicate PTSD symptoms (Stewart 2007). Studies of gender differences in PTSD presentation have shown that women do use drugs and develop problematic use after the development of PTSD symptoms, especially in cases of interpersonal violence (Epstein et al. 1998, Kaysen et al. 2007). The initial motivation to use drugs and alcohol is often to deal with the psychological responses to trauma (Stewart 1996). Self medicating using alcohol helps people cope with flashbacks, nightmares, hyper vigilance and strong feelings of anger, guilt,

helplessness and fear often associated with traumatic events. Alcohol use can also help promote sleep (Stewart 1996). Self medication may be the initial motivation to drink but then dependence on alcohol can start. If the alcohol consumption is reduced or stopped, often PTSD symptoms reappear and are made worse by alcohol withdrawal (Stewart 1996). Thus, as several authors have remarked PTSD symptoms and alcohol use become a vicious cycle where one disorder sustains the other (Stewart 1996, Epstein et al. 1998).

However, the presumption that women medicate using various drugs to cope with feelings of distress may be too simplistic. Trauma exposure does not lead to problematic AOD use per se (Marsh 2008). Variable that mediate between trauma and AOD use include PTSD symptoms. When PTSD symptoms are present the likelihood of problematic AOD use increases (Marsh 2008). Other variables that may mediate between PTSD symptoms and drug use include negative self-perception and self-esteem. Low self-esteem could be the key factor that leads women to unhealthy coping mechanisms such as problematic alcohol use (Epstein et al. 1998). Other mediating factors could be that after trauma, especially if traumatic events are experienced at young age, a woman may perceive her social and physical environment as threatening and use drugs as a way of coping with this overwhelming threat (Epstein et al. 1998).

A better understanding of the reasons for the higher rates of PTSD in women can lead to better treatment. Recent treatment programs have shown better outcomes for women where PTSD and drug use are treated concurrently rather than treated separately (Stewart 2007). This could be due to a number of factors. Successful women's programs that treat these issues concurrently strongly emphasize social support (Stewart 2007). This may be a particularly useful strategy as social affiliation appears to increase oxytocin levels in women. Oxytocin is a hormone that also acts as a neurotransmitter in the brain that in conjunction with female reproductive system hormones, particularly estrogen, has been associated decreasing anxiety and feelings of stress and promoting a calming and comforting effect (Olff et al. 2007). Women specific programs are also thought to be more helpful and appropriate due to the high level of interpersonal violence experienced by women compared to men (Stewart 2007, National Centre for Education and Training on

Addiction (NCETA) Consortium 2004). It appears that at least some of the links between traumatic events and drug use, especially alcohol use, are gender specific and that gender specific strategies may be required in order for treatment to achieve the greatest efficacy (Olff et al. 2007, Stewart 2007). However, more research is needed into how variables mediate trauma and drug use and how these variables interact with one another. Although there is a growing body of literature on the links between traumatic events and drug use, there is little cross cultural research in this area, especially with regards to women (Stewart 1996). Women from different cultural backgrounds who are experiencing co-occurring mental health and AOD issues may see their problems less as health issues but rather as spiritual or moral issues that need the guidance of an elder or spiritual advisor such as a priest (Koehn & Hardy 2007). Far more research is needed in this area.

2.5.7 PTSD and the Refugee Experience

Persons coming to Australia as refugees may be at particular risk of PTSD due to a variety of factors. The Victorian Foundation for Survivors of Torture estimates that 25% to 70% of humanitarian entrant clients have been tortured or severely traumatised (Kaplan 1998). However, these figures vary from year to year and depend on the humanitarian intake countries at any particular moment (Kaplan 1998) Although PTSD was recognised as a psychiatric category in 1980, the interpretation of the signs and symptoms of the condition and its treatment are culturally bound (Watters 2001). How many humanitarian entrants have symptoms that Western health and social service professionals would interpret as PTSD is unknown. Often little attention is paid to how clients from diverse backgrounds interpret PTSD signs and symptoms and what assistance they would like in dealing with them (Watters 2001). For example, some refugee clients may not wish to participate in talk therapies that discuss the traumatic events they experienced, rather their treatment wishes may be for practical assistance in finding appropriate housing, employment and language acquisition (Watters 2001).

From what is known about PTSD and its links to drug use, it has been argued that humanitarian entrants are at high risk for problematic drug use as not only are they likely to have experienced a high level of trauma due to the refugee experience but

also often experience difficulties in settling into an often very different socio-economic and cultural environment than the one in their homeland, lack knowledge about the drugs available in Australia, experience a relative ease of access to drugs, especially alcohol, and have poor access to treatment services (Sowey 2007). Adolescents from refugee backgrounds can be at particularly high risk for drug use not only due to the risk factors mentioned above but also due to the disruption of family and peer relationships, stressful life events due to death and chaos resulting from fleeing from conflict and/or being made to serve as child soldiers in conflict settings, academic problems often due to interrupted schooling and the use of aggressive tactics to handle interpersonal conflict often learned in refugee camps (Sowey 2007).

However, just because people from refugee backgrounds can be at high risk for problematic alcohol and drug use, does not necessarily mean such use is inevitable. Cultural prohibition against drug use such as alcohol may mitigate the likelihood of using drugs to cope with PTSD symptoms (Stewart 1996). The impact of trauma is not like a shopping list of experiences that if ticked places a person at higher and higher risk of problematic drug use until such use is inevitable. Drugs are used to cope with the symptoms of traumatic events rather than the traumatic event per se (Stewart 1996). Often women from refugee backgrounds have many protective factors that mitigate problematic drug use. These include cultural and religious attitudes, beliefs and practices as well as family and peer support networks (Stewart 1996).

2.5.8 Summary of Migration, Settlement Issues and Drug Use

There have been Australian studies that have examined the impact of migration, especially forced migration, settlement issues and drug use. However, gender issues in relation to drug use were rarely mentioned in the studies. Some of the issues faced by individuals with problematic drug use cited in these studies are not necessarily unique to people from CaLD backgrounds. For example, many AOD clients experience mental health problems, employment issues, feelings of shame and guilt and have difficulties in accessing services because of the stigma of going to an AOD service or face practical barriers such as lack of transport or long waiting lists. However, these studies have highlighted factors that may place additional barriers for

individuals from CaLD background in obtaining support and access to treatment services, such as lack of English.

Many studies also considered the impact of trauma as a risk factor for drug use. These studies argued that humanitarian entrants may be at particular risk of problematic AOD use due to the high degree of trauma they have likely experienced. However, these studies demonstrated that they are mediating factors between trauma and drug use. Just because someone has experienced trauma does not necessarily mean that there is a diagnosis of PTSD and that subsequent drug use is inevitable. Many of the studies with humanitarian entrants have failed to critically examine protective factors that mitigate the likelihood of drug use as a means to cope with PTSD symptoms and the stresses associated with migration and settlement. These protective factors include the cultural acceptance of drug use, age, gender, religion, income, education, employment, family and peer support and the interaction of these factors with one another.

2.6 The Impact of Mainstream Prevention Programs on Migrant and Refugee Communities

Mainstream health promotion programs such as QUIT and more specific health promotion messages that focus on various harm minimisation strategies are conducted by local, State and the Commonwealth government each year in Australia. Although not specifically targeted at people from CaLD backgrounds, they do generally try to be inclusive, for example, by including obviously CaLD images of people and families. Many of the strategies that these messages promote are taken up by people from CaLD backgrounds. Studies that look at this phenomenon are most readily found in the area of tobacco cessation.

The research by Zandes (2003) is a good example of one of these studies. This qualitative study used interviews with 26 key ethnic community leaders to look at changes in attitudes and behaviours of ethnic community members to smoking, especially passive smoking, in recent years. Zandes found that community leaders felt that there had been changes in attitudes and behaviours towards smoking in their communities similar to those in the mainstream Australian community. However, the rate of positive changes had been much slower. Community leaders felt that not

everyone in their communities had a clear understanding of the negative health effects of passive smoking especially the elderly and men.

This study demonstrated two of the many difficulties encountered in cross cultural research that can make findings difficult to generalise outside of the group that was interviewed. The first problematic area in this study was that only community leaders were consulted. Because of the difficulties in recruiting participants from ethnic communities, community leaders are often used as a sample because they are relatively easy to find and often more willing to talk with researchers than community members. However, just because someone is a community leader does not necessarily mean that they represent a culture or are representative of the majority of the views in a community (Temple 2002). The second drawback of this study was the use of language groups as the basis on which to collect information as opposed to cultural or ethnic groups. The use of language groups as a way of defining a sample without other demographic variables can be problematic. For example, Arabic speakers come from a diverse range of countries and cultures all of which can have diverse attitudes, beliefs and practices around health issues. For these reasons, the views of participants cannot be seen to be representative of the wider ethnic communities from which participants were drawn.

In another tobacco study looking at the impact of QUIT (Australia's national smoking cessation campaign) in ethnic communities, Wen, Hua & Rissel (2002) examined the smoking prevalence of Lebanese born people in Sydney to see if rates of smoking were influenced by QUIT. Wen, Hua & Rissel compared the results of telephone surveys conducted in Arabic or English in 1997 and 2001. Gender specific results were reported and showed a decline in both male and female smoking prevalence between 1997 and 2001. There was also an increase in the number of households that were smoke-free (smoking allowed outside only). There was a good recall of the national QUIT program and a good recall of a local Arabic smoke-free homes campaign. The researchers concluded that national tobacco control campaign did have a positive impact on this immigrant population even if they used mainstream messages in English and that small local campaigns assisted but could not replace national campaigns.

This article is significant for a number of reasons. Wen, Hua & Rissel (2002) put considerable effort into having a random sample in their evaluation study, something which is not easy when working with specific migrant groups when respondents may not speak English well. To use a random sample such as the one described requires considerable resources in terms of both infrastructure and funding. Although Wen, Hua & Rissel (2002) completed 242 interviews in the 1997 survey and 342 interviews in the 2001 survey, there was only enough power to detect a 15% change in smoking prevalence between the two survey groups. Given the difficulties in contacting and gaining information from migrant respondents, especially those who do not speak English well, the sample sizes obtained by Wen, Hua & Rissel are impressive. However, it serves as a reminder that even with considerable effort and expense to obtain such sample sizes, the resultant loss of statistical power will make it difficult to detect significant differences unless there are large changes. The study by Wen, Hua & Rissel (2002) was also of particular interest as it successfully used a national data set question on smoking status using bilingual workers, one of the survey questions used in the study described in this thesis.

The final QUIT evaluation study considered here was conducted in Melbourne in 1998 and aimed to gather more information on the smoking beliefs and practices of various ethnic communities to better inform the current Victorian QUIT campaign and to suggest possibilities for future campaigns (Trotter 1998). The Greek and Chinese communities were chosen for the study as together they comprised nearly 25% of people who reported speaking a language other than English at home in 1997 in Victoria. Rather than a random sample, smokers were particularly sought out in order to better understand their beliefs and attitudes. The paper included a useful discussion on the cultural influences on smoking and some of the attitudinal findings. Nearly 25% of Chinese smokers said that smoking was a sign of sophistication, being cool or adulthood which is much higher than the 8% to 12% found amongst Greek participants. The majority of both Greek and Chinese smokers felt that smoking helped relieve stress, worry, and/ or was relaxing, helped you to think. Even among ex-smokers in both these populations these perceptions still remained quite high. However, there did not seem to be any exploration of other reasons for smoking which perhaps are less culturally acceptable but still relevant such as

smoking being used to cope with depression and other types of mental illness and/ or to cope with unemployment or involvement in the criminal justice system.

Although most Greek and Chinese smokers showed a good understanding of the negative health effects of smoking including the effects of passive smoking, a large proportion of the Greek respondents, whether smokers (53%) or those who had never smoked (43%), saw smoking as "a traditional activity for public and social gatherings". For Chinese participants this was somewhat less: smokers (38%) or those who had never smoked (16%) saw smoking as "a traditional activity for public and social gatherings". The evaluation concluded that there were only small differences between the two ethnic groups studied and the Victorian population in smoking knowledge, beliefs and behaviours. It was felt that differences found were being addressed with existing campaigns but nevertheless specific supplementary campaigns may be needed to address specific issues found within each of the communities. One of the closing remarks was around the lack of consensus about the traditional role of smoking in the Chinese community. Trotter explained this could be due to the cultural diversity within the Chinese speaking community or that norms surrounding tobacco use vary more by family than by larger social units. However, no analysis was undertaken by socio-economic variables such as income and education levels which are known to influence such beliefs.

The National QUIT campaign is not the only large health promotion program that deals with AOD issues that has looked at its reach into ethnic communities. The National Illicit Drugs Campaign has also done an evaluation on the impact that its messages have had on families from CaLD backgrounds (Bertram et al. 2003). One of the campaign's primary target groups was parents from non-English speaking backgrounds. The campaign used both mainstream messages and language specific messages in 16 different languages to reach these parents. The evaluation of the language specific section of the campaign was done through a phone survey using a questionnaire similar to that used with mainstream parents but with the addition of several questions on the language specific media campaigns. The survey showed that 76% of NESB parents had seen, read or heard something about illegal drugs in the media, although this was significantly less than the 89% of mainstream parents who reported this. However, NESB parents had a much higher recall of campaign

specific TV ads compared to mainstream parents (21% versus 8%). Half of the NESB parents said the campaign had promoted them to take some action such as talking to their children about illicit drugs. NESB parents reported that the campaign made it easier to talk to their children about drug use, although they also reported being less confident than mainstream parents talking to their children about drugs.

The evaluators found there were differences between the language groups such as their preference for certain messages or certain television advertisements as well as different parental attitudes and behaviours regarding illegal drug use between the language groups. NESB parents reported recognising a combination of mainstream and NESB specific campaign materials. The evaluators concluded that the campaign and the language specific components of the campaign had been successful in reaching NESB parents and encouraging them to discuss issues around drug use with their children.

As with the study by Wen, Hua & Rissel (2002), some of the survey questions used in the evaluation of the National Illicit Drug Campaign could potentially be used in the Perth study. Ultimately one of the questions on parent's perceived knowledge to talk about drugs with their children was used in the CaLD questionnaire. Moreover, the work by Bertram and colleagues provided further confirmation that bilingual workers could be successfully used to gather information on sensitive issues.

2.6.1 Summary of the Impact of Mainstream Prevention Programs on Migrant and Refugee Communities

The above research suggests that individuals from CaLD backgrounds are influenced by major national health promotion campaigns around AOD issues. However, the QUIT research as well as the National Illict Drugs Campaign evaluation suggests that more targeted language campaigns contribute to the impact of the mainstream campaigns for individuals from CALD backgrounds. There are still sub groups that require more specific interventions. For example, in the area of tobacco cessation, practitioners should be aware that values within some of the subgroups will see tobacco smoking as a sign of sophistication, the use of tobacco as a way to relax and relieve stress and public smoking as acceptable. Bilingual/bicultural workers have

also been shown to be a successful strategy to gather information on beliefs, attitudes and behaviours associated with alcohol and other drug use.

2.7 AOD Prevention Programs with Women from CaLD Backgrounds

The last section of this literature review looks at Australian projects and studies that can inform future projects and intervention strategies for working with CaLD women around their drug use issues and concerns. There have been, and continue to be, many AOD projects and programs aimed at CaLD groups and communities looking at prevention, service access, and treatment (ADF DrugInfo Clearinghouse 2004). Of particular interest in the following reports were aspects of the programs that were highly relevant to the current research project and strategies that could be applied to working with CaLD women at WHS.

The purpose of the qualitative study by Bolton and colleagues (2002) was to develop a general model to improve the quality use of medicines in CaLD communities. The Sydney- based study took an action research approach, first collecting qualitative data from Chinese and Arabic speaking consumers. Qualitative data were then sought from professionals using in-depth interviews. In the second phase of the project, focus groups with a mix of GPS and consumers were held with a pharmacist in attendance to answer questions related to dispensing and use. The aim of the focus groups was to generate a common understanding of issues between professional and community participants. Three sessions followed in which a pharmacist provided a brief introduction to the use and side effects of a specific medication at each session: amoxicillin (an antibiotic); enalapril (an antihypertensive agent) and sertraline (an antidepressant). During the educative focus group sessions GPs and consumers had opportunities to discuss and share issues about these medications. Some issues appeared to be unique to either Arabic or Chinese consumers while other issues were common to both. Common issues included language barriers, consumers wishing more time for explanations, and the limited time spent by GPs with patients. For the consumers, the language barrier wasn't just about using interpreters but using terminology that they were able to understand. The commonalities experienced by the two groups of consumers provide some evidence that despite people being from disparate cultural groups there are common experiences and that different programs

are not necessarily needed for each cultural group. However, the authors tended to make fairly generalised statements about the Arabic and Chinese communities based on their qualitative data. Qualitative data of the type that they have collected is very useful in exploring the attitudes of consumers and health workers, especially GPs towards medicine use. However, the findings from such qualitative research cannot be generalised to all Arabic and Chinese speakers.

The study by Dimopoulos (1999) is a grey literature report from TRANX, a non-profit organisation specialising in benzodiazepine use and dependency located in Melbourne. The study is one of a few reports documenting recent problematic prescription medications use amongst migrant groups in Australia. The cause of problematic benzodiazepine use has been hypothesised to occur as the result of Western service delivery for emotional and mental health issues relying heavily on verbal communication techniques such as CBT or group therapy which require English fluency. Practitioners who are not bilingual and/or who have difficulty or are reluctant to use interpreters tend to prescribe medication for CaLD women for mental and emotional health issues (Working Women's Health and Women's Health in the North 2000). The purpose of the study by TRANX was to find strategies to reduce inappropriate and hazardous use of benzodiazepines amongst non-English speaking background groups, to improve TRANX's access for non-English speaking background groups and to improve information on benzodiazepines to people of non-English speaking background. The report was based on data collected from semi structured interviews with health and community service providers, prescribers and users of benzodiazepines. Of the clients interviewed 75% were women.

The study found that there was a great deal of confusion about the difference between benzodiazepines and antidepressants. The researcher noted that there was little literature available on benzodiazepine use in community languages compared to information on tobacco, alcohol and other drugs. In general, there were higher rates of use in more established communities amongst older people, aged 55 years and older. In the more recently arrived groups, higher rates of usage were found in younger people. In general, problematic use of benzodiazepines was not discussed and was kept within the family or within the community. Service providers participating in the project worked with over 15 different communities and only the

Chinese community was considered not to have problematic use. Workers felt that members of this community were more likely to use alternative therapies such as tai chi and herbal remedies rather than medication. Although a fairly large number of service providers (59) were interviewed who worked with ethnic community members, only 24 consumers from various cultural backgrounds were interviewed. This is a relatively small sample on which to make generalisations about the attitudes, beliefs and practices of people in different ethnic communities.

An interesting aspect of this study was that participants were asked to identify strategies that they thought would be helpful in addressing the lack of knowledge about benzodiazepines as well as identifying strategies to increase access to TRANX and other services for problematic benzodiazepine use. This generated a broad range of strategies for TRANX to consider. Participants were also asked to identify from whom they preferred to seek assistance. This resulted in another list that included doctors and other health professionals, counsellors/ psychologists, family, and friends. Fifty nine percent of respondents said they would use an interpreter. Using all of this information, recommendations were developed, ranging from the creation of policy and procedures for staff and volunteers at TRANX, to strategies for educating other professionals about the issues involved, as well as different types of community education to be undertaken. This report was particularly relevant to the current research project because of the practical strategies that were generated by asking both service providers and consumers questions concerning the best ways of providing information to culturally and linguistically diverse clients, from whom clients would like information and support, and whether or not interpreters were needed. Similar types of questions were eventually included in the semi-structured interviews and focus groups as well as the questionnaire in the current project.

The joint project by Working Women's Health and Women's Health in the North (2000) was an alcohol and drug health promotion project with CaLD women working in garment factories in Victoria. This grey literature report described the methods used, provides information regarding the training bilingual workers received, looks at the different sessions offered to CaLD women and summarises the evaluation of the project including recommendations for future policy and programs. Several aspects of this project were of interest. One was the community wide

approach used throughout the project. This approach emphasised that AOD issues impact on the whole community not just those who use, and that it is important for everyone to learn about AOD issues not just those who have a problem. In keeping with this community wide approach, the focus of the information sessions to the women in garment factories was on prevention, early intervention and harm minimisation. The training focused on what women wanted to know, thus each session was slightly different with a different emphasis depending on the needs of the women attending the session. There was a great deal of consultation prior to the information sessions being held. This consultation included discussions with a project reference group, employers in whose factories the talks would be held, with union officials and the women themselves. Unsurprisingly, a major finding of the study was the large amount of stigma associated with even participating in an AOD information session let alone seeking help for problematic use. Incorporating AOD information into information sessions on stress and wellbeing and other talks on health and social issues was a strategy to overcome the stigma associated with attending an AOD talk. Major issues that were raised by the women in the sessions included their own mental health issues and stress, dependency on prescribed drugs, lack of AOD resources in community languages, lack of knowledge and access to drug and alcohol services, concerns for their children around AOD use and coping with family members who have AOD issues. Although there was a process of evaluation of the sessions offered as part of this project, an impact evaluation that considered whether or not more women were accessing services, what kind of services, and any long term outcomes of either participating in the project or accessing services would have been extremely valuable.

Another innovative program was The African Companions Project in 2007 by Sowey at the Drug and Alcohol Multicultural Education Centre (DAMEC) in New South Wales. The project was a community education and capacity building project that aimed to decrease the harm caused by alcohol and other drugs and improve access to treatment services amongst newly arrived African communities. Interested men and women in these communities were trained to be African Companions. The Level One training program focused on increasing knowledge about AOD and was conducted in gender specific groups. A subsequent Level Two course was offered to those who had completed Level One. Participants were admitted to the Level Two training at

the discretion of the project officer. The Level Two course focused more on practical skills. At Level Two participants were in mixed gender groups as this offered opportunities to hear not only how people from different cultural backgrounds thought about and handled certain situations but also how men and women thought about and handled certain situations. The project was very successful in getting 76 people to complete Level One and 43 to complete Level Two. After the training the African Companions were introduced to their communities through a series of BBQs and participated in developing radio plays for their communities. Aspects of this program appeared useful as a model for future service delivery at WHS. However, no impact evaluation has been completed on the project as the project was only completed at the end of 2007. Therefore, its usefulness over a period of time is still to be demonstrated. In addition, training community volunteers to talk about AOD issues is much easier than providing an ongoing structure to support volunteers so they are a useful resource in this area. The large numbers trained by this project would require substantial support to remain effective over any length of time.

2.7.1 Summary of Successful AOD Prevention Programs with CaLD Women

These projects highlight a number of important points in planning and implementing successful AOD prevention services with CaLD women. Firstly, a community-wide approach that emphasises that AOD issues impact on the whole community is a useful strategy. This approach helps to remove some of the stigma around discussing AOD issues. These interventions also found that despite participants being from quite disparate cultural groups, there were commonalities in terms of the AOD information needed, the lack of understanding of AOD services and barriers to accessing services.

These interventions also highlight the importance of consulting with service providers, the community and women likely to be involved in the service delivery. Workers involved with these projects talked about the time consuming nature of a consultative process but that ultimately the consultations made the strategies more effective and successful. For example, these interventions showed that the information community women wanted, who they wanted the information from, and how they would be likely to access it was not necessarily what service providers initially supposed. These interventions also demonstrated that talking about issues is

important for many community groups. The lack of English literacy and even the ability to read in a woman's own languages are major obstacles in accessing AOD information. In addition, many cultural groups have a strong oral tradition so power point presentations, whiteboards and written resources such as pamphlets are likely to be less useful than strategies such as discussion and story telling. Language considerations also include using terminology that participants are likely to understand. Limiting the use of jargon and medical terminology is important.

Lastly, these projects recognised that participants led busy lives and that the service providers needed to acknowledge and accommodate this whenever possible. A good example of this was in the project by Working Women's Health and Women's Health in the North (2000) who implemented a series of AOD information sessions in factory women's lunch breaks.

2.8 What Has the Literature Shown?

Statistics show that CaLD women are under-represented among users of AOD services (Macfarlane Burnet Centre for Medical Research and the North Richmond Community Health Centre, 2000). This is reinforced by data obtained from the Drug and Alcohol Office (DAO) in Western Australia for 2006, 2007, & 2008. This data looked at episodes of presentation at DAO funded AOD services in WA for women and men by country of birth (Finn, 2009). As the vast majority of AOD services in WA are funded by DAO and the entry of episode data is a mandatory part of the funding contract, this data represents the best available information regarding who is presenting at AOD services in WA. This data was then cross tabulated against the 2001 Classification of Countries into English Proficiency (EP) Groups ((Department of Immigration and Multicultural and Indigenous Affairs, 2003). EP Groups are used by the Department of Immigration and Citizenship (DIAC) as a means of benchmarking populations for comparison purposes. This classification system allows data that consists of countries of birth to be summarized into four distinct groups. The EP Groups strongly correlate with settlement needs and disadvantage and are used by DIAC to target funding and other assistance. EP Groups also allows data to be compared against Australian born persons, for example

unemployment rates or skill levels ((Department of Immigration and Multicultural and Indigenous Affairs, 2003).

The EP1 group is the equivalent of the main English speaking countries such as the USA, Ireland, and Canada. The numbers of the EP groups proceed upwards to EP4. There is a high degree of correlation between the higher the EP group number and the level of disadvantage experienced (Department of Immigration and Multicultural and Indigenous Affairs, 2003). In looking at the DAO data, 83% (n= 12,716) of all episodes recorded by the DAO data base for women in 2006, 2007, and 2008 are women who are Australian born. Women from the EP1 Group make up 13% (n= 2013) of the presentations, 2.4% (n= 380) are from the EP2 Group, 1.5% (n= 237) are from EP3 Group countries. Only 23 episodes are recorded over the 3 year period for women from the EP4 Group. Clearly, women who are born overseas who experience a greater level of disadvantage coming from the higher EP Group numbers are not presenting at AOD services in WA.

When comparing men to women, Australian born women make up 36% of the episodes over the three year period of all Australian born people. When looking at episodes by EP Groups, women account for 43% of the episodes of the EP1 Group episodes. This is a much higher rate than their Australian born counterparts. Women make up 36% of the episodes in the EP2 Group and 32% of the episodes in the EP3 Group, rates similar to their Australian born counterparts. However, the percentage drops sharply for women from the EP4 Group as they make up only 19% of the episodes. Women clearly do not access AOD services at the same rate as their male counterparts. Why this may be so is discussed in greater detail in section 2.5.1 Women and Drug Use.

However, this may not be an indication that the use of AOD amongst this group of women is of less concern (De Jong, Valentine & Kennedy 1998, Straussner 2001). Low rates of access to AOD services by CaLD women may have more to do with language difficulties, lack of awareness of services, the stigma attached to drug use and cultural issues regarding discussing private issues with “outsiders” than with lack of need (Macfarlane Burnet Centre for Medical Research and the North Richmond Community Health Centre, 2000, Ng, Bartu & Sang 1999; Working Women’s Health

and Women's Health in the North 2000). Although there is Australian research on migrant and refugee groups and their issues and concerns regarding tobacco, alcohol, medication and other drug use, this area of research is still largely exploratory and specific studies on issues for women are rare. While some of the studies did overcome methodological problems common in cross cultural research, other studies were less successful. This has meant that their findings are difficult to generalise to broader groups. Some of the common methodological problems in cross cultural research are discussed in greater detail in Chapter Three.

Models that explain patterns of drug use in this area can be overly simplistic but are evolving to include more known factors that influence drug use as well as the impact of culture. However, culture is not the only factor to influence patterns of alcohol and other drug use. Other factors include gender, age, occupation, income, education, and level of acculturation into the dominant culture. In addition, it is important to note that cultures are not static but change over time, that larger cultures are composed of subcultures, and that individuals can themselves be multicultural belonging to two or more cultures. All of these factors and variables interact in complex ways and need to be considered in planning and implementing prevention strategies.

There are a range of reactions to women's drug use by the individual using, by the family, and by the community to which the user belongs. These reactions can include shame, loss of face, denial, stigma, and embarrassment. Individuals, parents and other family members and communities as a whole can feel a sense of failure at a perceived loss of honour. When working with CaLD individuals, families and communities separating health issues including alcohol and drug issues from social issues such as appropriate housing, appropriate employment, and safety may not be seen as particularly helpful by either the client or their carers. Clients often require assistance and advocacy with practical issues and the resolution of these issues will often assist with harm minimisation and reduction of use. In this way, these clients are very similar to mainstream AOD clients.

The studies reviewed here suggest that individuals, families and communities from CaLD backgrounds are influenced by major national health promotion campaigns around AOD issues. However, more targeted language campaigns contribute to the

impact of the mainstream campaigns amongst individuals from CaLD backgrounds. Mini campaigns may need to work with specific sub groups within CaLD communities depending on the drug and its use within a community.

Successful needs assessments and programs have been conducted in Australia with women from CaLD backgrounds. These successful projects have certain common features including using a community-wide approach that emphasises that AOD issues impact on the whole community. These projects also found that despite women being from quite disparate cultural groups, there were commonalities in terms of the AOD information they needed, their lack of understanding of AOD issues and barriers to accessing services. These projects also highlight the importance of consulting with service providers, the community and the women likely to be involved in a project before, during, and after the project.

2.9 Why Pursue the Research Question in this Thesis?

Western Australia has one of the largest populations of overseas born residents in Australia. Approximately 27% of WA's population is overseas born with 11% (almost a quarter of a million people) of the State's population speaking a language other than English at home (Office of Multicultural Interest 2003-2008). Projected migration intakes suggest that this high percentage of overseas born people in the WA population will continue (Department of Immigration, Multicultural and Indigenous Affairs, 2005). In light of these statistics, AOD issues and concerns for CaLD women and their families will continue to emerge, just as these are major issues for the mainstream community.

There is some evidence on which to base CaLD specific AOD prevention strategies and projects. However, there is relatively little Australian research that explores and documents CaLD women's perceptions, interpretations, and concepts of prevention and treatment around AOD issues. The current lack of research in this area hinders service providers from creating evidence based programs or services for this group of women. This project will contribute to the research already conducted in this area but will offer several unique contributions. These include examining AOD issues and concerns specific to newly arrived women, gathering details on what information

women want and what medium they would like it in, and piloting one or more strategies as suggested by the women.

Chapter Three

Methodological Issues in Cross Cultural Research

3.1 Introduction

This chapter will discuss some of the methodological difficulties and considerations in conducting cross-cultural research. It will also highlight the reasons that particular methods and strategies were used in the current research project. A more detailed discussion of the methods used in this project follows in the subsequent chapter.

3.2 Working with Marginalised Groups

Research with marginalised groups is often undertaken with the ideal that the outcomes and the knowledge gained will help improve the lives of participants and others like them, positively influence the development and improvement of policies and programs and contribute to social change (Dona 2007). In this way, the research has some value for the participants as well as for the researcher (Murphy-Lawless 2002). This was the hope with this research, which was undertaken with the intention that the findings would be used to improve programs and services for newly arrived women accessing WHS and other services.

3.2.1 Literature Reviews

One of the difficulties in health research with marginalised groups such as newly arrived women is the lack of published literature. Existing knowledge in this area is very often only published in the grey literature such as self-published agency reports or funding body reports. This grey literature can require large amounts of time to find and can be difficult to obtain. For this reason Kavanagh, Daly & Jolley (2002) have recommended that researchers discuss issues with colleagues, relevant service providers, and/ or hold consultations with relevant groups to formulate and refine the research question before starting the actual data collection. The time taken to explore the literature and to formulate the research question is time well spent, as knowledge of the intended sample prior to the commencement of the actual research helps prepare the researcher to handle issues such as language difficulties, lack of literacy, and cultural concerns all of which can inform and improve data collection and other aspects of the research process (Bloch 2007, Flaskerud & Nyamathi 2000). The literature review for the current study was challenging. In many cases, literature

published in academic journals was unusable because the definitions of ethnicity were different from country to country or were poorly defined. For example, much of the US literature uses broad racial classifications (black, white, etc) without distinguishing between those who have been in the US for generations and recent arrivals. In many articles, no gender analysis was undertaken or the number of women included in the study was not mentioned making the applicability of the results for newly arrived women uncertain. Many reports and articles in the grey literature were useful, but they were difficult and time consuming to locate. I relied heavily on my professional networks to obtain copies of reports and articles. In some cases there was no written report that could be given to an external researcher so I talked with the workers involved in the project about what had worked well and used their learnings to inform my work in the area. However, the limitation of this approach was the limitation of my networks, so that there is likely to be grey literature that I did not find or access.

3.3 Defining Ethnicity

An ethnic group or community refers to people who share common cultural traditions such as ancestry, language, and/ or religion (Anand 1999). However, ethnicity is not a simple construct and there is no explicit and widely accepted rationale in health research of how ethnicity is defined, categorised and measured (Bradby 2003, Anand 1999, Chen et al. 2000). For this reason, ethnicity was not discussed in detail in the definitions provided in Chapter Two, and is explored in more detail here. Ethnicity can refer to a general "otherness" of individuals who do not belonging to the majority group of the population, community, or country (Adamson & Donovan 2002). Ethnicity can also be more specifically defined using race, the colour of a person's skin, country of origin, language spoken, membership of a religious group, ancestry or a mix of these and other characteristics (Bradby 2003). Often the measurement of ethnicity has been driven by the needs of those collecting the data as in the case of census agencies (Ames & Rebhun 1996). This has meant the use of fixed response categories on survey instruments as these are easy to process. These categories have often been based on race that divides people on differences in skin colour and physical features such as black or white (Anand 1999, Bradby 2003). Race is an unsatisfactory measure of ethnicity for research purposes as the colour of a person's skin has little to do with people's cultural

heritage in today's multicultural world. In addition, the use of race as a variable makes research difficult to compare from country to country. For example, "Asian" in the US refers mainly to people of Korean, Taiwanese, Chinese ancestry, while in the UK "Asian" mainly refers to people coming from the Indian subcontinent (Dar et al. 2002). Fixed response categories can also imply that people fall into mutually exclusive groups which can have very negative overtones of not being "pure" if someone has ancestry from more than one group, and fails to recognise the complexity of identity (Bradby 2003). Ethnicity is also a social construct and as such it changes over time as how people identify themselves changes. Historical events and values placed on those events can influence how people identify themselves and this can change, especially in times of conflict (Bradby 2003).

The impact of acculturation also needs to be considered in cross cultural research. Acculturation is a slow process usually discussed in terms of generations or measured in decades. As discussed previously, health studies with ethnic groups have generally not controlled for acculturation of their participants. Thus, when using broad categories such as "Chinese", the sample can include people who are newly arrived with those who have lived here for 40 to 50 years as well as those who were born in Australia. By not taking into account different levels of acculturation, the factors impacting on the health issue being studied can be lost or disguised. For example, acculturation has been shown to be an influence on drug use, with more acculturated women having drug use patterns more closely resembling those of the dominant cultural group (Caetano 1994).

Capturing ethnicity in research can be done through a variety of means ranging from name analysis to collecting information about people's country of birth, language, religion, date of migration and/ or parent's country of birth (Bradby2003). These descriptors of ethnicity better reflect people's constructs of their identity than older views using race (Bradby 2003). However, capturing all this information in a questionnaire can be time consuming and make analysis more difficult. Some researchers have allowed people to self-assign or self-identify the ethnic group(s) to which they belong. However, this process and can add to the time and expense of coding responses as instead of processing perhaps six to ten pre-coded categories,

researchers may end up with over one hundred different response categories (Bradby 2003).

Ethnicity is both complex and dynamic (Bradby 2003, Anand 1999). However, ethnicity is not the only factor that needs to be considered in health research. The influence of gender, social class, education, and employment among many other identified social determinants also need to be considered (Bradby 2003, Adamson & Donovan 2002) If these are not taken into account, a stereotyped view of people from a particular ethnic background can be reinforced. For example, rather than people experiencing similar problems because of poverty regardless of their ethnicity, poor methodology can portray people from a particular ethnic group as experiencing a particular problem. These factors also needed to be considered in the research project.

3.4 General Methodological Difficulties in Cross Cultural Research

Often people from ethnic groups have been excluded from health studies because of the difficulties of recruiting participants, their difficulties in understanding English adequately to fill-in surveys or to be interviewed, and the substantial costs associated with translations and interpreters which can add significantly to the cost of a study (Barata et al. 2006). Having an ethnically homogenous sample is easier for data collection and analysis, and can reduce confounding factors. For these reasons many instruments, audits and norms have been set using Caucasian males. However, these tools may not be appropriate or valid for a more ethnically mixed sample (Oakley et al. 2003).

National surveys are often used for gaining data on subgroups of the population; however, looking at ethnic minority groups using national survey data is often impossible. The measurement of ethnicity in many national surveys has not been sensitive enough to give meaningful data. For example, all people born outside of Australia can be classified into one group. When ethnicity is measured, often the sample obtained from a particular group is too small to give any useful information. If a researcher is only looking at men or women the sample size becomes even smaller and less useful for drawing conclusions (Caetano 1994). This was true for

this project. Several state and national surveys with alcohol and other drug questions were examined prior to the commencement of this research project but ethnicity was often poorly measured or had been grouped into larger non-meaningful categories. Where ethnicity data had been appropriately obtained once the sample was divided by gender, the numbers were too small to be meaningful.

3.4.1 The Concept of Research

Like other groups within the Australian population such as the elderly, members of ethnic communities may be unfamiliar with the Western investigative idea of research due to limited educational opportunities and/or limited opportunities to participate in research projects (Dotinga et al. 2004). Potential participants may fear invasive and painful procedures and may not understand that not all health research is clinically based (Barata et al. 2006). Researchers may need to demonstrate that the practical outcomes a study may have for individuals or a community group justifies the time and resources spent by participants (Dotinga et al. 2004, Elam & Fenton 2003). Communities can also be over researched with multiple research projects recruiting similar participants to explore a variety of different issues. Ethnic communities can suffer "research fatigue" when community members are asked "all these questions" but see no tangible results from their participation (Bloch 2007).

3.4.2 Concerns about the Use of Research

Groups and individuals can be concerned that the results of the research could be used against the group they belong to or against them at an individual level (Murphy-Lawless 2002). Individuals may fear that disclosing poor health, participation in an illegal activity or what may be considered a deviant activity could jeopardise their immigration status (Elam & Fenton 2003, Flaskerud & Nyamathi 2000). Individuals may also fear being branded a troublemaker or fear reprisals either personally or against family and friends (Dona, 2007, Yick & Berthold 2005). For example, for many individuals who have fled repressive regimes, there is a fear of information getting back to their country of origin, such as that they are still alive, and putting family and friends still in that country at risk (Bloch 2007). This fear is often well founded and researchers need to be aware of this.

At the collective level, participants may fear that research will portray their group or community in an unflattering way and reinforce negative stereotypes such as that all young men from a particular group are unemployed drug users (Elam & Fenton 2003; Yelland & Gifford 1995). Fear of the results of research being used to cut programs or reducing existing resources and infrastructure can also influence people to give less than honest replies or not participate in the research at all (Dona 2007)

3.4.3 Determining the Sample

One of the most difficult questions in ethnicity research is seemingly one of the most basic – who should be included in the sample? As discussed previously, ethnicity is often a poorly defined concept and national and local area data may not keep ethnicity data in a way that is meaningful for the research question. Communities, including ethnic communities, can be defined in multiple ways by language, by cultural practices, by age, by interest, and by geography to name but a few (Ragin et al. 2008). The use of language groups as a way of defining a sample without other demographic variables can be problematic. For example, Spanish and Arabic speakers come from a diverse range of countries and cultures. People can also choose to participate in different communities and can identify themselves as belonging to several communities at the same time. Simply targeting individuals because they belong to one community association (a sample based on one characteristic) will limit the generalisability of the findings to a broader group. Other difficulties in the defining a sample include the fact that people have dual nationalities so a decision needs to be made as to whether to include them in a sample or not. Lists of people who arrive on a particular migration category e.g. refugee would be useful for generating adequate sample sizes and random samples but researchers, in general, do not have access to these lists for reasons of confidentiality (Bloch 2007). This was the case for this research project. People's migration status often changes, for example from temporary resident, illegal entrant, or visitor to permanent entrant or to citizen. In addition, basing a sample solely on immigration category can lead to un-intended bias in the research (Bloch 2007). There are hidden populations, for example, people who are in a country illegally. People with illegal status are often not included in research because of the difficulties in recruiting them (Bloch 2007, Yick & Berthold 2005). However, for some research questions, including these more invisible groups can generate a sample with different

characteristics than would have been achieved otherwise (Oakley et al. 2003). Recruiting hard to reach groups within any given population adds to the cost of the research as using appropriate data collection methods, recruiting participants, and organising and obtaining informed consent is more complex and time consuming (Oakley et al. 2003).

3.4.4 Cultural Issues

There are a myriad of cultural issues that can impact on health research with ethnic groups. Some of these issues manifest themselves in pragmatic ways such as the different meanings of time so that participants can show up anywhere from 15 minutes to two to three hours late for scheduled interviews or the reluctance of participants to schedule anything such as an interview appointment too far into the future (Small et al. 1999a). Other cultural practices can mean that participants may not respond truthfully to certain questions that are culturally taboo such as questions relating to suicide or self-harm (Small et al. 1999b).

Aspects of gender, like ethnicity, are a social construct and as a social construct can significantly influence on how women perceive health, illness, and what is considered a problem or an issue (Oakley et al. 2003). On a more practical level, women may need to seek the approval of the family or male household head before participating in research (Oakley et al. 2003). Cultural norms may mean that some issues are not discussed outside of the family, let alone with a researcher who is a stranger. Having an interpreter present may add to the discomfort as the interpreter can be a member of the same ethnic community (Oakley et al. 2003, Yick & Berthold 2005).

Other issues in cross-cultural research can be subtle. Empirical research as an aspect of scientific methodology comes out of historical western constructs where issues and phenomenon are explained by measuring and direct observation (Yick & Berthold 2005). In Western culture there is a tendency to present issues in a binary way such as agree/ disagree or healthy/ ill (Dona 2007). These Western constructs are not universal and may not apply equally to groups from other cultures (Yick & Berthold 2005). For example, there is a tendency when using Likert scales for people, regardless of the cultural background, to not pick extreme choices. However,

this tendency in some cultural group is more pronounced as following the middle path is considered culturally more acceptable (Yick & Berthold 2005). For other cultural groups hypothetical scenarios may pose a religious dilemma as speculating on a possible future can be seen to presupposing God's will (Dotinga et al. 2004). For other research participants making suggestions on program improvements or expansion of services may be considered impolite and denigrating a person of higher status e.g. service providers.

Concepts such as mental illness, PTSD, and domestic violence are not universal and may have no direct construct or have a different meaning attached to them in another culture (Yick & Berthold 2005). Careful choice of the wording of questions, community consultation, and piloting questions can all help ensure that the meaning of the questions is understood by both the researcher and the participants. If this is not done, the unintended meaning of questions can make participants seem more or less disturbed or appear to have more or less problems than they do in reality (Yick & Berthold 2005).

3.4.5 Sensitive Topics and in Particular, AOD Use

In cross cultural research there are many topics which may be considered sensitive, one of which is alcohol and other drug use. Topics are generally considered sensitive when they are regarded as private or evoke a strong emotional feeling. Participants generally dislike discussing or find difficult to discuss such a topic because these topics are not normally publicly discussed and participants may fear that their experiences, views or beliefs may not be normal (Elam & Fenton 2003). Researchers need to be tactful about introducing research on sensitive issues to potential participants but at the same time not lie about the nature of the research (Dotinga et al. 2004, Yelland & Gifford 1995). In research involving sensitive issues, participants can also lack the vocabulary (even in their own language) to discuss issues. Participants may have never talked about such things prior to participating in the research and may have difficulty articulating their experiences and views (Elam & Fenton 2003). Participants may also fear disapproval or reprisal after disclosing activities that do not follow a group's expectations or social norms for example, alcohol use by a participant whose religion prohibits alcohol consumption (Elam & Fenton 2003, Dotinga et al. 2004)

3.4.6 Trust

The building of trust is a lengthy process and involves developing good relations between the researcher and participants as well as the organisations with which the participants are associated. The importance of trust should not be underestimated and will impact on some of the most important aspects of the research process including recruiting participants to being able to obtain relevant and accurate information (Dona 2007; Elam & Fenton 2003). At an organisation level, trust can be fostered by meeting with workers and volunteers to discuss the purpose of the research, the requirements of the study and possible outcomes and benefits of the research (Culley & Rapport 2007). Adherence to transparent and ethical practice as well as good work practices such as showing up on time for scheduled meetings and appointments and completing tasks in the time frame agreed upon are all important aspects of building trust. Trust can also be enhanced during and after the study by feeding back the findings of the study to participants and the organisations involved as well as acting on findings.

3.4.7 Recruitment

Many studies with ethnic groups use non-random sampling methods such as snowball sampling (finding one participant and then using the networks of that participant to find others). Despite the potential for bias, these non-random methods are often the most viable given the constraints on time, budget and limited access to confidential databases (Small et al. 1999a). One of the biggest biases encountered with these non-randomised sampling methods is selection bias or gatekeeper bias. Gatekeepers are community leaders and service providers who give researchers access to their contacts in order to start the research sample (Bloch 2007). These gatekeepers are likely to give researchers potential participants who are easy to interview and have similar views to the gatekeeper, whether this is a conscious decision or not (Bloch2007; Sterk 1999). Thus, the sample may be demographically diverse but have very homogenous attitudes, practices and beliefs on the health issue being researched. This can impact on the validity of the studies findings (Bloch 2007; Gibbs et al 2007; Murphy-Lawless 2002). The best method for overcoming this type of sampling bias is to have many points of entry into a group and to have specific strategies to include more isolated individuals in the research (Bloch 2007).

Some recruitment strategies will work better with some groups than others. Thus, it is important to try a variety of strategies and allow enough time to try these strategies. For some cultural groups participants will need to be recruited by a trusted source such as a family member, friend or community leader so that the research is seen as legitimate (Barata et al. 2006). For other ethnic groups having the research endorsed by a respected and/ or learned member of the community such as a doctor will encourage potential participants to be involved in the research (Barata et al. 2006). Flyers, ethnic media, speaking to groups, and mail outs are all typical strategies that can work depending on the ethnic group involved and the community dynamics at that point in time. The success or otherwise of a particular recruitment method at any one point in time will be influenced by how social networks in a community are constructed and how people are currently identifying themselves (McLean & Campbell 2003, Yelland & Gifford 1995). For example, if the current political situation in a potential participant's home country deteriorates or there is an increase in armed conflict, a person may be reluctant to participate in the research if they are concerned that participants from rival factions may be present.

Table 3.1 Factors Shown to Improve Recruitment Success in Some Ethnic Groups

- Honorium payment compensating people for their time and travel expenses
- People's previous experience of research including how observant the researcher was of cultural courtesies such as offering food and drink;
- People's perceived benefit to the community of being involved in the research
- Personal contact prior to the interview and personal introductions/ recommendations through a trusted organisation or known person
- Matching of researcher/ interviewer with participants. This may be in terms of ethnicity, gender, age, values and/ or beliefs
- The credibility of the organisation conducting the research in the eyes of potential respondents
- Type of methodology being used and how much effort or resources is required by the participant. For example more time and resources are required to complete a longer face to face interview versus a short questionnaire over the phone.

(These factors were discussed in Krauss et al. 1997, Yick & Berthold 2005, McLean &Campbell 2003).

The factors referred to in Table 3.1 were discussed in a number of different articles on the subject (Krauss et al. 1997, Yick & Berthold 2005, McLean & Campbell 2003). Some of these factors will be more important for some participants than for others depending on what is happening in the community at the time.

Existing literature on recruitment and ethnic communities has tended to consider ethnic communities as homogenous groups (McLean & Campbell 2003). Within, as well as between each ethnic community, members differ in a number of ways. These differences include age, religion, education, reasons for migrating, length of time in Australia, language and literacy skills in their own language and English, and socio-economic status (Queensland Health 1996). There is a small but growing body of literature about the resources and strategies needed to accomplish more inclusive recruitment strategies and how to recruit more "invisible" subpopulations such as older women from ethnic communities (Oakley et al. 2003). However, more information is needed on how effective different recruitment strategies are for sub-groups (McLean & Campbell 2003).

Because of the difficulties in recruiting participants from ethnic communities many researchers have used community leaders, spokespersons and/ or ethnic specific service providers for their sample. The advantage of using this type of sample is the relative ease in finding participants in comparison to other community members. However, just because someone speaks a language or works for a community association does not necessarily mean that they represent a culture or are representative of the majority of the views in a community (Temple 2002). As Ragin and colleagues (2008) found, people can more easily identify the community to which they belong but have difficulty in agreeing on a spokesperson for their community, especially if this spokesperson is going to represent them in a community consultation on health issues or answer questions on their behalf. The views of the most marginalised and isolated member of groups are often lost because others are constantly speaking on their behalf. For example, refugees are often spoken of on their behalf by lawyers, case workers, aid workers, and interpreters so that their own views and opinions are often not heard (Dona 2007).

3.4.8 Informed Consent

Gaining informed consent from people to participate in cross cultural research may be better viewed as a process rather than a single act of signing a form (Barata et al. 2006). Ethnic minorities and other marginalised groups have been exploited by researchers in the past so particular care needs to be taken that consent is informed (Barata et al. 2006, Elam & Fenton 2003). Consent forms are often quite complex and require high levels of English literacy to be understood. So even though potential participants may have good spoken English, they may not be able to understand a written consent form. Even if a form is translated, the researcher may find that some potential participants have poor or no literacy in their own language (Barata et al. 2006). Talking to potential participants at community meetings and other groups gives people a chance to learn more about the study, ask questions, and discuss and seek permission with family and others if necessary, before becoming involved (Barata et al. 2006, Ragin et al. 2008). All of this can be seen as part of the consent process.

3.4.9 Using Focus Groups and Interviews

Focus groups and in-depth interviews are popular methods in cross cultural health promotion research and program evaluation (Yelland & Gifford 1995). Although focus groups are seen to be cheaper and faster than other types of research methods, in cross cultural research they can be difficult and time consuming to organise and transcribing and analysing the data can be more difficult because of the interaction between participants (Yelland & Gifford 1995, Culley & Rapport 2007) However, focus groups potentially can provide a greater range of information on the issue being discussed as participants' comment on the contributions made by other participants. This can not happen in an individual interview (Barata et al. 2006, Bolton, Hammoud & Leung 2002). Focus groups can be useful in exploring ways people collectively make sense of their experiences and the meanings that they give these experiences (Culley & Rapport 2007). Focus groups are also useful for generating ideas and discussing issues that participants may not have thought much about before. Focus groups also allow participants to bring up issues that they deem important that the researcher may not have otherwise identified or considered (Culley & Rapport 2007). On a more practical level, focus groups can give opportunities for people to be included in the research that would not necessarily attend an interview

on their own or answer a questionnaire. People may also speak more freely about negative experiences such as racism, waiting lists or poor service (Culley & Rapport 2007).

However, a number of practical issues can impact on the success or otherwise of focus groups in cross cultural research. The size of the group, the English fluency of group members, whether participants know one another, and past experiences of participating in a focus groups can all influence how easy the group is to facilitate, how equally participants contribute and how much information is obtained (Yelland & Gifford 1995). Participants with a better command of English can dominate a group (Yelland & Gifford 1995). If interpreters are being used, the facilitator may have difficulty in facilitating the group, especially if the discussion is quick and lively in that the facilitator can get "left behind" because he/she does not speak the language (Culley & Rapport 2007). Discussing issues, especially sensitive ones, with strangers can be culturally unacceptable. At the same time it can also be difficult to discuss sensitive issues with people who know each other or who are from the same community. People of lower status in the group may be unwilling to voice their opinions deferring to people who are older or of more status (Yelland & Gifford 1995). Participants may also want to appear to agree with the facilitator or seek approval from other group members so may not be forthright with their own views (Yelland & Gifford 1995). Caught up in the discussion, participants can also unintentionally disclose more personal information than intended in a focus group (Culley & Rapport 2007). In addition, often participants from ethnic communities lack health information, so facilitators may find their focus group turning into an information session as participants may be more familiar with this type of activity and also need and want information (Yelland & Gifford 1995). Data from a lively group discussion can also be more complex to analyse often with people lapsing into their own language if the focus group is being conducted in English or not waiting for the interpreter if the focus group is being held in another language (Culley & Rapport 2007). However, formulating strategies for dealing with these issues beforehand and good facilitation skills can overcome most of these difficulties.

Leask, Hawe & Chapman (2001) have looked at whether constructed groups, where participants have not known each other before, generate more information than

conducting focus groups in natural occurring groups (groups that already exist in the community). In general, these researchers found that natural occurring groups tended to talk less, agree with one another more and conform to the more accepted norms and pre-established patterns of leadership within the group. Constructed groups often had more divergent views, were more talkative, and told more stories to the group as the group wasn't already familiar with a participant's life experiences (Leask, Hawe & Chapman 2001). However, as Leask, Hawe & Chapman (2001) point out, there are some pragmatic constraints when doing cross cultural research using focus groups. Researchers may find it difficult to recruit participants that don't know each other given the research criteria and the dynamics of ethnic communities at the time.

3.4.10 Questionnaires

Questionnaires can be particularly useful in cross cultural research if the researcher is aware that certain attitudes, beliefs and/or behaviours may be considered offensive or deviant and are unlikely to be reported truthfully in an interview or focus group. Providing that the participants are literate, a questionnaire that participants can complete anonymously can generate much needed information (Dotinga et al. 2004). However, a number of issues need to be considered when choosing this method of data collection.

Translations

There are significant monetary costs and time considerations related to translating questionnaires for health research. Translations can also be fraught with problems. These include the language being used in a translation being too academic so that the meaning is not clear to the vast majority of its intended audience. Colloquial expressions used in one language may not have an exact equivalency in another language so that a literal word for word translation may not be possible. The translator, in an attempt to convey the significance of a phrase, may unintentionally change the meaning (Culley & Rapport 2007). Different versions of a language may also exist in different countries with often country-specific expressions. Thus, a translation may not be understood by all speakers of a language (Flaskerud & Nyamathi 2000) In a good translation process, a translation is back translated and also may be given to community members for their comments on clarity and meaning for non-health professionals (Small et al. 1999b). However, this often

results in disagreement between translators or between translators and community members on the choice of wording. A process as well as time is needed to resolve these issues.

For the researcher with little or no experience in dealing with the translation process these issues can be both new and overwhelming. There is little published literature on using translations in health research to guide researchers through this process and funding bodies often baulk at the costs of translations (Small et al. 1999b). Despite translating a questionnaire, participants may not have sufficient literacy in their own language to understand it or to complete the questionnaire on their own. Some participants find filling in forms threatening because of past experiences where written information has led to reprisal and persecution. Having interviewers administer the questionnaire verbally may overcome these issues (Dotinga et al. 2004, Barata et al. 2006). Using face to face interviewers may also result in a higher rate of completed questionnaires, especially if the questionnaire is lengthy (Bloch 2007).

3.5 Using Interpreters and Bilingual Workers

Using interpreters and bilingual workers to recruit and gain information from participants either in a semi-structured interview or focus group or by administering a questionnaire has the advantage of recruiting participants into the research that might otherwise not have had access. Participants can also clarify questions resulting in more comprehensive data being collected (Oakley et al. 2003). However, there are a number of considerations in using interpreters and bilingual workers. The first of these is that bilingual/ bicultural workers need to feel comfortable with the topic being discussed. If they are not, workers may skip or skirt around certain questions because they are uncomfortable or embarrassed about the topic (Elam & Fenton 2003, Oakley et al. 2003; Flaskerud & Nyamathi 2000, Yick & Berthold 2005)

3.5.1 Ethnic matching

In order to be effective bilingual/ bicultural interviewers need to be proficient in both English and the community language of interest and have a good understanding of both cultures to form the link between the participants and the research team (Small et al. 1999a). At the simplest level, ethnic matching is this matching of language

between interviewer and participant. Although the interviewer will need to have a good grasp of both language, it may be difficult for an English speaking researcher to know just how well a potential bilingual interviewer speaks a community language. If the potential interviewer has been educated in the community language it usually means literacy in that language as well as the acquisition of more formal vocabulary. If the potential interviewer has just "picked up" the language without any formal education in that language, this can be problematic in health research. When people have not been formally educated in a language they can often lack the health vocabulary required. These bilingual workers can also use less formal language as they have never had to use their language skills in a professional setting (Small et al. 1999a).

The matching of gender and language is often necessary for cultural reasons, for example, when the topic of the interview is considered "women's business" (Dona 2007). At the higher levels of ethnic matching, matching can also include considerations of age, socio-economic status, status within the community and beliefs and views (Elam & Fenton 2003; Pitchforth & van Teijlingen 2005, Culley & Rapport 2007, Flaskerud & Nyamathi 2000). This may become more important when interviewing on particularly sensitive topics where there may be a strong possibility of social desirability bias. Participants may not report or under report attitudes, beliefs and practices that are different to the norms and values of the interviewer for fear of offending the interviewer or other repercussions of discussing stigmatised behaviour (Elam & Fenton 2003, Dotinga et al. 2004). An example would be a young woman under-reporting her alcohol use and omitting information on her resulting sexual activity to an older woman interviewing her as she knows that an older woman from her community would not condone such behaviour. If some degree of ethnic matching is not possible, researchers may need to consider if it is better for the interviewer to be outside of the community even though it may be more difficult to recruit participants (Dotinga et al. 2004).

Ethnic matching is not without problems. Participants may wish to be interviewed in one language or another or interchange between both languages in the interview. People with cultural heritage from two or more cultural or language groups may be difficult to match so a decision needs to be made regarding who interviews them. In

smaller ethnic communities, finding interviewers who are not related to participants can be problematic. Some of these issues can be overcome by offering participants a choice of interviewers e.g. a bilingual worker or a researcher with or without an interpreter (Adamson & Donovan 2002, Elam & Fenton 2003)

Bilingual/ bicultural workers also need to be recruited and trained. Training for workers needs to include basic information about the research and who is carrying it out, dealing with issues of confidentiality as well as practical aspects such as what questions they need to ask and who they contact if there are problems or issues with an interview. The worker's role also needs to be clarified as there can be an expectation by community members that the worker will fix or assist with the problems being discussed. The worker can become a de-facto social worker or community worker if the researcher does not make clear what the worker can and cannot do in their role (Elam & Fenton 2003, Small et al. 1999a, Temple 2005). Rarely will the researcher be able to cover every eventuality in the initial training of bilingual/ bicultural workers. For this reason follow up sessions and/ or opportunities for discussion about issues interviewers may be having can be extremely helpful (Small et al. 1999a). Follow-up sessions or opportunities for individual discussion can also help control bias and other problems that can creep into the interview process. Small numbers of interviews can be done in a block and the results checked with the researcher and any issues discussed before the next block of interviews is undertaken (Bloch 2007). Interviewers can also keep diaries or record their comments and/ or incidents that occurred for later discussions with the researcher (Small et al. 1999a). Depending on the topic of research, interviewers may need support and debriefing particularly if participants are disclosing traumatic material, especially if the worker themselves has had similar experiences (Elam & Fenton 2003, Yick & Berthold 2005). Safety concerns may also need to be addressed, for example, if workers are interviewing in people's homes (Yick & Berthold 2005). Some workers will also need training on their interview techniques so that that the interview doesn't resemble an interrogation (Dotinga et al. 2004).

An important part of the training and subsequent follow-up is recognition by the researcher and bilingual workers that there is often no right way to translate concepts across cultures. Gaining equivalence of meaning across languages is difficult

especially when you are collecting data in one language and reporting it in another (Pitchforth & van Teijlingen 2005, Temple 2005). People's lives and experiences influence the way in which they translate and interpret the questions they ask and the responses they are given. Thus, the bilingual/ bicultural worker or interpreter is not neutral but rather a participant in the research (Temple 2005). Researchers may find it useful to discuss how workers will interpret the meaning of the questions and the answers as part of their training and follow-up sessions. This can offer an insight into possible different perspectives on the research findings (Pitchforth and van Teijlingen 2005). In this way, workers can be more involved in the research process than just collecting the data. They can provide "inside knowledge" that can be useful in explaining issues that might not be apparent to an "outsider". Such inside knowledge complements the outside view that the researcher often has and allows the data to be looked at from several different perspectives. In this way, bilingual/ bicultural workers can compliment the research process and result in research with greater depth.

3.6 Summary

There is not a great deal of health research that looks at the impact of politics and exile, language and literacy, gender and immigration status, so researchers in this area must rely not only on published research but their professional networks, relevant service providers and community organisations and their members to inform the research (Bloch 2007). Although there is Australian research on migrant and refugee women and their issues and concerns regarding tobacco, alcohol, medication and other drug use, this area of research is still largely exploratory. For example, there is no widely accepted standard method to measure ethnicity. Authors have used race (black, white, Asian, etc) country of birth, language spoken at home and other demographic variables or combinations of these variables to describe ethnicity. The lack of commonly used definitions and methods to measure variables such as ethnicity or acculturation reflect that this is a newer area of research and that the research is still largely exploratory rather than the research being poorly conceived and managed. This chapter has examined a number of the methodological difficulties in cross cultural research. The next chapter gives a more detailed description of the methodology, phases of the project and how cross cultural issues were addressed.

Chapter Four

Study Processes and Development of an Appropriate Methodology

4.1 Introduction

To address the methodological issues discussed in the previous chapter, the project was divided into seven phases as outlined in Figure Two.

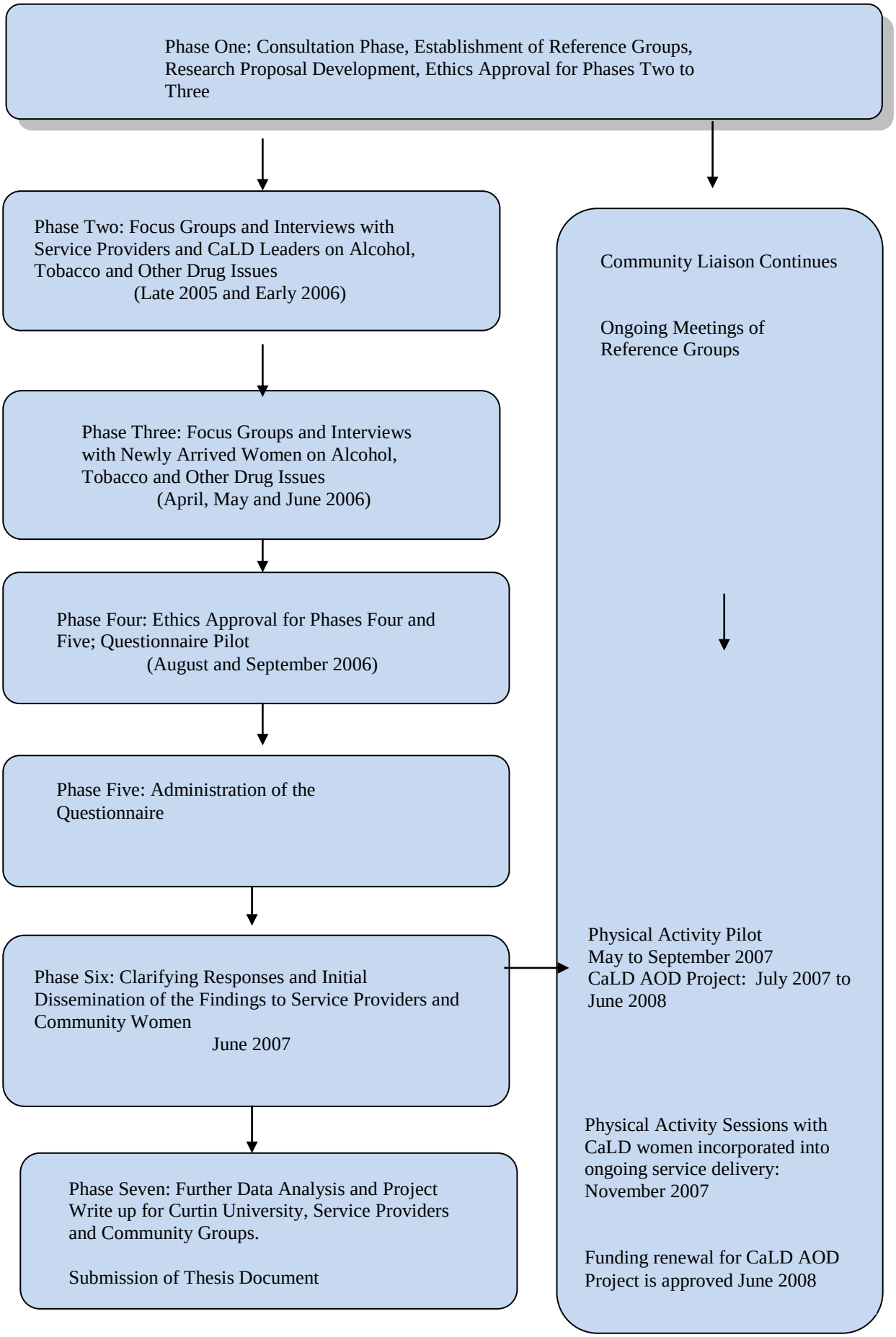
4.1.1 Ethics

The proposed project was discussed with Program Managers at WHS and received approval by the CEO of WHS to be conducted as a joint project between Curtin University of Technology and WHS. The project received ethics approval from the Human Research Ethics Committee at Curtin University of Technology (HR 127/2005). The main ethical issues considered in the project were those of informed consent, voluntary participation and the right to withdraw. As discussed previously, cross cultural issues and limited English language fluency and literacy meant that obtaining informed consent was a process rather than just signing a consent form. Protection of confidentiality and anonymity was also a major consideration. Some of the ethnic communities in Perth are small and even by simply reporting on a women's country of birth, women could potentially be identified. Service providers who work with new arrivals in Perth are also a relatively small group and by identifying the gender and profession of a service provider others could deduce their identity. Thus, it was important that reporting was on aggregated data and that all quotes were suitably de-identified.

4.1.2 Funding

Funding for the project was obtained from several sources. I received an Australian Postgraduate Award from 2006 to January 2008. WHS provided office space and administrative support for the project. WHS also provided meeting space for groups, interviews and childcare during the course of the project. The West Australian Network of Alcohol and Other Drug Agencies (WANADA) paid for interpreters for the project. I applied for and was awarded a grant of $5,600 from the Office of Multicultural Interests to assist with payment for the bilingual workers and expenses related to the feedback sessions on the results of the project with service providers and

Figure Two: Project Structure



community women. The Centre for International Health at Curtin University of Technology also contributed to the expenses related to the quantitative phase of the project.

4.2 Phase One: Community Consultation and Establishment of a Reference Group

In this phase, I engaged community leaders and service providers to talk about the project. This provided an opportunity for questions to be raised and answered, and started the process of informing community leaders and service providers about the study and discussing issues around alcohol and other drugs. This preliminary process was important in facilitating recruitment of potential participants for focus groups and interviews (De Jong, Valenitne, & Kennedy 1998, McDonald & Sayger 1998, Ng, Bartu & Sang 1999, Working Women's Health and Women's Health in the North 2000). The processes involved in this initial stage assisted in establishing the two reference groups that helped oversee the research, developing community ownership and establishing mechanisms so that community women and other interested stakeholders could be continually updated on the project. Although time consuming, I was guided by information from other agencies that have reported that this consultative phase was invaluable when they later come to implement an intervention as the women have been involved in the process from its earliest stages (Working Women's Health and Women's Health in the North 2000). The project used a "community wide" approach, which emphasised that AOD concerns impact on the whole community and that everyone in the community needs to be informed, not just those who have a particular problem. This approach has been successfully used in the past as a strategy to talk about AOD issues with members of ethnic communities in Australia (Reid, Crofts & Beyer 2001). Considerable effort on the literature review occurred during this first phase of the project. Like the community liaison and work with the reference groups, the gathering of relevant literature continued throughout the rest of the project.

4.2.1 Consumer Participation

As previously mentioned, two reference groups were established for this project. The first was a Professional Reference Group of service providers and proved to be helpful in identifying possible avenues for funding the project. The Professional

Reference Group was also essential for support of the project within the organisations they represented. The best example of this was the provision of interpreters through-out the project through the Interpreter Access Project at the West Australian Network of Alcohol and Other Drug Agencies (WANADA). The extended networks of the Professional Reference Group also helped with mapping the current project with other projects and services happening both in Western Australia and in Australia, enabling the development of synergistic links with these other projects and services.

The Consumer Reference Group was made up of women from culturally and linguistically diverse backgrounds that had an interest in alcohol and/ or drug issues. This group required more time and effort to establish and this next section looks at some of the considerations in forming this group.

The adoption of Primary Health Care policies in the 1970s promoted consumer participation in health (Stone 1992, Walt & Rifkin 1990, Zakus & Lysack 1998) The word "consumer" is generally used to describe anyone who is accessing or has accessed a particular health service or program or any one who may use a particular health service or program in the future (Health Outcomes International 2005). Consumer participation can happen either through individuals, or collectively such as by a group of interested consumers or a community as a whole. Consumer participation is often cited as the key to success for primary health care programs as it is the mechanism by which consumers can become involved in the decision making process around health care priorities and resource allocation (Walt & Rifkin 1990). Ideally consumers assess their own health needs and problems, plan and implement solutions to these needs and problems, create and maintain organisations or processes to support these efforts, evaluate their efforts and bring about any necessary changes to achieve their goals on an ongoing basis (Stone 1992, Zakus & Lysack 1998).

However, the reality of consumer participation varies greatly. The ideal of consumers being involved in all aspects of health services and programs including planning, implementation, and evaluation is relatively rare (Stone 1992). The types and ways that consumers participate in health services and programs varies enormously, from

tokenistic passive involvement where an organisation makes plans and announces them, to "community control" where consumers have full control of the health organisation (for example, WHS at its inception as an unfunded feminist health collective) or a community being involved in all the key decisions in identifying issues, goals and means of achieving goals (Zakus & Lysack 1998, Dawson2004.).

There is a strong ideological view, especially in Western democracies, that those affected by decisions should have some input into the making of those decisions (Brownlea 1987). The concepts behind consumer participation are consistent with the principles of equality and self-determination (Brownlea 1987, Stone 1992, Cordwell 2005). This ideological view holds that consumer input should not be tokenistic, for example being informed about decisions that have already been made (Brownlea 1987). Supporters of consumer participation cite not only this ideological standpoint but practical evidence in support of consumers being involved in health projects and services. Projects from around the world have shown that when local people are involved in health projects and services - other things being equal - that there is a greater likelihood of success (Stone 1992). As the level of involvement increases, benefits to individuals and communities involved in the participatory processes also increase. These benefits include reaching more participants as new values and perceptions are incorporated from consumers into the design and evaluation of a project or service. This subsequently expands access, strengthens responsiveness to needs and produces more appropriate programs and policies (Smith 1998). Other benefits include opportunities to learn more about health and the health system, more equitable relationships between clients and health service providers, greater diffusion of health knowledge in the community, greater use of local expertise, a sense of contribution, a feeling of some power or place in the system, and in some cases better future employment prospects for individuals (Zakus & Lysack 1998, Brownlea 1987, Smith 1998). Governments, organisations and funding bodies also see consumer participation as a cost-effective way to increase limited monetary and human resources (Zakus & Lysack 1998).

As part of this research project, it was considered essential to establish some form of consumer participation to assist with issues of cultural sensitivity, advice around recruitment and to ensure shared communication between the researchers and

relevant community members. Community partnerships can be created at any phase of research process but are most helpful with groups are involved from the conceptual phases it design through implementation, analysis and dissemination (Elam & Fenton 2003). Community involvement allows the researcher to become familiar with the groups involved which increases cultural understanding, assists with recruitment, helps increase the validity of any data collection instruments as well as the findings, and can form the basis for the continuation of any activities initiated by the project after the conclusion of the research (Sterk 1999). Having ongoing community participation can be particularly useful if there is doubt over the meaning of findings. Consulting with community members who are familiar with the research project can help explain unexpected or contradictory findings so that problems are not distorted or overly pathologised (Yick & Berthold 2005, Gibbs et al. 2007). However, the greater the community involvement and the more participatory the research the more time intensive the project becomes.

Many guidelines now exist for increasing consumer involvement in research and community-based health service delivery. Often these guidelines are established around a single issue or to empower a single, identified marginalised group. There is a surprising dearth of published advice or material on creating a reference group for a more heterogeneous disadvantaged group that includes individuals from different cultural, language and educational backgrounds. This has been reported by other researchers and practitioners especially around consumer participation in relation to AOD issues and mental health issues and/or by migrant and refugee consumers (Health Outcomes International 2005). This lack of information is surprising as, like WHS, many organisations are not focussed on a single ethnic group but rather work with a number of language and cultural groups. There appears to be a need for more information and research on how to promote and incorporate consumer participation of culturally heterogeneous client groups in health programs and services as well as research.

4.2.2 The Consumer Reference Group

Effective consumer participation can use a variety of methods to facilitate participation (Consumer Focus Collaboration 2001). Although WHS often uses relatively passive forms of consumer participation such as consumer satisfaction

surveys, the lack of ethnic women attending alcohol and other drug services at WHS suggested that a more dynamic form of consumer participation might be more helpful in understanding and reducing the barriers to service access. A good way to ensure that participation is more meaningful is to give consumers greater access to the decision making processes in the planning, implementing and evaluation of service delivery. Other projects involving consumer participation with ethnic communities have found a reference group useful as a forum for discussion, debate, decision making and action (Karantzas-Savva & Kirwan 2004). An active reference group that met regularly with staff facilitators was the type of participation model WHS staff thought would best overcome some of the barriers that other types of participation models face such as the logistics of finding and organising consumers and staff to attend one off consultations (Nathan 2004, Stone 1992)

4.2.3 Practical Considerations

Given the multicultural nature of Australian society today and the prevalence of drug and alcohol problems, the lack of broad reference groups with culturally and linguistically diverse (CaLD) consumers to inform delivery of alcohol and other drug services is surprising. Although consumer reference groups and consultative processes with ethnic communities are an established component in the mental health area (Sozomenou et al. 2000), their use is still in its infancy in the alcohol and drug sector, especially in Western Australia. However, the various models used by the mental health sector offered a starting point in setting up an alcohol and other drug consumer reference group. Yet, despite using learnings and models from the mental health sector as a starting point, WHS encountered many practical and philosophical considerations in establishing the consumer reference group, These included: agreeing upon what the purpose of the group would be; how it would operate within the internal structure of the organisation; the level of English language necessary for the group to function; if there would by any payment or reimbursement of expenses; and ensuring an appropriate and workable demographic mix in terms of age, language, and migration experiences.

4.2.4 Defining the Purpose

The level an agency is ready or prepared for consumer participation has been cited as one of the most important factors in successful consumer participation in health (Dawson 2004). This readiness includes management and staff commitment, having processes and structures that facilitate consumer participation, and clear aims and objectives for consumer participation (Dawson 2004). For this reason, discussions upon the purpose of the Reference Group, how it would relate to the research project and to WHS service delivery overall, and how it would function within the existing organisational structure of WHS were an important first step in the process of establishing a Reference Group. Discussions with the program managers and the Chief Executive Officer (CEO) of WHS ensured that, when established, the proposed group would be incorporated within the structure of the organisation and its decision-making processes. The group would not be a tokenistic gesture operating outside of the health service's planning, implementation, resource allocation and evaluation systems.

The purpose of the group was described in terms of assisting Womens Health Services to:

- Plan education and prevention programs for migrant and refugee women and their families around smoking, alcohol, medication and drug issues;
- Review WHS' alcohol and other drug services for culturally and linguistically diverse (CaLD) women; and,
- Develop better smoking, alcohol, medication and other drug information for migrant and refugee women and their families

Having some general statements about the purpose of the group helped with the initial advertising and recruitment of women to participate in the group. The description of the group was intentionally left broad to allow participants to determine a more exact direction, a strategy reported as useful in other projects involving community participation with other ethnic communities (Karantzas-Savva & Kirwan 2004). Indeed, the description of the purpose of the group was revised by the group members during the first year of operation to give group members greater clarity as to the purpose of the group using words and terms they were familiar with. This statement of purpose can be found in Appendix One.

4.2.5 Consumers as Representatives

Through the internal discussion, WHS staff decided that women would be invited to participate based upon their capability and interest rather than as an appointed representative of an association or an ethnic group. The word "representative" implies that there is a constituency that the consumer is accountable to, reports back to, and liaises with (National Resource Centre for Consumer Participation in Health, 2004). WHS was not so much interested in a consumer representative, but rather in gaining a consumer perspective in planning, implementing and evaluating services and programs. Given that WHS works with women of over 60 different nationalities, it would be difficult to choose or manage "representatives". As Zakus and Lysack (1998) have noted, communities are heterogeneous not only demographically but in terms of people's interests and concerns. This can create real problems for selecting representation and accountability of individuals: who is a legitimate representative? It is also difficult for one person to represent a community that, although having a common first language, is diverse in other respects such as of age, gender, migration experiences, length of residency in Australia and interest in the issues needing to be addressed. Moreover, any one ethnic or language based group may have several community associations to which people belong and at the same time many people of the same ethnicity or language group that do not participate in any community association. WHS staff felt that they could formally liaise with ethnic organisations if a specific issue arose. Women in the Reference Group were encouraged to ask other women in their community, work or places of study or women they know their opinions on issues raised in the group, but women are not representatives of any association or group.

Potential pitfalls for consumer reference groups have been outlined by Zakus and Lysack (1998) who reported that consumers participating in health planning may be criticised for appearing to be too closely allied with health service providers. It was recognised that working with AOD service providers could be highly problematic for Reference Group members as drug use in many ethnic communities is often highly stigmatised. Reference Group members could be criticised by members of their communities for talking about drug use issues and their experiences in their community, for "inventing problems" and aligning themselves with "interfering

service providers" instead of leaving drug use issues to families to deal with as a private matter. Because drug use especially by women is so highly stigmatised within many ethnic communities, Reference Group members by merely having an interest in the area and working with AOD service providers could be shunned by other community members. Being part of an AOD reference group, other community members could assume a woman member to have a current AOD problem, to have an unsavoury lifestyle or have been morally corrupted in some way. Fortunately, to date none of these concerns have been borne out.

4.2.6 Interpreters and Translations

Because of the cost of employing interpreters and potential difficulties with requiring multiple translations, it was decided that all meetings would be held in English and that the minutes would be distributed in English. Because the meetings were to be held in English, women interested in joining the Reference Group needed to have reasonable English language listening, speaking and literacy skills but not necessarily be fluent in English. Having a good command of English was also important so that participants could communicate their ideas and opinions to staff and other service providers and that staff could communicate information about the agency and its programs to women in the group. As Brownlea (1987) commented, participants need to be able to communicate insights and concerns to others so that others can understand what the issues and options are and where the constraints lie.

This decision to require English as a common language within the group obviously precluded some women. However, not using interpreters meant the group was financially viable and more sustainable for a not–for-profit organisation over the long term, increasing the likelihood that the Reference Group would become an enduring part of the organisation.

4.2.7 Resourcing the Reference Group

In many circumstances, the only people who are able to participate are those with the time, money and other resources to participate (Brownlea 1987, Zakus & Lysack 1998). Without taking potential participants' resources into account, only relatively privileged segments of society can contribute, which often effectively excludes people from lower incomes, often the same individuals who most require public

health services and programs (Zakus & Lysack 1998). Disadvantage is best seen as a continuum and not a dichotomy (Nathan 2004) with some women experiencing more disadvantage than others. The plan to recruit volunteers for the Reference Group through women who accessed WHS programs required that WHS staff recognise the disadvantage that many potential participants would have to deal with, including low income, lack of transport, unemployment or underemployment, having English as a second language, and difficulties given responsibilities for care of children and others. Women would need to juggle to fit the Reference Group around work, study and/ or family responsibilities.

One of the keys to successful involvement is that participants should experience few out-of-pocket costs in order to participate as even small costs may be excessive for those on low incomes (Sozomenou et al. 2000). As much as possible in planning for the Reference Group, factors that could be barriers for women participating in the group were addressed. Strategies included planning flexible meeting times, offering child care, providing healthy snacks at meetings for women coming straight from English classes or work and offering transport if a meeting was held elsewhere from WHS, which is well serviced by public transport.

Two WHS staff members acted as liaison and contact people for the Reference Group. This meant if one staff person was sick or away, meetings could still be held. These staff were allowed time within their schedules to prepare for and attend the Reference Group meetings but also were allocated time to be 'available', to listen to personal problems and issues that arose as barriers for women participating in the group, regardless of whether the issues could be resolved. The experience of other consumer participation projects with CaLD consumers is that the facilitator(s) can become seen less like a worker and more like a colleague or friend (Sozomenou et al. 2000). In the mental health field, the allocation of a facilitator(s) has been seen to demonstrate the service or agency's commitment to involving consumers and/ or carers in the planning, delivery and evaluation of the service (Sozomenou et al. 2000)

4.2.8 Staff Roles in the Reference Group

Being involved in the Reference Group meant that staff would need to take on primarily a facilitation role by providing necessary information, resources and administrative support for the group. This required staff to step away from the traditional health professional role of defining needs and solutions to a less traditional role of assisting community women in developing a belief in themselves, that their viewpoints and contributions were worthwhile, and that their contributions could influence health issues, programs and services (Browne & Courtney 2006, Llewellyn-Jones 2001). Staff hoped that women participating in the group would gain and develop from the experience as a result of their participation. Staff realised that they may need to also change their viewpoints and practices as a result of being involved with the Reference Group. Effective consumer participation requires that both consumers and health service providers accept that the others' contributions and viewpoints are equally valuable (Browne & Courtney 2006). Other successful consumer participation projects in the mental health field have found that changes occur both in consumers and staff (Browne & Courtney 2006). Thus, service providers need to be open to the possibility of reflecting on and changing their own opinions and practices. This is true for staff directly involved with the Reference Group as well as other staff at a health service.

4.2.9 Philosophical Considerations

A number of philosophical concerns were considered by WHS staff around the establishment of the Reference Group, particularly that a consumer reference group should not be seen as the only way ethnic women could become involved in influencing health service planning, delivery, and evaluation at WHS. Staff were also aware that concepts of consumer participation are primarily 'Western', based on notions of self-reliance, equality, and individualism as well as a Western biomedical model of health (Bevan 1997). These values and understandings are not universally shared by women from different cultural backgrounds, and asking women to participate in the Reference Group could be regarded as yet another example of Western ethnocentrism (Stone 1992). Not all cultures desire participatory approaches to health decision making (Brownlea 1987), nor do all groups place a high value on participating in health services. Groups that have been accustomed to not being consulted or have been consulted in only a tokenistic way may have little interest in

being involved (Zakus & Lysack 1998). Community participation also does not take place in a vacuum. Community participation and the form it takes depends upon many factors: the way the health care system is organised, the political economy of the county and the place that health care has within that political economic system, the skills and knowledge of local people in social organisation and health-related issues, the level to which health is a priority issue, and community opinion about collective responsibility for health issues ((Borwnlea, 1987, Zakus & Lysack 1998, Bevan 1997). Cultural factors also influence the ways individuals and communities participate in health services and programs (Stone 1992). Thus, for some women the idea of participating in a formal reference group may be too different to their notion of how clients and service providers should interact based upon their experience of the health system and consumer participation in their own countries. By establishing a consumer reference group there was also a concern that WHS might exclude more collectivist cultural viewpoints from being represented. WHS staff also recognised that women in the midst of a personal crisis needed other, less structured ways to participate. For these reasons, the establishment of the Reference Group was seen as an additional way women might participate in improving service delivery at WHS and not the only way they could have influence. As Zakus and Lysack (1998) comment, community participation comes in a variety of different forms. If only some ways of participating are considered valid and valuable, there will be problems. Experience from other projects with ethnic communities (Karantzas-Savva & Kirwan 2004) shows that consultation and participating needs to occur in a variety of ways even for the "same" community, as there is a great deal of diversity within any given community.

The Reference Group continued through out the project and still remains active. This group is one of a small number of consumer reference groups in Australia looking at AOD issues amongst migrant and refugee women.

4.3 Phase Two: Views of Service Providers on Alcohol, Tobacco and Other Drug Issues

In the second phase, formal data collection occurred through focus groups and in-depth interviews which were conducted with service providers from government and non-government agencies who worked with newly arrived women. (Appendix Two outlines these focus group and interview questions.)

4.3.1 Recruitment

Service providers interviewed were from general health, mental health and social services. Service providers were recruited from my professional networks and by snowball sampling. A typical focus group consisted of one or two people known to me, and the colleagues of this service provider who had been invited to join the discussion. In some focus groups, I knew all of the service providers in attendance. I had previously met or worked with all service providers who were individually interviewed. All focus groups and in-depth interviews were held in the Perth metropolitan area, and utilising both individuals and group interviews enabled flexibility to accommodate the busy schedules of service providers. For this phase of the research, recruitment was not difficult with more service providers willing to be interviewed or attend focus groups than was necessary to interview. Therefore, service providers were selected so they came from many different fields of work and engaged with newly arrived women in a variety of ways. Many of the service providers interviewed were community leaders and were able to provide multiple perspectives, as a service provider, as a community member and as a leader.

4.3.2 Consent

Potential participants were given both verbal and written information about the project. Service providers were interested in attending a focus group or interview, a mutually convenient meeting time was arranged. Prior to the beginning of the interview or focus group the purpose of the project was explained again and consent forms signed.

In total, twenty-two service providers working with migrant and humanitarian entrant women participated in either one of 5 focus groups or in one of 4 interviews

(repetitious responses were occurring after this point). The focus groups and interviews were held in late 2005 and early 2006. Focus groups and interviews sought information on what service providers considered the alcohol and other drug issues facing newly arrived women. This included the use of tobacco and prescription medications, how any issues should be addressed, experiences of referring to alcohol and other drug agencies, and any other health issues identified in working with newly arrived women

Focus groups and interviews were recorded and transcribed so that issues and themes could be identified using the transcripts. Initially, two recordings were given to an experienced transcribing service for transcription. However the professional transcriptions proved problematic as the service's completion time was slow, costly and large gaps of dialogue were missing as many of the service providers spoke English with heavy accents. However, due to my familiarity with working with people who have English as a second language and my experience with the content as I had conducted the interviews and focus groups, I was able to transcribe the vast majority of dialogue that the transcribing service was unable to capture. After the initial recordings, I completed all other transcriptions. This was time consuming but resulted in more complete transcriptions.

It is common practice for subjects who agree to participate in research to be asked to further consent to being tape recorded in qualitative research. Notes were taken for one interview and one focus group where the participant service providers were reluctant to be recorded during the interview. In these instances where participants were reluctant to be recorded, the interviews were written up soon afterwards, usually within the hour following the interview. Not to have included these participants would have resulted in the loss of some unique perspectives and information that was later confirmed by participants in subsequent interviews and focus groups. The dilemma of whether or not to drop participants from the study because they do not want to be taped is a good example of some of the methodological difficulties in cross cultural research as discussed in Chapter Three.

Transcribed interviews were initially coded into categories. As I was both interviewing and transcribing, I was able to consider some information that was not

captured in words, such as the tone and body language of the participants and their mood which was captured in field notes made after the interviews. Although such information is subjective, reflective practice helped me improve subsequent data collection by incorporating better approaches as to how questions were asked, responses were clarified and the overall pace of the interviews. This reflective approach based upon observations may have been difficult to capture if the interviews, transcription and data analysis had been done by different people (Green et al. 2007). While it was initially proposed to use Nudist software, instead a manual system of colour coding and physically cutting and pasting sections onto butcher's paper was used to draw up categories and identify emerging themes. It is recognised that coding can be done in a variety of ways from using software to writing notes in the margins to using coloured markers (Green et al 2007, Greenhalgh & Taylor 1997). Using one coder avoids the difficulty of inter-coder variability and to ensure coding reliability, the categories used in the coding were discussed with work colleagues, academic supervisors at Curtin University and validated through feedback with both the professional and the consumer reference groups. Though-out the interviews and focus groups, particular attention was made to clarifying the meaning of what participants said which also improved the reliability of the coding process. As the major categories were identified in the transcripts, subsequent focus groups and interviews were used to explore and clarify these ideas (Phan & Fitzgerald 1996). The focus groups and interviews continued until they were producing repetitious information. A range of categories and issues identified in coding led to the identification of key themes. Themes give explanations to a range of categories or issues identified in the data (Green et al. 2007). These categories and themes were then further explored in subsequent focus groups and interviews with community women.

4.4 Phase Three: Views of Newly Arrived Women on Alcohol, Tobacco and Other Drug Issues

Although this project started with seeking the views of service providers, it was important to hear about women's own issues and concerns in their own words. For this reason the project sought information from a wide range of newly arrived women, not just community leaders. Seeking these views started with focus and

interviews with newly arrived women. (Appendix Three outlines these focus group and interview Questions.)

4.4.1 Recruitment

Participants for Phase Three of the project were recruited through my networks and snowball sampling. The snowball sample was purposive in that there were multiple starting points. Snowball sampling with multiple entry points helps ensure participants have a range of opinions and experiences and limit the bias inherent in snowball sampling (Jacobsen and Landau, 2003). These starting points included WHS programs, other service providers who provided access to women's groups and through the networks of the bilingual workers and students.

A number of recruitment methods were tried without particular success. These included flyers, advertising for participants on ethnic radio, and a mass mail out to all ethnic community organisations known to the Office of Multicultural Interests with information about the study and a request for participants. The two most successful recruitment methods were those where project workers could meet with women informally to discuss the study prior to their participation and recruiting women through the networks of bilingual students and workers. Using personal contacts and recruiting through friends, other community members, and trusted service providers enhanced recruitment of this otherwise difficult to reach group.

Special efforts were made to involve women who were likely to be more comfortable giving information orally versus responding to written surveys or questionnaires due to poor English language skills, cultural norms, and/or distrust of written forms. Attempts to access less visible groups of women such as sex workers and women involved in the criminal justice system were unsuccessful. However, women from other more marginalised groups were recruited. These women included women who had experienced domestic violence, fiancé or spousal visa holders and students who had come to Australia for tertiary study and then applied for residency.

Participants were reimbursed $20 for their time and travel expenses. Monetary compensation helped encourage participation, however given the modest nature of

the reimbursement it was unlikely to have unduly influenced someone to act against their inclination not to be involved.

The sample for the project was defined as women 18 years or older who were permanent residents of Australia or in the process of obtaining residency and had been in Australia 5 years or less. One of the reasons this project focussed on women that had been in Australia five years or less was that although there would be differences in acculturation amongst the women, all women would be relatively early on in the process. Residency was made a requirement to exclude tourists, women on working holidays, and overseas students who often have very different health concerns and health service access issues than permanent residents. However, the issues and concerns of women who were in process of obtaining residency such as those who had come to Australia on a fiancé or spousal visa needed to be included. These women could take a number of years to complete their residency requirements but during this period lived and worked in the West Australian community. These women often had a number of health concerns on arrival but received little information on how to access services. In addition, a number of these women were accessing the Multicultural Women's Advocacy Service at WHS, a CaLD specific domestic violence service.

One of the considerations in formulating this project was that the research project and the methods used were fair and equitable and seen to be so. Having one group of new arrivals appearing to receive more attention, information, and/or services can be seen as "playing favourites" and can have serious negative implications for the viability of the research as well as damaging a worker's and an organisation's credibility within the community (Whiteside-Mansell, Crone & Conners 1999). This was one of the reasons that the project did not focus on a specific ethnic group but looked at newly arrived women overall. In addition, although having an ethnically homogenous sample would have been easier for data collection and analysis, an ethnically homogenous sample may not have given the most accurate picture of the issues. The sample needed to reflect the women in the WHS catchment area and not just women who were accessing WHS. This meant the sample needed to have newly arrived women from different countries, different migration categories and with different life experiences. Having a sample of participants that reflected the

population of newly arrived women accessing or potentially accessing WHS programs would make the findings of the research more meaningful (Oakley et al. 2003).

From the outset of the project I realised that potential participants were likely to be resource poor in terms of lacking private transport and having difficulties with childcare. Potential participants were likely to have busy lives in terms of caring for children, work, English classes, further studies, medical appointments, required welfare and job program interviews as well as other appointments. The priority of potential participants was more likely to be day-to-day existence rather than participating in research (Flaskerud & Nyamathi 2000, Krauss et al. 1997). Practical issues such as catching public transport with young children when the weather was too hot, too cold or too wet would influence women's likelihood of participating in the research project (Yelland & Gifford 1995). Religious celebrations and school holidays are known to be busy family times and interviews were not held during these periods (Yelland & Gifford 1995).

Newly arrived women who are often unfamiliar with Australian systems, resource poor, and who may have limited social networks, require information. Participating in a research project can be seen as a way of gaining as well as giving information. Providing information is a relatively simple way of reciprocating women for their participation (Culley & Rapport 2007). This can be done by providing fact sheet, contact details of services and/ or running health information workshops for participants (Culley & Rapport 2007). Information on how to access services and aspects of using the WA health system was given to participants who requested this after interviews and focus groups, either individually or as a group. Yick and Berthold (2005) have also recommended researchers prepare in advance referral pathways that participants can use if needed - not just a list of agencies to be given out but information on specific people to contact who have been approached by the researcher to facilitate faster and more appropriate referrals. This was done at WHS where participants in the study were considered "internal referrals" so that they did not necessarily have to wait six to eight weeks to access the clinical or counselling services. Other referrals were made to specific workers at agencies or in the case of women wanting to access a GP, the names of three women GPs that were considered

the most appropriate for the woman were given to her. Appropriateness was determined in consultation with the participant and this was often in terms of language spoken or location.

4.4.2 Consent Process

Once potential participants were identified, the purpose of the research was explained. The project was described as a needs assessment that would help WHS improve its health services and programs with newly-arrived women. The project followed a strategy similar to that of Dotinga and colleagues (2004) in describing alcohol and other drugs as health issues. Many women from CaLD backgrounds refer to "drugs" as only illicit drugs and consider issues related to tobacco, alcohol, and medication use as health or social issues. Once potential participants agreed to be interviewed or attend a focus group an informed consent form was given to participants prior to focus groups and interviews. If necessary, the plain language information was read out loud in English or by an interpreter for those that had difficulty reading English. The information sheet outlined the nature of the study, what the information collected would be used for, what sorts of questions would be asked, the de-identification of data, how confidentiality issues would be managed, and the risks and benefits of participating in the study. Potential participants had the opportunity to ask both general and specific questions about the research, to meet with me and to think about whether or not they would like to participate in the study prior to consenting to participate. Those opportunities limited the possibility of individuals feeling coerced or pressured to participate. Once potential participants indicated preparedness to be interviewed or attend a focus group, a suitable meeting time was arranged. Prior to the interview or focus group commencing, issues around the research were outlined again including how to contact the project officer in the future and how to withdraw from the study. The consent form was signed at this time. The signed consent form was retained at Women's Health Services in the client record system and participants were given written information about the project, my contact details and my supervisor's contact details at Curtin University to take with them.

The views and experiences of twenty-six women from a variety of cultural and linguistic backgrounds were gathered through six interviews and five focus groups in

April, May and June 2006. The use of both focus groups and in-depth interviews provided flexibility to accommodate women's schedules. The use of both focus groups and in-depth interviews also provided flexibility in the study design as it was unknown whether women would openly discuss issues that could be considered shameful, private or stigmatising in a group. Some literature had suggested that this could be the case with this area of research (Elam & Fenton 2003, Dotinga et al 2004) and having a more flexible study design would be helpful. Child care was made available to participants for interviews if required. All participants were 18 years of age to avoid issues around the participation of minors. Participants were either Australian citizens, permanent Australian residents or in the process of being granted permanent residency and had lived five years or less in Australia. All groups and interviews took place in the Perth metropolitan area. Participants were given the choice of participating in the focus groups and interviews in English or through an interpreter. Accredited interpreters from TIS were used in focus groups and interviews when participants requested an interpreter. Further details about the interviews and focus groups and use of interpreters are provided in Table 4.1 below. This table makes mention of natural occurring groups which were groups of women that met for other purposes, for example sewing or English classes. Constructed groups refer to groups that only came together for the purposes of the project. Constructed groups often yielded more information but participants often knew one another. Although Perth is a capital city of over one million people, its geographical isolation means that in small minority groups people often know each other.

During the focus groups and interviews information was sought on the women's use of and opinions on smoking, alcohol, over-the-counter medicines and prescription drugs, illicit drugs, and the impact of other people's drug use on women e.g. verbal or physical abuse by someone affected by alcohol. Women's views also were sought on what the alcohol and other drug issues women faced as new arrivals, how these issues should be addressed, what health information women needed and what other activities or services women would like.

Table 4.1: Community Focus Groups

Focus Group or Interview*	Agreed to be recorded	Women were from	Language of Focus group or Interview
Focus Group Natural Occurring	Yes	Iraq	Arabic with Interpreter
Focus Group: Natural Occurring	Yes	India Nigeria	English
Focus Group Constructed	Yes	Macedonia Liberia Sudan Congo Myanmar (Burma)	English
Focus group Constructed	Yes	Russia Ukraine Kazakhstan Thailand Afghanistan	English
Focus Group: Natural Occurring	Yes	Indonesia Iran Thailand China	English
Interview	Yes	Indonesia	Indonesian with Interpreter
Interview	Yes	Congo	English and French No Interpreter (Both the participant and the interviewer spoke English and French)
Interview	No	Burundi	English
Interview	Yes	Sudan	Arabic with Interpreter
Interview	Yes	Macedonia	English
Interview	Yes	Sudan	Arabic with Interpreter

During this phase of the project, index cards with pictures were used to elicit from participants the types of services and information that newly arrived women would like. This was based upon previous personal experience working with ethnic women that ink pen drawings were strongly preferred over photographs of people. Visual aids such as drawings have a history of effective use in developing countries for education around health, agricultural, and social issues. (Rohr-Rouendaal 1997). Visual aids are especially effective with people with poor literacy and language skills and can be used as starting point for discussing what people want and need (Rohr-Rouendaal 1997). The cards had a drawing of the health topic with the English name underneath and proved to be effective in communicating ideas with women from a wide variety of cultural and socio-economic backgrounds. However, sourcing drawings of ethnic women specific to alcohol and other drug issues was difficult and time consuming.

Women were asked to pick from approximately forty health-related cards the issues with the most important activities and information for them. The topics on the cards were chosen using the information gained from the interviews and focus groups with service providers. Other topics were included based on the settlement literature on identified health issues of new arrivals, personal work experience and topics that reoccurred in the community consultation phase of the research. Women were also given the opportunity to suggest other topics. These suggestions were written on an index card and put on to the table or board that was being used to sort the topics.

The group or the woman being interviewed was asked to put the cards into three piles: most important, important, and less important. This was described as "voting" for the issues that were the most important to the women. The idea of voting for an issue or activity was easily understood by all the women participating despite the wide variety of cultural and socio-economic backgrounds from which the women came. Women were then asked to choose the five most important topics from the cards in the "most important" pile. In the process of choosing the top five issues and activities the women would create new categories by combining topics together. For example, family planning, sexually transmissible infections and information on pap smears and breast checks were often combined into one topic of women's health. Often women were more forthcoming with information during the process of

choosing and ranking health topics and activities than they had been with responding to my previous questions. The women seemed to enjoy this activity and it elicited a great deal of information from participants which is why it was used again during the quantitative phase of the project.

As with the service providers, all interviews with newly arrived women were recorded and transcribed so that issues and themes could be identified using the transcripts. Transcribing also served to identify questions or concepts that were often misunderstood or difficult for women. Reviewing the original recording of how questions were asked identified that participants some times had problems in understanding particular questions that was related to the manner in which the questions was asked rather than English comprehension. This occurred if a question was asked too quickly or quietly, or if there was background noise, or if it had not been made clear that the question was on a different topic than the previous question. Re-listening to the tapes of the focus groups and interviews was instructive and it helped improve processes in subsequent interviews. As with the interviews with service providers, there were some women who were reluctant to be recorded. In these two instances, important information was taken as notes during the focus group or interview and then written up immediately after the interview.

The research process of interviews, transcription, colour coding the transcripts and physically cutting and pasting sections onto butcher's paper ensured a great deal of familiarity with the data which helped when it came to identifying emerging themes. The formation of the categories started shortly after the first interviews and emerging issues were explored in more detail in subsequent interviews and focus groups. As with the interviews with service providers, a similar process was used to ensure the reliability of the coding, given that I was the only one doing the coding. The categories used in the coding were discussed with work colleagues, my supervisors at Curtin University and validated through feedback with both the professional and the consumer reference groups. Though out the interviews and focus groups particular attention was again made to clarifying the meaning of what participants said which also improved the reliability of the coding process.Focus group sessions and interviews continued until little new information was emerging.

4.5 Phase Four: Development and Piloting of the Questionnaire

Information gathered from the focus groups and interviews with service providers and newly arrived women helped inform the design and content of a questionnaire. The questionnaire was designed to clarify the extent to which the issues, attitudes and perceptions explored during the interviews and focus groups were applicable to a broader cross section of newly arrived women. The qualitative information gained in the previous phases ensured the questionnaire was constructed to be sensitive to the meanings and interpretations that respondents might place on questions. This helped to avoid responses that might have otherwise been ambiguous or misunderstood (Stewart et al. 2008)

The questionnaire used a mixture of open and closed questions. Many of the questions were taken or modified from questionnaires used elsewhere in Australia such as the National Drug Strategy Household Survey (2005) and the WA Health and Wellbeing Surveillance System survey (2006) so that relevant Australian population ranges and distributions would be available for comparison. The questionnaire also included questions exploring specific issues identified from the focus groups and interviews. As the research project was exploring AOD concerns and issues as well as the content and preferred way of delivering health promotion interventions, there were a number of closed ended questions. Closed ended questions force participants to choose from a set of limited responses and can be used to set priorities or clarify information (Polgar & Thomas 1995). In the questionnaire, closed ended questions were used to determine the perceived priority of issues and preferences for how information should be conveyed. Open questions enabled women to give shorter answers or more detailed explanations, and were manually coded for recurring issues and themes.

As gathering information on alcohol and other drug issues was likely to be sensitive, the questionnaire started with less threatening topics such as demographic information. More sensitive questions on drug use were placed towards the end of the questionnaire. Careful thought was also given as to what personal data needed to be collected from participants so that the questionnaire was not too intrusive and did not bring up unrelated issues. For example, women were asked how many children

lived with them in their house or apartment and not how many children they had. Many humanitarian entrant women have children who have died in conflicts or remain in refugee camps. Details concerning how these children came to be missing or how they died were not needed for the purposes of the project.

4.5.1 The Pilot

As part of the development process of the questionnaire, community leaders and service providers were asked to comment on the wording and content of the questionnaire. This occurred during August and September 2006. Piloting of the questionnaire with community women from several CaLD communities occurred following this.

4.5.2 Views of Service Providers

The steering committee of professionals with relevant expertise reviewed the questionnaire. Community development workers and students at WHS also provided input on the wording and content of the questionnaire. Although many of the questions were from or based upon national or state surveys such as the National Drug Strategy Household Survey, both women and service providers reported that the wording of the questions was awkward and the words used difficult to understand. Many of the questions were reworded and simplified as a result. Service providers suggested to ask a woman's age, not the year they were born in, as some women did not know the year of their birth but had a rough idea of their age. They also encouraged retaining in the survey the more sensitive questions on whether respondents had ever been verbally abused, physically abused, or forced to have sex with someone who was under the influence of alcohol or other drugs. Their advice was that direct questions were the best way to ask about such sensitive issues. However, service providers recognised that questions on a woman's own illicit drug use could be problematic as deportation was a fear for many newly arrived women. Thus, there was recognition that participants might not give an accurate answer and may refuse to answer such questions. Service providers were also interested in obtaining information on general practitioner usage and residential mobility in order to inform service provision for newly-arrived women.

4.5.3 Views of Community Women

Women from ethnic backgrounds were recruited from my personal networks and through WHS contacts for participation in a pilot of the questionnaire. They were offered twenty dollars reimbursement for travel and for their time. Besides responding to the questions in the survey, participants in the pilot were asked to comment on the wording of questions, the length of the questionnaire, potentially embarrassing or sensitive questions, the usefulness of the questions and any other comments or thoughts they had on the issues discussed. Thirteen individuals were interviewed who came from Botswana, Kenya, Ethiopia, the United Kingdom, New Zealand, Indonesia, South Africa, and Germany. Two women interviewed for the pilot were from Australia with overseas born parents.

Comments from Community Women participating in the Pilot

As a result of the pilot, the questionnaire was reduced in length. Women suggested that the questionnaire take a maximum of fifteen minutes, with ten minutes seen as preferable.

Many comments about wording showed the original questions did not have the same meaning to women from different cultural and language backgrounds. Asking women "who lived in their home with them" illustrates how the same words did not have a shared meaning amongst women from different ethnic communities. Some women commented that this was not their "home". They considered their "home" their country. When asked if, "Who lives in your house with you?" was a better question, some women stated that they did not live in a house or that it was not their house as they were renting. Asking women about who they lived with also gave a number of responses that were not in the initial set of coded responses. Some women were not living with their families but in shared accommodation with friends and other women who were housemates. The question was finally worded as "Who lives with you in the house or apartment you are living in now?" Although longer, this question seemed to be understood the same way by women from different cultures.

During the focus groups and interviews with women and the piloting of the questionnaire, women found words such as mental health and mental wellbeing difficult to understand. These words were almost all dropped from the questionnaire.

These words were replaced by words such as sad, anxious, worried, and stressed. These words have been shown in other studies to carry the same meaning in other languages (Tilbury 2007).

The pilot of the questionnaire also showed that many participants did not understand the question "What is your ethnicity?" This may be due to the unfamiliarity with the term in English and/ or the lack of a similar construct in their language. In the end, participants were asked a number of questions concerning their country of birth, the language(s) they grew up speaking, their religion and where their parents and family were from. These questions provided more information and demonstrated often complex migration patterns and the multi-ethnic background of participants.

Most measures and scales used in AOD research have been developed for Caucasian males. Such measures may or may not be appropriate for women from different cultural groups (Sterk1999). This was the case with the Alcohol Audit developed by the World Health Organisation that was at one stage considered being included in the questionnaire. As part of the community consultation process, a small group of Muslim women were asked if these questions would be offensive and responded that such questions would not be offensive. The women seemed slightly bemused by the fact that a professional would ask their opinion about such a matter and that someone would ask questions to women such as themselves about excessive drinking. During the pilot phase of the questionnaire, the Alcohol Audit was trialled. However, the audit tool did not collect sufficient information on the changes in drinking behaviour and the concerns and issues newly arrived women had with alcohol consumption. Questions around alcohol use were then taken from the National Drug Strategy Household Survey (2005). These questions were also found to be a poor match to women's alcohol consumption. Some women reported only taking a sip for "medicinal purposes" or drinking only at weddings or special occasions. Women found it difficult to adequately report this within the choices in the National Drug Strategy Household Survey which was designed more for people who drank one or two drinks or more regularly. In the final version of the questionnaire, a filter question was used so only women who drank a standard drink of alcohol at least once a month were asked alcohol related questions.

The questions on alcohol-related violence and illicit drug use were regarded as very sensitive by women participating in the pilot. These questions were based on the National Drug Strategy Household Survey (2005) and did not ask women to describe an incident but rather if such an incident had happened to them since arriving in Australia and who the perpetrator(s) had been. Before asking these questions, participants were reminded that the answers were confidential and that they did not have to answer any of the questions. The pilot indicated that these questions could be problematic as respondents reported that women from their culture were likely to give inaccurate responses rather than not answer the question. In many cultures, it is difficult to refuse to answer a direct question especially when asked by someone held in esteem or in a position of power (Sowey 2007). Providing incorrect or untrue answers is considered more socially acceptable than not providing an answer at all. Shame may also lead to inaccurate replies about sensitive issues such as alcohol related violence and illicit drug use.

When women in the pilot were asked if they had had ever used khat, participants asked many questions about what khat was. These questions were dropped so as not to promote khat use, especially amongst younger respondents. As khat use is only common amongst some ethnic communities, khat was included as one of several drugs mentioned in the question:

"*Since coming to Australia have you been worried about or had any arguments with family or friends about <u>their</u> using alcohol, marijuana, khat or other drugs ?"*

Similar to women participating in the focus groups and interviews, women participating in the pilot were asked to choose the most important information and/ or activities for newly arrived women by using index cards that had drawings with English titles. Women could also add their own choice if it did not appear on the cards by the interviewer writing the topic on a blank index card. Women then chose five topics (including their own if they wished) that were the most important to them, and ranked them from 1 (most important to them) to 5 (least important). The cards depicted the choices most requested in the qualitative phase of the project or the broader groups into which the woman had put topics. Some topics or issues made it into this list even though they had received a fairly low ranking by women in the

qualitative phase of the project. This was because the topic may have been particularly sensitive to discuss in a group setting, for example how to best provide support for a woman whose husband or children were drinking too much alcohol. Often the final deciding factor in whether to include a topic in the questionnaire was how much discussion women had about the topic overall during the course of the interview or focus groups. For example, there was little interest or discussion around women wanting to quit smoking and it was rarely chosen as a priority topic when women were voting on issues. Thus, this topic was not included in the questionnaire. The pilot interviews also provided the opportunity to see if using the cards and a ranking system for the cards was viable as part of the questionnaire. As with the women in the focus groups and interviews, women in the pilot found this section of the questionnaire enjoyable and it was easy to administer. Thus, this method of choosing and ranking issues and activities was used in the questionnaire.

The final question of the survey was an open ended question. This was,

> *"Is there anything else you would like to tell us that you think would help newly arrived women?"*

This was an opportunity for women to say more about their needs, especially those needs that perhaps had not been covered in the previous questions in the survey. A space for interviewers' comments was also added as interviewers in the pilots often had relevant information to record about the interview.

4.5.4 Other Information Gained From the Pilot

As a result of the pilot more space was included in the questionnaire to answer open ended questions. Bilingual interviewers sometimes made notes in the margins, especially for open ended questions. There needed to be space to do this.

Some participants who had English as a second language found it helpful to have a clean copy of the questionnaire to read. The interviewer still marked the participant's

responses on the interviewer copy of the questionnaire. Having a participant copy provided a visual prompt to the questions being asked orally.

Interviewers also found that showing participants the Womens Health Services pamphlet at the beginning to explain services and to refer back to the WHS programs at the end of the interview was useful. By using the pamphlet, participants knew about the organisation and how to contact the organisation in case any of the questions brought up issues for the respondent. However, some women found the pamphlet too wordy or too big to keep for future reference and instead preferred a business card. Interviewers also gave participants my work phone number so I could facilitate referrals to appropriate services if required.

During the pilot phase, interviewers and women participating in the pilot were asked to think about a small gift that could be given to women answering the questionnaire. The gift needed to be small, easy to store and carry, and culturally appropriate to a broad range of women. Chocolates and water bottles were seen by both community women in the pilot and WHS staff and students as appropriate ways of thanking participants. Items such as pens were not seen as a good thank you gift as some newly arrived women were illiterate. Based upon this information, during the data collection phase participants at the end of the administered questionnaire were offered a muesli bar as a thank you as these did not melt like chocolates, and they were also reimbursed $10 for their travel and time.

The pilot also helped to confirm the decision that the questionnaires would be completed by interview. There were two main reasons for using an interview process. Firstly, there were many new humanitarian entrant arrivals who were illiterate in their own language and/or who had good English oral language skills but limited English literacy. Having a questionnaire completed by interview meant that the issues and concerns of these women would be included in the data. Secondly, feedback from community women during the piloting of the questionnaire had been that the questionnaire was very long. It was felt that a face-to-face interview would

result in a higher rate of completion. However, provisions were made that a woman could complete the survey on her own if this was her preference.

The questionnaire for this project was not translated. There were a number of reasons for this decision. As participants in the project were newly arrived women, it was anticipated that there would be many languages spoken by potential respondents. (This did turn out to be the case, as women from over 40 different language groups participated in the project.) Translating the questionnaire into only one or two languages may have meant getting the opinions and views of women from only one or two language groups. In addition, as previously mentioned, translations would not have helped women who were illiterate in their own language. A third factor was the prohibitive cost of translating a fourteen page questionnaire even into one or two languages. In the end, bilingual workers were seen as the best option for administrating the questionnaire.

The development and piloting of the questionnaire was time consuming but resulted in a questionnaire that was well understood by women from different cultural and socio-economic backgrounds (Appendix Four contains the final version of the questionnaire). Some women participating in the pilot also commented that the questionnaire was good and asked "good questions" about the issues facing new arrivals. One woman commented that the questions about accessing a general practitioner were very good and this was a big issue for her. Other published research has used similar methods to the ones described here to design, pilot and revise their survey instruments. These researchers have also commented that the process was time consuming but resulted in a better survey instrument (Bradby & Williams 2006).

4.6 Phase Five: Administering the Questionnaire

4.6.1 Recruitment of Participants

The project's aim was to collect approximately 200 completed questionnaires. This number was calculated in consultation with a bio-statistian at Curtin University so that there would be adequate numbers to stratify participants according to variables

that had been identified in the literature as being influential on AOD beliefs, attitudes and behaviours such as age.

Participants for the questionnaire phase of the project were also recruited through a purposive snowball sampling technique with multiple starting points. Some l respondents were recruited through English classes, community organisations, workplaces, community based clubs and groups run through WHS. These settings were often chosen because they were likely to be potential sites for the delivery of interventions, especially interventions with a prevention focus. In these settings one or two interviewers would come usually after a class or activity and interview one to two women each. In some cases, if the women were participating in a session that was loosely structured such as a sewing group, they would take turns to come out and be interviewed and then return to the group to the activity. These settings maximised the interviewers' time as a number of women could be interviewed in a one to two hour block. However, getting permission to go to the sites to ask women if they would be interviewed was often a lengthy process. The site would be contacted usually by phone, subsequent e-mails were exchanged with information about the needs assessment and, if needed, about WHS. A meeting was usually then arranged with the manager or person co-coordinating the group or activity and the permission obtained to ask women to be interviewed or permission gained to advertise the needs assessment was taking place. During the first few phases of the project, many service providers learned about the project and had verbally agreed to assist in recruiting women. Unfortunately, before the questionnaire implementation phase of the project commenced changes in the policy of the Australian Government meant that service providers funded by Department of Immigration and Citizenship were no longer able to provide researchers access to their clients unless the research was being conducted by the Department of Immigration and Citizenship. The change in policy meant it was more time consuming to find women to interview than originally anticipated.

Respondents were also recruited through the personal networks of bilingual workers employed by the project. This was by far the most successful recruiting mechanism and also ensured a highly diverse sample of participants.

4.6.2 Consent Process for Questionnaire Respondents

Potential respondents to the questionnaire were given information about the research project in a manner similar to that of focus group/ interview participants. A consent form was given to participants prior to the interview. If necessary, the plain language information was read out loud in English or by an interpreter or bilingual worker for those that had difficulty reading English. The information sheet was nearly identical to that used with the focus groups and interviews in that it outlined the nature of the study, what the information collected would be used for, what sorts of questions would be asked, the de-identification of data, how confidentiality issues would be managed, and the risks and benefits of participating in the study. Potential participants had the opportunity to ask both general and specific questions about the research, to meet with their interviewer and to think about whether or not they would like to participate in the study prior to consenting to participate. The consent form was signed before the interview and collected by the interviewer. Participants were given written information about the project, my contact details and my supervisor's contact details at Curtin University to take with them.

4.6.3 Issues Arising while Conducting the Questionnaire

Several issues arose whilst under taking the recruitment of women to complete the questionnaires. Several women who were interviewed had no schooling or only one or two years of primary school. These were the most challenging interviews and took the most amount of time. An interview with a woman who was reasonably fluent in English with a high school education would take about 25 minutes. (This does not include the time spent arranging the interview.) Interviews with women who had no or limited schooling were much slower, taking at least twice as long as those of women with a high school education. Respondents with limited or no primary school education often did not know their age, the age of their children and frequently responded to numeric answers by telling their personal story around that topic so that the interviewer would pick out the details needed to answer the questions in the survey.

Strategies were put in place to support and protect the interviewers' and participants' safety and confidentiality. Interviewers were encouraged not to do interviews in

women's homes unless they knew the family well and were comfortable in a private home. Workers were encouraged to do the interviews in public venues such as libraries, community centres, cafes and at Womens Health Services. All interviewers had my mobile number should they wish to debrief or had questions about the interview. Interviewers also had referral information for WHS as well as other health and domestic violence services available to give to women. Regular updates about the project were held with the domestic violence service at Womens Health Services to improve the referral process to this service.

4.6.4 Analysis of the Questionnaires

The results of the questionnaires were entered and analysed using SPSS. The data were screened for errors before analysis. This was particularly important as there were multiple languages involved in the interviewing process and interviewers often had English as a second language. All questionnaires were read and corrected for any potential problems before being given to the data entry operators. For example, some African languages have multiple ways of spelling the language name, so these were re-written to one spelling so the data entry operator would not code these as several different languages.

As already indicated above, a bio-statistian at Curtin University of Technology provided statistical advice as required. The focus of the analysis of the questionnaire was with the primary aim of prioritising the development of practical strategies and interventions that could be undertaken by Womens Health Service or other service providers working with newly arrived women in the future. Key variables in the analysis were English language skill, migration category, employment and other socioeconomic factors. Other studies have found demographic information such as employment status is significantly related to attitudes towards the acceptability of some drugs and the issues and concerns experienced by women (Ng, Bartu & Sang 1999, Working Women's Health and Women's Health in the North 2000). The data were also explored to identify major issues and concerns of respondents and how these issues were different or similar to those identified through the focus groups. The analysis also examined respondents' preferred ways to receive information as newly arrived women whether by ethnic radio, information sessions, websites or

community newspapers. This exploration included how these preferences vary across groups based on English language skills, other socio economic factors, and cultural background.

4.7 Phases Six and Seven: Clarifying Responses to the Survey and Dissemination of the Findings

Researchers who work with vulnerable groups need to consider unexpected and unintended outcomes of their research, for example participants being portrayed as dangerous or in some other unflattering way (Adamson & Donovan 2002). Alcohol and other drug research is a sensitive and contentious topic area and there is a risk that findings will be misunderstood by service providers, community leaders and members and/or being used in an inflammatory way by other groups or the media. For these reasons, feedback sessions with service providers and community groups were undertaken to ensure that there was an opportunity to discuss the findings and outcomes of the research project, including those findings that were potentially controversial or risked portraying participants and their families in an unfavourable way. A series of information sessions about the preliminary findings of the project were held in June 2007 aimed at giving service provider stakeholders an opportunity to hear and comment on the preliminary findings and comment on these. There were six sessions held for service providers. These sessions comprised a more formal presentation of the findings followed by discussion of the results including what additional information service providers would find most useful. This process helped determine some of the subsequent data analysis and the choice of information and presentation of information in the final project report. Information sessions about the preliminary findings of the project also were held with community women. These sessions were much more informal, taking place in community centres and on one occasion in a woman's home where her friends had gathered. There were five sessions held for community women. These sessions tended to focus on aspects of the study that were of particular interest to the women instead of an overview of the findings of the entire project. At the feedback sessions, the women were particular interested in the service delivery aspects that would result from the findings of the project. Community members participating in research can expect a much quicker response time to their identified issues and suggestions than government departments

and non-government agencies are able to accommodate. This occurred many times during this research project, especially during the feedback sessions, and it was often difficult for participants to understand that major shifts in service delivery took time – at least longer than two weeks.

In Western Australia, there has often been criticism of the poor communication between academic researchers and service providers so that the results of research with ethnic communities and/or groups are not fed back to service providers working with these communities or to the community members themselves in a way that is timely and useful. Thus, findings of research may have resulted in limited opportunities for changes in policy and service delivery and, at times, participants have felt that their efforts to participate in research and their opinions have not been valued. For this reason, the dissemination of the project's outcomes was seen as an important aspect of the project and was planned as part of the research process. Broader and more formal dissemination of the results of the project has occurred through conference presentations and information on the WHS website. A number of articles for publication in professional journals are currently underway so that other groups and organisation can benefit from the findings of the research project.

4.8 Summary of Methodology

The project used both qualitative and quantitative methods to identify and document common alcohol and other drug concerns and issues of newly arrived women living in Perth, and identify potential approaches to addressing these concerns. The project needed to overcome a number of barriers specific to working cross culturally as well as with women who do not speak English well and/ or have limited literacy either in English and/ or their primary language.

Chapter 5

Views of Service Providers: Alcohol and Other Drug Issues and Concerns of Newly Arrived Women in Perth

This chapter examines the views of service providers about the alcohol and other drug issues and concerns faced by newly arrived women. Twenty-two service providers working with migrant and humanitarian entrant women participated in either one of 5 focus groups or in one of 4 interviews. Quotes from service providers are italicised and in most cases are separated from the main body of text. The participant identification number after the quote allows the quote to be traced back to the original interview or focus group. In order to ensure anonymity, quotes from workers may at times be identified only as "Service Provider". Issues and themes from the focus groups and interviews with the service providers are arranged by topic, not necessarily in the order they were discussed in the focus groups or interviews.

5.1 Tobacco

Many service providers reported that they did not ask their women clients if they smoked, but instead waited for the clients to bring the subject up. This was illustrated a number of times in the focus groups and interviews with service providers.

> *"Many of them do (smoke) but it's not brought up as an issue. And I don't know if we're so much bringing it up as a question."*
>
> Service Provider
>
> SP13

> *"Do they see that (smoking) as a problem? Umm, I don't know. I've really not addressed it with them…"*
>
> Service Provider
>
> SP 17

One African service provider gave an interesting insight into the cultural prohibitions on women smoking. She commented that for many of the African cultures, female smokers are a "different class of women", not a "good class of women". It was more acceptable for a man to smoke as it is considered "macho" but for women it is "completely frowned upon".

A few service providers did ask their clients about their smoking habits which provided interesting insights on smoking as an issue amongst new arrivals. One service provider reported that amongst his former clients people had stopped smoking. These ex-smokers had advised relatives joining them in Australia to quit smoking. This was not for health reasons but because of the various prohibitions on smoking in public spaces. As he said:

> *"…clients who have relatives in Australia that they have come to join were warned, oh. when you come to Australia you're not allowed to smoke in a lot of places. It wasn't seen as a health thing but a law thing."*
>
> Service Provider
>
> SP 14

The use of tobacco as a method of coping with extremely stressful situations was also noted by a service provider who worked with men and women from the former Yugoslavia. Although these men and women smoked before the war, heavy smoking became a pattern during bombings and other events and then continued after community members had left the war zone.

5.2 Alcohol

In focus groups and interviews with service providers there were many interesting comments on how Australia's drinking culture impacted on female clients. Service providers commented that because it is much more acceptable for women to drink in Australian culture compared to other cultures women could either start drinking or drink more alcohol in Australia than they would in their own countries. As one service provider of African background remarked:

> *"The women now drinking, competing. They are drinking, or will drink…. Yes, back home they wouldn't do it. According to their culture, they wouldn't do that. It's only the men who are expected to do that, not the women. So now that the law is a bit relax here, the women are saying 'Oh, I can drink this, you can drink, they can drink."*
>
> SP 08

Service providers also commented on the concerns women had about their teenage and young adult children, especially men, drinking alcohol. They reported that women's concerns were often around their children "falling in with a bad crowd" rather than the drinking of alcohol itself.

> *"..not so much the danger part but getting into the bad habit of drinking. It doesn't seem like it's much of a problem now but it's in their… they're worried that this might happen. They'll see the dissolution of their families …"*
>
> Service Provider
> SP 12

Another service provider within the same focus group, then went on to elaborate her interactions with her clients:

> *"… in my own experience in working here with single mums who are raising children without the assistance of or the structure of or the support of a strong male figure. Mums have talked to me about really wanting to find activities with good children and good groups of people and not bad groups of people where it's really relaxed and there's no boundaries and they have no idea where they're going, what they are getting into. The concern is alcohol and drugs and crime all going together."*
>
> Another Service Provider
> SP 13

A service provider from Africa agreed that young people were drinking alcohol, noting that what was considered an acceptable level of drinking for young people and for mothers was different. Young adults stayed out, over at a friend's house for example, so parents were not aware of their drinking. Youth drinking, she believed, was about young people wanting to fit in with their peers. If heavy or binge drinking was occurring, it was happening outside the family home.

Service providers also commented on religious beliefs that in some cases acted as a protective factor for young people. Many young people take their religious beliefs very seriously and do not yield to Australian cultural norms around alcohol use.

> *"... the Muslim young people umm they are very much able to contain, not contain, but they're very clear about what they will and will not do and even when there is a lot of peer pressure around them. So, I think you'd probably find that umm even though some of like with the Muslim families they may be concerned about their children, for some of them they don't need to have a concern. Yeah, because their children are so clear already because of their strong religious belief …"*
>
> Health Service Provider
> SP 17

However, religious prohibitions don't necessarily stop all people from consuming alcohol. As one Muslim service provider explained about women's concern about alcohol use in their families:

> *"There is definitely a concern. Over there I mean you can't say just because they are a Muslim they would not. And there's a lot of Muslim countries that sell alcohol and they do consume it. But because there's that religious prohibition that prevents a lot of people so, I think the reduced rate is because of that…. "*
>
> Service Provider
> SP 05

5.2.1 Alcohol Related Problems within the Family

Problematic alcohol use within families was also discussed with service providers. Some service providers reported that discussions with women concerning alcohol were about how a husband's drinking could or was impacting on the family, especially the wife. Often this drinking was reported as a new behaviour used to cope with past trauma and current life stress.

> *"…it's been women whose husbands have been drinking so that the alcohol is creating a problem for the family. And that comes from all kinds of backgrounds. I think significantly from Muslim backgrounds where men hit the bottle when they come to Australia. It wasn't something that they used to do..."*

This service provider went on to say that many women often felt in some way responsible.

> *"…'What can I do to stop him from drinking?' and usually she feels in some way responsible… If I was a better wife, he wouldn't drink. So…the modelling of enabling it, collusion and then becoming a victim is borne out or shared out is definitely there. I don't think any of the women clients who I've spoken with have said that they go buy the bottle but …"*
>
> Mental Health Service Provider
> SP 14

Some service providers noted that problematic alcohol use impacted more than just the person drinking. For example, drink driving caused car accidents that resulted in the family car being unable to be used or alcohol related issues at work such as constantly being late or poor work performance resulted in the male breadwinner being fired. Some service providers drew a strong link between alcohol use by men and domestic violence. However, many service providers pointed out that not all domestic violence stemmed from alcohol and that in some cases the alcohol was an excuse for the violence.

> *"They (the women) actually say 'when he's not drinking, he's a very good man but when he drinks he's terrible', they make that distinction.*
>
> Domestic Violence Service Provider
> SP 06

> *"Actually one client said to me 'he actually uses the drink as an excuse' so like he, in this particular case it was a form of sexual abuse and she said to me that he would often say to her 'I'm sorry but I*

> *needed that because I had a drink'. So he used the drink as an excuse to support these actions and that's what she had great difficulty in dealing with."*
>
> Another Domestic Violence Service Provider
>
> SP 07

One doctor noted that the difficulties experienced by newly arrived women whose partners were drinking excessively were no more or less than in other women she may see. However, newly arrived women were more likely to present with issues regarding their partner's use rather than their own use.

> *"We might see more probably in the alcohol presentation might be more related to domestic violence presentation -where one partner drank and short term marriage and with alcohol involved. No, I don't think, I don't think it's certainly not the women presenting themselves with an alcohol problem. It might come up in conversation that their partner has one, yeah. Not sure that it's any more than other women coming in."*
>
> Doctor
>
> SP 02

5.3 Illicit Drugs

Service providers were also asked about illicit drug use amongst newly arrived women as well as use by significant others that impacted on their female clients. Few service providers said they had come across any newly arrived women who had used illicit drugs, but they felt this was due to women not being asked about use. Compared to other service providers interviewed, those working in the mental health area were more likely to ask women questions about illicit drug use as this is often part of the required patient intake information or required information needed for referral to mental health services. When newly arrived women were asked about drug use this seemed to give permission for at least some women to indicate what they were taking and/ or talk about their concerns. As one doctor commented:

> *"… or they filled in the little thing in the (health intake questionnaire) have you used any recreational drugs. People frequently put down ... I used marijuana last week or ecstasy a month ago as though, you know, like well did I have a cup of tea…"*
>
> Doctor
>
> SP 02

5.3.1 Drug Use by Significant Others

Service providers mentioned women being concerned about drug use by their partners and other family members, but felt that the general fear of drug use, even by teenagers was not necessarily founded in reality.

> *"How do you know if some one is taking drugs? It's always the bogey man of drugs. And it's always drugs. It seems to be much more of what they are fearful of rather than what they're experiencing."*
>
> Service Provider
>
> SP 12

One worker provided a good summary of the situation for parents:

> *"So, some parents have every reason to be concerned like all of us and others probably don't and are still concerned because they're a parent."*
>
> Health Service Provider
>
> SP 17

Although some workers felt that there was more fear than actual use of illicit drugs, other service providers had worked with newly arrived women where there had been illicit drug use in the family either by partners or children. One settlement worker described a case in the following way:

> *"Well I had one lady … a migrant who was new to the country and she was very concerned that she had just found out that her husband was smoking marijuana. And she was very, very upset, and asked for*

> *drug counselling for him and I referred them to a counsellor close to their home."*
>
> Service Provider
> SP 11

Other service providers had supported women whose teenage and young adult sons and daughters were using illicit drugs.

> *"...you know the boy and he's very young. Yeah it's a problem because the Mother is very hard to deal with it, because the language barrier and she only found out, I think, from school that he was you know taking drugs so, I think it's hard for the Mother because they don't know how to deal with."*
>
> Domestic Violence Service Provider
> SP 09

Service providers who had supported parents in these cases felt that drug use by these young people was a "cry for help" and that there were underlying issues of trauma, anxiety and depression with drug use not just a result of peer group pressure.

Some service providers reported that clients with alcohol and other drug issues often tried to deal with their drug issue within their ethnic community using a GP, psychiatrist, or psychologist that spoke their language. Service providers felt that alcohol and drug services were not considered part of ethnic communities and many considered that "Australians wouldn't understand". Residential withdrawal or rehabilitation services were not necessarily what clients were looking for or what parents wanted for their children.

5.4 Health Service Access, Medication Usage and Priority Areas for Information and Support for Newly Arrived Women

Service providers in the focus groups and interviews were asked a number of questions concerning health related issues they saw amongst their newly arrived women clients. What they identified as issues for newly arrived women were often related to the type of service provision they gave. For example, health service

providers were more likely to identify strictly health issues. Social service providers often identified settlement related issues such as accommodation and finding appropriate childcare. Workers seemed to be well-networked and readily referred their clients to other service providers to deal with specific issues they were facing. Some workers had many women clients with uncertain immigration status due to relationship break down with or domestic violence from the person who had sponsored them into Australia. In such cases, workers reported a major concern of their clients was getting permanent residency so that they could then access a range of crisis and health services and remain in Australia. In cases of domestic violence, service providers typically identified the safety of the woman and any children in her care as their primary concern. Service providers who worked with refugee women who had already gained permanent residency said they were much more likely to be approached by their clients for immigration information and support in order to bring other family members to Australia than with women's own immigration concerns. Workers recognised that for many of the women their needs focused on basic settlement issues such as accommodation, getting their children enrolled into appropriate schooling, and getting employment. Once these basic issues were taken care of, women could consider other aspects of their lives. However, dealing with these basic needs was often difficult. Many service providers reported families having great difficulty in finding accommodation. Employment was also an issue because of women's lack of English and difficulties finding affordable childcare close to their homes.

Many issues were raised by service providers about health related problems and concerns. Many saw humanitarian entrants who had just come into the country, and for these service providers providing very basic health information to their clients was part of their job.

> *"Nutrition and water well that's how we start every year, don't we?....Just basic hygiene, nutrition, eating properly and coming from different cultures their exposure isn't what it has been here. Getting to supermarkets, talking about the ability to drink water (from a tap)…."*
>
> Service Provider
>
> SP 03

Those who worked with humanitarian entrants identified war-related trauma and its sequelae of depression, anxiety and PTSD as major health issues facing many of their clients. Some of these service providers reported that clients often presented with physical symptoms associated with trauma and mental health problems such as lack of appetite, headaches, and general body aches and pains rather than a self-identified mental health problem.

5.4.1 Women's Health Issues

Many service providers mentioned a variety of women's health issues that were of concern to their female clients. These ranged from women wanting to have children and requiring pre-conception information and support to information on contraception to information and treatment of sexually transmissible infections. Service providers often worked with women who had had multiple pregnancies very close together and remarked on the physical impact this had on women's bodies. One health service provider noted that the concept of spacing births was different for women from different cultural backgrounds. As she said:

> *"... you know, we're getting women coming through and getting pregnant and the baby is only 5 months old and they've already got 4 or 5 children at home. And I just feel sorry for them in a way. I think…. oh, you know… it's hard not only are you dealing with coming here and trying to get your mind around everything and now you've got another baby on the way. And I'm concerned for them because physically their body hasn't gone back to being what I would consider to be a normal pre-pregnancy because their body hasn't had time. So, already...their body is looking four or five months pregnant already and they're only 5 weeks pregnant. So, it's a lot of load and I know that this is coming from my point of view and may be that's quite natural and normal for them..."*
>
> Health Service Provider
>
> SP 17

As this Australian born service provider noted, her perceptions were from her own cultural perspective. Although she worried about the impact of multiple pregnancies

on some women, the women did not seem to share her concern. Women from some places, especially those from refugee camps, appeared to recognise that not all their children would survive past childhood, and to ensure that some children did survive they needed to have many children.

5.4.2 Teenage Pregnancy

Many service providers mentioned that they had seen a number of newly arrived pregnant teenagers. These young women were primarily from Africa and were a mix of young women arriving pregnant and young women who had been in Australia, in some cases for a number of years, and then becoming pregnant. Service providers explained that many young women arrived pregnant as a result of sexual assault, being taken advantage of in refugee camps, or trading sex for protection, food and other necessities. In the situations many of these teenagers had come from, there was no money for food let alone contraception, even if it was available. Yet service providers understood that not every teen pregnancy was a result of sexual assault. Some young women arriving pregnant had partners who were still in their home countries or had been resettled in other countries.

Some service providers also had seen young women who had been living in Australia and then had gotten pregnant. As one service provider explained some of these pregnancies were unplanned while others were intentional.

> *"…We're also seeing a lot of young girls who come and got pregnant within a couple of years of being here. Umm, usually without intending to get pregnant. But, there have been a few strategic ones like I've been advised that I can get a house separate from my 9 siblings if I'm pregnant and there's a sort of a professional foul there. We've also seen a lot of very shocked parents of 14 to 15 year olds who have become pregnant. Whether that's an issue of early maternal health, are they getting everything they need or whether it's basic family planning – probably both. And we're also seeing families breaking down over this issue."*
>
> Service Provider
>
> SP 14

As reflected in the comment of the service provider above, there was concern by professionals as to whether or not these young women getting pregnant in Australia were getting adequate information and support prior to their pregnancy, during the pregnancy and after.

5.4.3 Access Issues to Health Services

Service providers identified general access to health services such as access to GPs, hospital based services and dental services as problematic for their clients. This included difficulties accessing transport so that women could get to health related appointments.

5.4.4 Medication Use

Service providers were asked specifically about a number of issues around primary health care. One of these was how service providers felt their clients understood and used Australia's system of prescription medication and medication use in general. Many service providers reported women not really understanding what medications were, what they were taking the medication for, being fearful of becoming addicted to non-addictive drugs and problems with taking the medication appropriately. Some women were taking medication for depression or anxiety, as reported by this service provider:

> *".... well if we're talking prescription medicines there are... is a percentage of women who are definitely on antidepressants. That's probably the highest prescription medicine. Ummm if we're talking about that then there would also be quite a few women using pain medication for whatever reason umm and there also be some, not quite a few but a percentage of women on the anti-anxiety medication."*
>
> Health Service Provider
>
> SP 17

Another worker reported problematic use of this type of medication as some clients only took it when they felt they needed it.

> *"…people often don't take the pills as prescribed but they'll take an antidepressant when they are feeling depressed but they won't take it tomorrow but they might take it on Saturday. It's worse than useless. It's an irritant dosage."*
>
> Mental Health Service Provider
>
> SP 14

Service providers noted that some women were concerned about becoming addicted to anti-depressant medications. But as one doctor pointed out, this concern may be no different to other women in the community who have been prescribed anti-depressants or minor tranquillisers.

> *"I think cross culturally there's a suspicion of those regardless. A lot of people are very resistant to going on to anything like that. Whether that's more in new migrants I don't know. I think everyone is very … it's just got a bad name you have to do a lot of hard work to get them… even people who have been brought up here to take."*
>
> Doctor
>
> SP 02

Problems with understanding medication use were not just problems with understanding English instructions. Trauma also played a role as did cultural understandings. One service provider gave a good example in explaining how patients were told to space their medication e.g. twice daily. But as she pointed out, for many new arrivals that is not clear enough as they are often working with different culture concepts of time and have experienced trauma as well. So when is twice daily, one now and one in a couple of hours? There were many assumptions made both by clients and service providers which are left unexplored with the result of medications being taken inappropriately. Another service provider further expanded on the issues facing new arrivals. As she described, medication use needs to be better explained but this takes time, especially when working through an interpreter, and often busy health professionals have not allowed for this.

Service providers also reported clients having difficulty with making lifestyle changes along with taking medication. There was an expectation that the medication would "fix the problem" without the client having to make changes in diet, for example.

> *"One of things that I've come across ... (is) people wanting medication for something like diabetes or raised cholesterol but not understanding what the GP has said about making lifestyle changes and wanting to (just take) medication and not understanding why the GP won't give them more tablets."*
>
> Service Provider
> SP 16

A similar situation was also reported by service providers working with women in domestic violence situations who were prescribed sleeping tablets or anti-anxiety medication by their GPs. One worker described part of her role as helping women look at some of the issues that led the woman to be taking medication in the first place.

> *"..., you know tablets aren't going to actually resolve the situation, so it's been about talking to them about using the tablets as a short term but then encouraging them to feel empowered enough to go and do some counselling and try and deal with some of the actual issues."*
>
> Domestic Violence Service Provider
> SP 07

Overall, many of the problems around medication usage were considered to be a mixture of different models of health interacting, cultural beliefs as well as language difficulties. As one doctor and nurse discussed during a focus group, English speaking patients who have been brought up in Australia have difficulties with appropriate medication usage so it was not surprising that newly arrived women do.

5.4.5 Sharing Medication

Service providers were also asked about clients sharing medication between family and friends. Many of the service providers identified this as an issue.

> *"Sharing medication is a big problem, unfortunately. Like..umm something has been prescribed for one family member and it's worked to sort of maybe have a headache and then it's given to somebody else who is experiencing headache and that could be medication for a very specific medical condition. That's a problem and I think there needs to be some education on that, yeah."*
>
> Settlement Service Provider
>
> SP 05

Asked if the sharing of medication was occurring because of lack of knowledge, the cost of medication, or other reasons, service providers felt that the sharing of medication was a complex mixture of different models of health interacting, cultural beliefs as well as practical difficulties including the cost of medication and language difficulties. As one service provider explained why her clients share medication:

> *"and maybe also that because they've tried and it (the medication) must be good so it hasn't killed them then it's not going to kill me...so I'll try that. Probably... maybe the cost and accessibility as well. Rather than me going to the doctor and spending a whole lot of money and getting a new medication, hey, it's already available I'll just take it…"*
>
> Settlement Service Provider
>
> SP 05

Other service providers reported similar situations where women were more likely to believe in the personal testimonial of friends and family of a medication's effectiveness rather than the advice given by a health professional. Some service providers reported that this could lead to the sharing of medication so women could "try it out" to see if the medication was effective for her situation. Some service providers also noted that some clients were not totally convinced of the efficacy of Australian medications and they had family and friends from their home country send "trusted" medication from back home.

5.4.6 Providing Information to Women

A wide range of strategies were suggested by service providers as good ways to get information out to newly arrived women around alcohol and drug issues and services. There was general agreement amongst service providers of a need for factual information to parents and community members regarding drug use in Australia. Alcohol and drug information was seen to be best delivered in conjunction with other health and social information such as parenting, and not separated out as a discrete topic due to the stigma and shame associated with drug use. Some service providers commented on the fact that alcohol and other drug information could be difficult for a woman to access within her own ethnic community for fear of being judged. As one service provider said:

> *"Yeah, because even for some of them to say I'm really concerned, it's like in their community saying… thinking, why are you concerned? Is your child using drugs and alcohol?"*
>
> Settlement Service Provider
>
> SP 05

Pamphlets, posters and information sheets were suggested by many service providers. However, service providers working with new arrivals also mentioned how short of time they were to search out suitable information and then either download it from websites or order it. Several service providers said that it would be useful to be given this information rather than having to search for it themselves. One focus group provided a good example of this when they had a discussion around a visit they had received from a staff member from the WA Drug and Alcohol Office.

> *"[...] said there was an awful lot of translated material. I don't see it out and about but he said you certainly can get it…*
>
> Service Provider
>
> SP 13

Three other workers then admitted that they hadn't accessed the web based information since the worker's visit. The participants then agreed it would be better to have the information given to the workers directly for them to pass on to clients as needed.

Business card size information was suggested by many service providers as being useful. It was small, discrete and women did not feel like they were advertising that they had a problem or concern. It was suggested that information be provided in more pictorial formats as opposed to information with lots of writing.

Information sessions especially sessions associated with English classes were seen as a good way of providing information. One service provider commented that women often had many questions around alcohol and drug issues but all the information they wanted to know about could not be could not be covered in one pamphlet. For this reason information sessions were considered a better approach. Written information was considered useful to reinforce information given verbally. Service providers also suggested TV, videos, DVDs, CD ROMs and short film clips on websites, especially for women who had limited literacy and who couldn't get to information sessions. Service providers said that seeing issues portrayed visually usually helped new arrivals understand the subject matter, especially if their English was limited.

Websites were considered by many service providers as a useful way to get information out to newly arrived women. One service provider remarked that using websites to access health information was also a way of assisting new arrivals with computer literacy.

> *"Also I think that whole computer angle with these particular new arrivals is perfect anyway because that's a second skill they're learning as well. That's a connected type thing. Brochures just end up at the bottom of people's bags."*
>
> Service Provider
> SP 04

One group of service providers were particularly keen on providing more opportunities for young people, parents and service providers to talk about drug use together. These service providers had had a very positive experience in the past in holding a forum with young people, parents and service providers.

However, there was a need to assure communities that talking about drug use and providing drug education did not promote drug use amongst young people. Two service providers in particular talked about the advantages of using a community-based approach to talk about drug use. They used this approach when they worked with young people.

1st Worker: *"I think it's pretty important to acknowledge .... that not everyone drinks or takes drugs but be informed ... Coming from an angle that you might be able to help someone that does have an issue even if you don't have one yourself"*

2nd Worker: *"Even drink spiking, just to be aware that things like that are out there and don't leave your drink even if you're just sitting there with a soft drink. It doesn't matter what they do. I don't think our cultural women go out as much as the boys but it doesn't mean that they don't go there like you say to select clubs or whatever But I think they need to be prepared. They are in a whole new world."*

SP 03 and SP 04

5.5 Discussion

It appeared that most service providers did not routinely ask their clients about their tobacco, alcohol, or other drug use unless required to as part of a referral process.

Service providers, especially in the mental health area, were cognizant of the fact that some of their clients used alcohol and other drugs to cope with stress and/ or mental health problems. However, given the high numbers of women accessing these service providers for mental and emotional issues, it was surprising questions around AOD use were not more frequent. The lack of inquiry about AOD issues with women clients by services providers may be a reflection of the stigma associated with women using drugs as many of the service providers worked with cultural groups that have strong cultural proscriptions around women and drug use. An important role of workers is providing women a safe space to disclose their concerns about their own or a significant others drug use and to let women explore strategies suitable for them. However, if workers are uncomfortable in discussing AOD issues, women are less likely to disclose problematic use.

Service providers supported giving information on tobacco use, the dangers of passive smoking and strategies to quit smoking to newly arrived women even though many of these women were non-smokers. Service providers felt that women needed to be aware of these issues as other family members smoked.

Service providers were clearly aware of the impact Australia's drinking culture had on their clients and the pressure clients encountered to drink alcohol. It was interesting that the vast majority of service providers did not appear to offer their clients any strategies for dealing with this. Service providers reported clients feeling pressured to drink or to drink more than before their arrival. A number of service providers commented on how alcohol fuelled but not caused domestic violence and how alcohol was often used as an excuse for acts of family violence. However, many service providers who worked with both new arrivals and other client groups felt that the difficulties newly arrived women experienced with alcohol and domestic violence were not unique to new arrivals but were similar to those of other clients groups with which they worked.

Some service providers reported that the use of illicit drugs was quite low and the concerns of parents about their children using illicit drugs were often disproportionate to the likelihood of actual drug usage. However, many service providers reported that their impression was that for many mothers the concern about drugs was more of a concern that their children would fall into a "bad crowd" where there was alcohol and drug use and even criminal activity. The low usage of illicit drugs was attributed to the cost of illicit drugs and the often scant economic resources of clients when they first arrived.

A prominent issue in the eyes of service providers appeared to be prescription drug use and the various issues around taking prescribed medication appropriately. These issues ranged from clients not understanding why medication needed to be taken, to clients sharing medications with family and friends, to issues around compliance. Many service providers reported difficulties of medication use being due to a complex mixture of different beliefs about the efficacy and suitability of Western medication for women from different cultural backgrounds, beliefs and practices

about how and when medication should be taken (for example, after alternative or herbal remedies have been tried without success) as well as practical difficulties such as poor English language fluency. It was interesting to note that this issue was far more openly discussed by service providers compared to alcohol and illicit drug use. This may be in part to the use of prescription drugs, even hazardous use of prescription drugs, being far less stigmatized than other types of drug use.

Many service providers appeared to lack the knowledge of where to access information and/ or time to access appropriate information about AOD issues for their clients. Workers appeared to know that translated information existed somewhere but were often unsure as to where to order it from or where to access it.

Many of the issues raised by service providers were similar to those mentioned in the literature such as problematic use of medication. Information obtained from service providers was subsequently explored with community women in the following phase of the project.

Chapter 6

Views of Newly Arrived Women: Alcohol and Other Drugs Issues and Concerns

This chapter examines the issues and concerns about alcohol and other drug amongst newly arrived women. The views and experiences of twenty-six women from a variety of cultural and linguistic backgrounds were gathered through six interviews and five focus groups. Quotes from community women are italicised and in most cases are separated from the main body of text. In order to ensure anonymity quotes from community women may at times be identified by region not by country e.g Woman from Africa as opposed to woman from Zambia. The identification number following the quotes refers to the focus group or interview from which the quote is taken. Issues and themes from the focus groups and interviews with newly arrived women are arranged by topic, not necessarily in the order they were discussed in the focus groups and interviews.

6.1 Tobacco

Many women participating in focus groups and interviews reported that it was unacceptable for a woman from their culture to smoke. As one Burmese woman remarked that it was a commonly held belief that for women *"…smoking leads to loose character,"* (Id No. 190506*).* However, not all cultures frowned upon women smoking. In some cases women had found smoking was less acceptable in Australia than in their own countries. Women (ex) smokers in the focus groups and interviews reported that they had learned more about the dangers of smoking since coming to Australia and as a result many had quit or cut down. As one participant said:

> *"Yes, I smoke before but when I came here I stopped smoking because I learned more about smoking and how smoking is no good for health but especially for heart and lung cancer, everything, and I stopped smoking"*
>
> Macedonian woman
>
> NW 50

Another Macedonian woman also reported quitting for health reasons:

Interviewer: *Did you give up here or did you give up in your country?*

Participant: *Here, yea… That's good try to… give up…. I was not a big, big smoker about 8 cigarettes …5 cigarettes a day … not a lot…*

Interviewer: *And why did you give up… too expensive or?*

Participant: *No, no…not expensive…for my health because nobody smoke here, but back in my country... in my country almost everybody smoke…*

NW 44

There were a few women in the focus groups and interviews who continued to smoke in Australia. The majority of these reported smoking as a means of managing stress. As one domestic violence survivor described her smoking habits:

> *"Sometimes when I'm stress and have too much problem I smoke outside. But after I think okay I stop. When I'm really under pressure then I start smoke because I don't know what to do and nervous… but I know that it's not good but stop. But sometimes the smoke makes me little bit better. Will lighten up thing again. But I'm not like, you know, a heavy smoker and I just need company when under pressure…"*
>
> Indonesian Woman
>
> NW 54

Some newly arrived women said they wanted information on smoking even though they did not smoke. This information was to give to their family members who smoked such as their fathers and husbands, as well as to inform themselves in order to talk with their children and other community members. Being the provider of such health information seemed to fit comfortably with participants' perceptions of a woman's role.

6.2 Alcohol

Issues of alcohol use were also discussed in the focus groups and interviews with newly arrived women. Many of the women reflected what the service providers had reported in that they did not drink or drank in very moderate amounts. One woman provided a fairly typical response:

Interviewer: *Do you drink alcohol?*

Woman: *No, not really, no. Sometimes glass of wine but no.*

Interviewer: *Like a glass of wine if you go out to a party?*

Woman: *To a birthday party, you know? Wedding day…*

Interviewer: *But not normally*

Woman: *No, I drink water and juice.*

Macedonian woman

NW 50

6.2.1 Cultural and Religious Beliefs and Practices Impacting on Women's Alcohol Use

Women participating in the qualitative phase of the project were from a diverse range of ethnic backgrounds and religions. Many of the women did not drink alcohol because of their religious beliefs, particularly those of Muslim and Christian faith. There was often a diverse range of practices within one group and women were often interested and surprised to hear others' views.

Liberian woman: *No I don't drink at all. My religion is Christian and church wouldn't… we don't drink…don't drink… no wine, no…*

Macedonian woman: *I'm Christian too but we drink… for parties, weddings and some special occasions.*

NW 45 & NW44

It did not appear that many women were drinking to excess. Rather women reported having one to two drinks on social occasions such as birthday parties and weddings. However, many of the women who drank alcohol remarked that their drinking patterns had changed since coming to Australia. Some women reported that these changes were due to Australian cultural values around alcohol use and women and alcohol use.

> *"I hadn't touched alcohol before. When I come here you know, I got friends, 'oh, come on…' when I try I don't like but I keep trying but it's not mean I like it but I when I socialise so maybe when I got party… little glass of wine because I can sip it otherwise I get headache…but at least I try a little bit…"*

Interviewer: *Do you feel that it's more acceptable?*

> *"Yea, yea. You cannot say no to your friends but everybody who knows you say, "just drink a bit." "Alright." I never touch alcohol because I don't like but they say, how come you don't drink, beer, alcohol it's not taste good (laughter) .. You know. Only one like is a Bailey's it's like thick milk and sweet. I like this one but the rest no."*
>
> Indonesian Woman
>
> NW 54

Although some of the changes in women's drinking patterns were due to different cultural expectations in Australia around women drinking, other women had changed what they drank as they tried new things in a new country.

> "*I don't know about others but myself I just wanted to try new things because in my own country we don't and I didn't drink wine and I found over here, oh wine's good."*
>
> Thai Woman
>
> NW 31

An interesting perspective was provided by a young African migrant woman who had started university in Africa and then had continued her university studies here in Perth. She noted that in Australia there was a greater expectation to drink alcohol when socialising with friends.

> *"It's very… quite different like the first time that I went with friends… going out, "why don't you drink?" and it's a bit like uncomprehending like, you know, why not? And what, I have to drink*

> *to have some fun? But mostly I don't drink to get drunk. I can have fun without drinking. But my friends understand and know me now that they don't pressure… peer pressure or anything. Yea… there is an expectation that you must drink when they go out."*
>
> African woman
> NW 36

Not all women reported an increase in alcohol consumption. Some women especially from Russia and the former Soviet Bloc countries reported drinking less alcohol since coming to Australia. As one woman from Kazakhstan explained the hot climate in Australia made it difficult to drink as much as in her own country.

> *"I just drink one glass of wine and it was … hot day and bad, bad condition and same as men. You know in Russia, especially Siberia they can drink a little bit because it's a cold climate and here it affects really a lot and most are drinking less."*

Interviewer: *"So you find people drink, think people drink less?"*

> *"From my country who come, definitely less"*
>
> Woman from Kazakhstan
> NW 30

Newly arrived women did not report problems with their own alcohol use. This may have been due to the sensitive nature of the topic and an unwillingness to disclose such issues. The problems that were reported by women were to do with male partners or children drinking alcohol excessively. This led to problems within the family, including family disintegration. In relating problems about excessive alcohol use by a family member and the impact on the family, some women drew from experiences beyond their own immediate family, from women in their extended family or women they knew socially.

> *" I guess having my experience with other women and children and families where the social situation is frustrating for the husband takes it out on drinking and the role of the wife with the husband is*

culturally for most umm people from Africa originally the wife is meek and doesn't say much and puts up with it and they get …with the children than they are afraid to come up and stand for themselves so they suffer in silence and so I think they need to be empowered you know so they can just don't have to tolerate it,.. yea.. drunken behaviour…"

African woman
NW 36

Another woman from Kazakhstan when rating the importance of issues to be dealt with as a priority chose "support for women whose husbands were drinking too much alcohol" and explained her choice to the interviewer and other focus group members.

Woman: *… for this women who has a problem it's most important because it's a big problem for family.*

Interviewer : *So, for women who have that, it's most important?*

Woman: *For women who have that it's first place, yes, it's a big problem for families*

Woman from Kazakhstan
NW 30

Community women in the focus groups and interviews discussed their concerns about their children drinking alcohol as well. These remarks reflected what service providers had said about women's concerns for their children "falling in with a bad crowd".

"Yes, yes here in Australia everybody can drink not good for our children where to go to school, meet their friends, who raise ….it's not good okay….okay, learn to drink too… I'm worried about this …"

Congolese woman
NW 47

However, not all women were concerned. Family's religious beliefs offered a protective factor. For example, two Muslim women in a focus group said they didn't worry about their children drinking alcohol. These women were certain that their children would simply follow their parents' religious practices as they grew up. In addition they would supervise their children and go wherever they went and ensure that they would not drink.

6.2.2 Alcohol related Abuse

Many of the women in the focus groups and interviews had experienced unpleasant incidents related to alcohol use by strangers. This was an issue that was brought up by newly arrived women in the focus groups and interviews but not by service providers. An example was told by a one focus group participant:

> *"…In my country if you are drunk you are not allowed to get on a bus you can't get on the bus… or the train… or public transport… if you want to drink …but here some do… I really I feel miserable…some time because one time on the bus I sat by one man who smoked and drink and he was very drunk and sat by me and just talking to me… talking to me and I was…when I get out of the bus I was miserable... "*
>
> Liberian woman
>
> NW 45

Some women reported that they did not have strategies to deal with such incidents. Sometimes this was because they were uncertain of what they should or could do or who they could ask for assistance. Other times they were uncertain of what the person was saying to them because they were still learning English. Asking the person to repeat their request was often mistaken as wanting to engage in further conversation or the woman being willing to give money when asked by some one begging.

6.3 Illicit Drugs

Issues of illicit drug use were discussed in the focus groups and interviews with newly arrived women. Women did not report problems with their own drug use. As with alcohol use, this may have been due to the sensitive nature of the topic and an unwillingness to disclose such issues. Newly arrived women were concerned about their young adult children and drug use. The media's coverage of illicit drug use seemed to fuel women's perceptions of a large drug problem in Australia. However, many of the women participating in the focus groups and interviews were fairly realistic that drug use did not just happen in Australia but occurred in their own countries as well.

Interviewer: *"Do you think there is more of a problem in Australia with the drugs for young people?*

Woman: *"…It's a problem everywhere in Sudan and abroad, but here according to what her husband reads in the newspaper it's more"*

Sudanese woman through an interpreter

NW 55

An interesting perspective was provided by an African migrant woman who had taught high school both in Africa and in Perth. She strongly felt that drug taking amongst young people was more common amongst the Australian schools she had taught at than in African high schools where she had taught.

> *"From my experience many school kids also take drugs and where I go to schools I sometimes see young kids talking about drugs and they ask me have you taken drugs and they are quite surprised and can't believe that I have never even seen it, what it looks like… Then over there (in Africa) you know there are some certain people who take drugs they are bad people you know…the real bad people you know like the thugs … but it's not like common in the schools definitely."*
>
> African Teacher
>
> NW 37

Overall, women in the focus groups and interviews were interested in drug information, especially drug information for parents. Women considered this important information for parents of teenagers, especially parents of teenage sons and young men. One Sudanese woman explained that illicit drug information was important to those in her community, especially "those who have young men." As one Iraqi woman said:

> "*Because there are so many bad people that children come in contact with so that want to explain all these factors to their children so that they won't …know how to avoid taking something from their friends or to do it voluntary… to tell them it's bad, …"*
>
> Iraqi woman through an interpreter
>
> NW 51

Another Iraqi woman commented:

> *"And there are so many provocations for teenagers. If you do this you become strong, if you do that you're a man, they provoke so they would like to try it so they become quickly man … "*
>
> Iraqi woman through an interpreter
>
> NW 52

6.4 Differences in Health Systems

Newly arrived women were then asked about access to health services, medication usage and how best to get information out to newly arrived women. Many of their comments concurred with what service providers had said while other comments offered a different emphasis or a different view point. Some women reported that the health system in Australia was very different than in their own countries. However, this was not always the case. Some women remarked that the health system they had used in their own countries was surprisingly similar to the Australian system. These women had fewer problems navigating the Australian system for this reason. However, some women reported being frustrated at long waiting times for appointments whether it was to see their GP or to see a specialist.

> *"The problem is in our country when if you need really to go and it's urgent and you go straight ahead and set appointment with doctor.*

> *Here it is very difficult even when you have to wait for a long time for appointment."*
>
> Russian Woman
> NW 33

Many women reported their frustration at the long waiting lists to see specialists or to get hospital appointments.

> *"Yes, it's very different and it's a little bit hard for myself because in Macedonia if I want to see a specialist doctor and I don't use an appointment or anything I go. I went to him and talking to him about my problem. But here I must make an appointment and after three or four months I go to a specialist. I think it's not good because what happens if I have a serious problem?"*
>
> Macedonian Woman
> NW 50

6.4.1 Difficulties in Finding a GP

Many women remarked on the difficulties in finding a GP. While women who had arrived as humanitarian entrants had received help from community nurses to find a GP, the experience in finding a GP for women who had come under other visa classes varied enormously. Some women had help from friends or family or had learned about how to make an appointment through English classes. Other women, however, had said it had been very difficult to find a GP or learn about the system. As one newly arrived woman explained why she selected information on finding a GP as 'Most Important':

> *"Most important because I found one friend who actually arrived 3 months ago and she was disappointed, she didn't even know to make appointment, and she didn't know where to go, what to do, ... definitely important for new arrivals"*
>
> Woman from Kazakhstan
> NW 30

Many of the women spoke of wanting to see a female doctor for "women's issues" which had been their practice in their own countries. Many women were very happy with their family doctor, especially if they consulted in the woman's language. However, many of these same women spoke of needing a woman doctor for gynaecological matters for cultural and/or religious reasons, but had found it difficult to find a woman GP for "women's problems". As one newly arrived woman explained:

> *"We go to women and explain our problem ... women problem and women tend to women and know what to do. That's why we do in our country"*
>
> Liberian woman
> NW 45

Some women identified that the reason they were having difficulties with the health system and accessing GPs were due to the fact that they had never had to do this before. These women were doctors, nurses, or other types of health professionals or had relatives that were. Hence, they were used to working the health system from the inside. These women were now operating without these family and professional support structures, were not employed in the Australian health system and were finding the experience challenging.

6.4.2 Communicating with General Practitioners

Women reported a variety of ways they communicated with their GPs. Many women spoke in English and asked their doctor to speak slowly so they could understand what was being said. Other women had found a doctor that spoke their language.

Other women reported taking family members such as their husband or older children along to interpret for them. This seemed to be more common when using GPs rather than in the hospital setting.

6.4.3 Medication Use

Women in the focus groups and interviews gave many interesting insights into medication use by newly arrived women. Given the difficulty and time consuming process of finding a GP, making an appointment, going to the doctor to get a prescription, and then going to the chemist for medication, it was surprising how many women felt the system in Australia was better than the one in their own country.

Women pointed out many positive points in the Australian system in that they were not having to self diagnose or diagnose family members, medication was more available and in some cases cheaper, women knew what they were purchasing as the chemist was not mixing pills or putting fake pills into the packets, and the medication was sold within the use by date.

> *"They said here it is much, much better because they get the good medicine. They don't need to be the doctors and guess the medicine. And some times they bring medicine which is not suitable for what they have… like uh… her sister had a son who coughs. She brings him the medicine sometimes it doesn't work at all because it's not the good one. So here it is much better….. And much cheaper…. And here it is much, much cheaper"*

Interviewer *"So in some ways it's longer but perhaps a bit better?"*

"Much better. And here they look at the expiry date …over there you can buy it when it expired … They don't care what happens to the people."

Iraqi women through an interpreter

NW 51 & NW 52

However, some women expressed concerns over medication use in Australia. Some women were unable to get medications they had taken in their own country that they had found particularly effective, for example medication for endometriosis. These women were often frustrated that they couldn't get the same medication here. Other women, especially women from Africa voiced their concerns that they had taken

their children to the doctor and were not given any prescription medication for their children's cold/ flu symptoms.

6.4.4 Sharing Medication

In general, women felt that herbal medicines and teas were acceptable to share with family and friends. However, many women distinguished between these types of medicines and prescribed medicines for more serious conditions such as medication for a heart condition. Many women commented that this later category of medication they wouldn't share with friends or family. A third category of medication seemed to be medication for common ailments in the women's country of origin where the woman had a reasonable idea of what the problem was and what the treatment was. For these conditions, self-assessment and the sharing medication between family and friends was not viewed as problematic. As one African woman explained:

Interviewer: *"So you didn't need to go to the doctor to get a script or anything?"*

Participant: *"Generally no because you become so familiar with what malaria headache or malaria… so you get to recognise the symptoms and so you self-medicate to some degree because you recognise this as malaria and go to chemist and ask…for anti-malarials…you got them. You really didn't have to go to see a doctor and get a prescription. It's much easier. You don't have to make an appointment…"*

African woman
NW 36

Depending on the cultural background of the woman and her socio-economic status, antibiotics were either seen as a medication that should be used under the guidance of a doctor or a medication that women could use relying on her own self-assessment and as such could be freely shared with family members and friends.

6.5 Information and Support Nominated by Community Women

As described previously, women in the qualitative phase of the project were asked to rank in order of importance topics of information and areas of support from a group of approximately 40 health related topics depicted on index cards. Women were also given the opportunity to suggest other topics. The group or the woman being interviewed was then asked to put the cards into three piles: most important, important, and less important. Women were then asked to choose the five most important topics for them from the most important pile. Table 6.1 shows the most frequently chosen topics and their rank. Several choices received a similar rank, hence the reason for several topics with a third place ranking. Some topics were selected by just one group or by one interviewee. These were: activities or support for women, social activities for women, support for women whose husbands or children drank too much, and quit smoking information.

Table 6.1 Frequently Chosen Topics for Information and Support by Women in Focus Groups and Interviews

Rank	Choice*
1st	Employment or pathways to employment through re-qualification and/ or further study
2nd	Information on depression and postnatal depression
3rd	• Information on how to get a GP and how to talk to the GP more effectively • Where to get foods and ingredients from one's own country in Perth • Information on eating better • Family violence and where to go for help • Information on family planning, • Information on illegal drugs for parents • Exercise classes
4th	• Information on pap smears and breast checks • Information on parenting in a new country • Sleeping better

*Several choices received a similar rank

6.6 Providing Information to Newly Arrived Women

Views were gathered from participants about the best methods to provide information to newly arrived women. Again, a diverse range of suggestions were made about the best methods to provide information to new arrivals.

6.6.1 Information Sessions

Information sessions or talks were seen as one of the best methods to give information to new arrivals. Talks needed to be in a woman's own language or via an interpreter if women's English was not at a sufficient level to understand the topic. As one woman said:

> *" It might be hard to get them there…. It might be difficult… but generally you get the message across… if you talk…"*
>
> African woman
>
> NW 36

Participants elaborated on why information sessions were thought to be so useful. For many women this was how they were used to receiving information on health issues in their own countries so it was a familiar concept. Other women liked the interactive nature of information sessions. They could ask the questions they needed to ask. Information sessions were best provided on the weekend as people were busy during the week with English classes and other commitments while on Saturdays and Sundays women were often able to leave children with their husbands or other relatives while they attended a talk.

Information sessions and talks in bridging courses and English classes were seen as especially useful as many women were time poor due to family and other commitments. Women found getting information as part of their English classes was easy and time efficient. Some participants felt that it would be best to separate the men and women as it may be hard for the men to understand the women's point of view. Other women felt that it would be good to have men and women in the same information session as many of the health issues were shared e.g. information on smoking. Some women said even on topics of reproductive health they would be happy for the men to be present as the men would learn something as well.

> *"…Okay, I'm not shy for that. Because the men should know about women's health because everyone has a woman and we should know about."*
>
> Macedonian Woman
> NW 50

Other women said that on sensitive topics such as specific women's health information, the classes would need to be separate for men and women. One woman pointed out that some new arrivals waiting to receive permanent residency like herself didn't have access to government supported English classes. So for her and others like her, there needed to be other avenues of getting information besides just educational talks in English classes.

6.6.2 Written information

Most women said they liked written information, especially if it was given out as part of an information session or talk as they could refer back to it to remind them of particular points. If the information session was in English, which often happens for women attending multicultural groups, written information helped women clarify points they didn't understand or missed. Women also suggested having written information in both community languages and in English as it helped the women improve their English comprehension. As one woman explained:

> *"… I'm suggest we have English pamphlet so if we don't understand the meaning we try to open dictionary… we learn again you know. That's twice you learn, reading and meaning. If you use your language you don't learn nothing and your English level is getting worse and worse but that's why I want to learn English this way. I have to push myself even if …I don't understand I ask or I open dictionary. That's the way you learn."*
>
> Indonesian woman
> NW 54

Some women in the focus groups and interviews said information sessions were useful but that such sessions were not their first choice as a way of accessing information. These women found it difficult to get to information sessions often due to family commitments as illustrated below.

> *"… to go to a seminar where somebody talks and then give something written about what she say…it would be excellent, the best way. But she is so much limited in her time because she has 6 children. She doesn't have time to go out all the time."*
>
> Iraqi woman through an interpreter
>
> NW 51

For these women written information was seen as a good option, especially if it was translated.

6.6.3 Other Ways of Providing Information

Focus group and interview participants were asked to suggest other ways to provide information to newly arrived women than those suggested. This resulted in a number of suggestions. Many newly arrived women said they got information from the internet. One focus group participant recognised that although she got information from the web that many other women and their families would not find web based information useful as they had poor literacy skills and computer access. Community newspapers were also suggested a number of times as a way of getting information to newly arrived women. The community newspaper was seen as a good source of information as it was delivered to your door free of charge. As one woman commented:

> *"If something is happening in the community if you can put something in the community paper, the local paper and people read there is something happening and they'll try to be there…"*
>
> African Woman
>
> NW 37

Informing sponsors (people who "sponsor" others to come into Australia) of services and providing them with information was not necessarily seen as a useful way to get

information to new arrivals. Many women commented that sponsors were often too busy to give a great deal of information to new arrivals. However, if information could be given to other women in the ethnic communities, these women then have contact with new arrivals and information can be shared.

6.7 Discussion

Information from the focus groups and interviews provided some interesting insights into attitudes by newly arrived women towards tobacco smoking that would have been missed if information had been collected only by questionnaire. Negative cultural attitudes towards women smoking by many African and Asian communities may be assisting with keeping the prevalence of smoking low amongst women from these backgrounds who have settled in Perth. The findings of this project regarding low smoking rates amongst women and proscriptive cultural values around women smoking concurs with the results of other studies (Rissel et al. 2001, Bradby & Williams 2006). In new arrival groups, negative cultural attitudes towards women smoking may act as a protective factor to keep newly arrived women from taking up smoking. However, these same negative cultural attitudes may also make it difficult for some women who currently smoke to seek assistance in quitting.

Although the majority of women surveyed were non-smokers, women suggested giving information on tobacco use, the dangers of passive smoking and strategies to quit smoking to newly arrived women. Participants explained that women needed to be aware of these issues for the sake of their children and to help other family members who smoked. Information on smoking is also part of women's health literacy in Australia. Such information allows women to understand what is being said in the media and participate in current debates regarding tobacco sale and use.

Information from participants supported service providers' assessments that the alcohol consumption patterns of women that drink change after arrival in Australia, largely due to Australia's drinking culture. Although some women reported consuming less alcohol, most of the women who drank reported greater alcohol consumption since coming to Australia. Women's self reported drinking changes along with some self-reports of quitting smoking in response to greater awareness of

the health risks of tobacco smoking and less acceptability of smoking in Australia, suggests that women may be acculturating to Australian drug use patterns faster than originally theorised.

6.7.1 Differences in Health Systems

Women from the same country had varying experiences with the Australian health care system. This may be due to socio-economic differences within the country of origin. For example, one Sudanese refugee women from a well-educated upper-middle class family reported that the health system she used in the Sudan was very similar to that in Australia. Her experience was very different to that of Sudanese women from lower socioeconomic circumstances who were interviewed.

The responses of some women in the focus groups concurred with what service providers reported about different cultural concepts of health and illness. For example, as one service provider explained in some countries people are not considered sick unless they have visible physical symptoms. A patient waits until these symptoms are acute and then goes to the hospital where he or she expects to be treated straight away and not placed on a waiting list. In the WA system, patients are expected to consult their GP for preventive care and when they are unwell. If a patient is unwell, there is an expectation that whenever possible patients will consult their GP before symptoms become very acute and require hospitalisation. These cultural practices have also been documented in the literature (Multicultural Access Unit 1996). Another example of cultural understandings impacting on women's satisfaction with primary care services was that many African women voiced their concern that they took their children to the doctor and were not given medication for their cold/ flu symptoms. The expectation was that a doctor would prescribe medication for these symptoms. Other studies have also found a belief amongst some but not all non-English speaking background cultural groups that antibiotics will cure all ills (Bolton, Hammoud & Leung 2002).

The discussions on how women liked to access information were thought-provoking. Traditionally, information to newly arrived women has been through information sessions and information to sponsors. Participants indicated that although information sessions were very effective, information to sponsors was not a very

useful means of information dissemination for women. A surprise was the number of times participants suggested that the use of web based information and information in community newspapers would be a particularly useful way of reaching newly arrived women.

The ranking exercise of prioritizing women's health information and support needs was very helpful in determining what issues would be discussed in the questionnaire. Although support for obtaining employment or further qualifications was not a surprise, the level of interest in exercise classes and support for issues around family violence was unexpected. Women may have been more willing to nominate particularly sensitive topics such as those related to family violence or alcohol use by partners or children because they did not have to disclose why they chose a particular topic. However, as mentioned previously, women were given WHS contact details if they wished to access one of WHS' programs at a later date or were assisted with referrals to programs and services after the interview or focus group as requested. Many women did take up these opportunities for referral.

6.8 Summary

This chapter has examined the qualitative findings of the twenty-six women participating in the focus groups and interviews. Information from the focus groups and interviews provided some interesting insights into attitudes by newly arrived women towards tobacco, alcohol and other drugs that would have been missed if information had been collected only by questionnaire. It was interesting to note how similar the issues were amongst participants despite women being from very diverse ethnic and socio-economic backgrounds as well as migration experiences. The qualitative information gained from both service providers and community women was used in the next two phases of the project: to pilot a questionnaire and then administer it to a larger sample of newly-arrived women.

Chapter Seven

Findings from the Questionnaire

Information from focus groups and interviews with service providers and newly arrived women revealed a number of AOD issues as well as issues around health service access and usage. To determine how generalisable these concerns were to a larger and more diverse group of newly arrived women, a questionnaire was developed, piloted and administered. This chapter examines the issues and concerns about alcohol and other drugs amongst newly arrived women as gathered from the 268 administered questionnaires. This is followed by a general discussion of the data. Specific findings about refugee women have been included in each of the following subsections that discuss the results of the questionnaire as information about this group of women was requested by service providers working with humanitarian entrants. Some quotes from open ended questions have been included and these have been italicised. The significance level for statistical tests was set at .05 for all tests. The 268 respondents to the questionnaire were born in 50 different countries and reported 48 different languages as their primary language. Further demographic data on respondents are in Tables 7.1 and 7.2.

Table 7.1 Demographics of Questionnaire Respondents*

	All Questionnaire Respondents		Refugee Women Only	
Time in Australia	**Number**	**Percentage**	**Number**	**Percentage**
Under 12 months	54	20.4	17	15.7
1 to 2 years	73	27.5	42	38.9
2 to 3 years	63	23.8	19	17.6
3 to 4 years	40	15.1	16	14.8
4 to 5 years	35	13.2	14	13.0
Total	265		108	
Age				
18 to 29 years	113	44.8	51	52.6
30 to 39 years	84	33.3	23	23.7
40 to 49 years	43	17.1	18	18.6
50 years or more	12	4.8	5	5.2
Total	252		97	

*Numbers do not equal 268 questionnaire respondents and 109 refugee women respondents as there was missing information.

The substantial number of young women in the sample is a reflection of Australia's migration policies which encourage younger applicants as well as the younger age of refugee women due to the harsh conditions in many refugee camps.

Table 7.2 Migration Categories of Questionnaire Respondents

Migration Categories	Number	Percentage
Humanitarian Entrant	109	40.7
Student Visa	38	14.2
Fiancé Visa	18	6.7
Spousal/ Partner Visa	46	17.2
Other Family Visa	12	4.5
Skilled Migrant	15	5.6
Business Development	5	1.9
New Zealand	2	0.7
Other	7	2.6
Missing	16	5.9
Total	268	

7.1 Tobacco

The survey contained a number of questions for participants' about tobacco use both at the time of the survey's completion and since coming to Australia. The vast majority of respondents to the survey (n = 207; 80.2%) had never smoked. Given the negative cultural attitudes towards women smoking amongst many of the newly arriving communities, it is not surprising only a small number of women surveyed reported smoked daily or occasionally (Table 7.3).

The women who reported smoking daily or occasionally (n=19) ranged in age from 19 to 50 years. Women aged 25 years and under accounted for 41.2% (n=7) of the smokers. The women who smoked came from twelve different countries, the most frequent country of birth being Singapore (4) and Russia (3). The vast majority of smokers (89.5%; n=17) reported speaking English very well or well and also reading English very well or well (84.2%; n=16). Of the nineteen women who smoked, thirteen had completed high school or equivalent and six had completed a university degree. Of the women who smoked, all were engaged in studies, employment or a combination thereof except for one woman who was looking for work and another woman doing home duties full time.

Table 7.3 Description of Women who Smoke

Description of Respondent	Number (n=258)	Percentage %
Smokers		
Smoke Daily	8	3.1
Smoke Occasionally	11	4.3
Non-Smokers		
Never Smoked	207	80.2
Don't smoke now but used to Smoke	14	5.4
Tried it but never smoked regularly	12	4.7
Others		
Unsure/ Don't know	2	0.8
Refused	4	1.5

Of those women who reported smoking at some time, 8.2% (n= 22) had cut down or stopped smoking since coming to Australia. In open-ended questions, reasons for stopping varied. The cost of cigarettes was not a major factor given for women in reducing their cigarette consumption, with only one respondent giving this as a reason for stopping or reducing the amount she smoked. The most common reason women reported for reducing or quitting smoking was pregnancy or concerns about the health of their children. Four respondents reported that they did not have friends who smoked in Australia so they had either stopped or reduced the amount they smoked. One respondent reported that working in non-smoking areas had led her to cut down.

Women who continued to smoke in Australia gave a variety of reasons for this (Table 7.4). The use of tobacco as a coping mechanism when a woman was stressed or worried concurs with the information given by focus group and interview participants.

Table 7.4 Reasons for Smoking*

Reasons for smoking	Number of Respondents (n=19)	Percentage of smokers giving this response
Helps manage stress	11	58
Helps manage weight	9	47
Enjoy it	2	11
Helps fit in with Australian friends and family	2	11
Addicted to nicotine	1	5
Not as bad for health as people say	2	11
Other	4	21

*Multiple responses allowed

7.1.1 Refugee Women

Of the 109 refugee women answering the questionnaire, the vast majority of women reported that they had never smoked. Only four women reported either smoking daily or smoking occasionally. Reasons these women gave for continuing to smoke included managing stress, anxiety or worries; managing weight; and being addicted to nicotine.

7.2 Alcohol

As with tobacco use, the vast majority (76.1%; n= 201) of women surveyed reported that they had not drunk more than one standard drink of alcohol in a month over the last twelve months. However, as respondents answered several alcohol questions, an additional three women told about their alcohol use other than reported in the original filter question about drinking alcohol. Thus, in total there were 65 women who reported drinking alcohol. Although this study had a much smaller sample size compared to that obtained for women of similar ages in the 2004 National Drug Strategy Household Survey, women in this survey drank significantly less (Table 7.5 below).

7.2.1 Refugee Women

Of the 109 refugee women surveyed, over 91% (n= 100) had not had more than one standard drink in the past twelve months. Of the six women who drank alcohol, only one woman reported drinking 1 to 2 days per week and the remaining five women reported drinking less often than this.

Table 7.5 Table of Drinking Status of Newly Arrived Women Compared to Women in the National Drug Strategy Household Survey (NDHS) 2004 of Similar Ages

	Percentage NDHS N= 29,445	Percentage Newly Arrived Women N=268
20-29 years		
Daily	1.3	1.5
Weekly	38.4	4.1
Less than Weekly	47.0	2.6
30-39 years		
Daily	3.2	0.4
Weekly	38.9	3.7
Less than Weekly	44.8	3.0
40-49 years		
Daily	6.3	0
Weekly	43	3.3
Less than Weekly	36.9	1.9

7.2.2 Short Term Harm

Using the National Health and Medical Research Council's Australian Alcohol Guidelines: Health Risks and Benefits (2001), women are drinking at risky levels for short term harm if they are drinking five to six standard drinks on any one day. Under the same guidelines, women are at high risk for short term harm if they have seven or more standard drinks on any one day. Using these definitions there were four women who were drinking at risky or high risk for short term harm:

- 3 women who reported drinking 5 to 6 standard drinks on 1 to 2 days a week and
- 1 woman reported drinking 7-10 standard drinks on 3 to 4 days a week

7.2.3 Long Term Harm

Again using the National Health and Medical Research Council's Australian Alcohol Guidelines: Health Risks and Benefits (2001), women are drinking at risky levels for long term harm if they are drinking three to four standard drinks on an average day with an overall weekly level of 15 to 28 standard drinks per week. Women are at

high risk for long term harm if they have five or more standard drinks on an average day with an overall weekly level of 29 or more standard drinks. Using these definitions seven women could be seen as drinking at possible risky or high risk levels for long term harm:

- 5 women reported drinking 3 to 4 standard drinks 3 to 4 days a week
- 1 woman reported drinking 3 to 4 standard drinks every day
- 1 woman reported drinking 7-10 standard drinks 3 to 4 days a week

Given the small numbers, it was not possible to discern demographic patterns amongst the ten women who reported their drinking at risky or high risk levels for short and/or long term harm. Five of the ten women reported drinking more alcohol since coming to Australia. Six of the ten women wanted information and support for depression and five women wanted information and support around family violence.

7.2.4 Changes in Drinking Habits

Changes in alcohol use were also explored in the survey amongst women who drank alcohol. Women were asked to compare their drinking habits now to their drinking habits in their own country. Women were also asked why they thought their drinking pattern had either changed or remained the same. Of those women who drank alcohol and answered the question, 38.3% (n = 23) reported drinking about the same amount of alcohol, 28.3% (n=17) reported drinking less alcohol and 31.7% (n=19) reported drinking more alcohol. Reasons for drinking more alcohol were varied and included alcohol being cheaper in Perth than in their own country, socialising with Australians who drank alcohol, and as a way of coping with stress. There were also a range of reasons for women drinking less alcohol. These reasons included having fewer occasions to socialise as new arrivals, health reasons or to be a good role model for their children.

7.2.5 Others Use of Alcohol Impacting on Newly Arrived Women

Women who completed the questionnaire were asked if they had ever been verbally or physically abused by some one who had been drinking alcohol or taking drugs. The survey went on to further ask about respondents being put in fear, made to feel uncomfortable or embarrassed or made to have sex she did not want to.

In Table 7.6 Alcohol Related Incidents by Strangers, Current or Ex- Partners and Others are compared between women in this project and the National Drug Strategy Household Survey (2005). Although the wording was not directly comparable with the National Drug Strategy Household Survey (2005) because the phrasing of questions was slightly different, some general comments can be made. Newly arrived women surveyed in this project were significantly less likely to report being verbally abused than women surveyed in the National Drug Strategy Household Survey. However, they were significantly more likely to have felt fearful than women respondents in the National Drug Strategy Household Survey. There was no significant difference between refugee and non-refugee new arrivals regarding verbal abuse experienced by strangers. However, migrant women were more likely to experience being put in fear by a stranger than refugee women (χ^2 = 5.444, df 1, p=.020) and migrant women were more likely to have felt uncomfortable or embarrassed by someone who had been drinking alcohol or taking drugs (χ^2 = 9.99, df= 2, p=.007). Migrant women were also more likely to report having been made to have sex when they didn't want to by someone who had been drinking alcohol or taking drugs (χ^2 = 5.850, df 2, p=.054). Strangers and partners accounted for the overwhelming majority of cases where women were abused, fearful or embarrassed.

Incidents by a Stranger

The 46 women who had experienced one or more incidents by a stranger of verbal abuse, physical abuse, being put in fear or forced to have sex when they didn't want to were from 19 different countries. They had a range of English language abilities and religious affiliations and had come to Australia under a range of different migration categories. Women in their twenties and thirties were significantly more likely to have experienced these incidents by a stranger (χ^2 = 12.478; df =4; p =.014). Participants were asked if they had been drinking and/or taking drugs at the time of any of these incidents. Of the 80 women who answered the question, fifteen women (18.8%) reported that they had been drinking alcohol when the incident took place, one woman refused to answer the question and the remaining 64 women (80.0%) responded that they had not been drinking alcohol or taking drugs when the incidents took place.

Table 7.6 Alcohol Related Incidents by Strangers, Current or Ex- Partners and Others*

Type of Incident	Strangers		Partners		Others		No. of Women
	N	(%)	N	(%)	N	(%)	
Verbal abused	28	(64)	14	(32)	2	(4)	44
Physically abused	3	(27)	8	(73)	0	0	11
Put you in fear	36	(65)	17	(31)	2	(4)	55
Uncomfortable or Embarrassed	38	(63)	19	(32)	3	(5)	60
Made you have sex when you didn't want to	1	(8)	12	(92)	0	(0)	13

*Multiple responses allowed

Incidents by a Partner

The second group of people who accounted for the majority of incidents was current or ex-intimate partners. There were twenty women who reported that they had experienced one or more incidents by their current or ex partner of verbal abuse, physical abuse, being put in fear or forced to have sex when they didn't want to. The women were aged 21 to 48 years and were from 13 different countries with varying English language abilities and religious beliefs. There were more women entering Australia under spousal or fiancé visas who had experienced these incidents (n= 9) but there was no significant difference between migration categories. Eight women (42.1%) reported having drunk alcohol before the incident(s) took place.

7.2.6 Support for Women with a Family Member Drinking Too Much Alcohol

Women were also asked to rank their priority issues and activities. Overall, support for women whose husbands or children were drinking too much alcohol rated tenth out of ten possible choices. Of the forty women (14.9%) who included this item in their top five choices, six women chose this either as their first or second priority. Of the women who chose support for a woman whose husband or children was drinking too much alcohol, five reported verbal abuse by their current partner, three reported physical abuse by their partner, five reported being put in fear by their partner and five reported being forced to have sex when they didn't want to by their partner (for two this was by a former partner).

Seven women reported having concerns or arguments with family or friends about their family member's or a friend's alcohol and drug use. These women were a broad mix of ages, from country of births, length of time in Australia, and occupations. Two of the women who wanted support for a family member were drinking at levels considered risky or at high risk for long term health consequences themselves.

7.3 Illicit Drugs

Women respondents were asked about their own illicit drug use, if they were concerned about a family member or friend's alcohol and/or drug use, and where they would go for assistance with issues around their own or that of a significant other's drug use. Only five of the 268 women respondents reported using cannabis since coming to Australia. Two of these women were humanitarian entrants. One respondent reported using other drugs but refused to specify which drugs or usage. Newly arrived women answering the questionnaire were also asked if since coming to Australia they had been worried about or had any arguments with family or friends about their use of alcohol, marijuana, khat* or other drugs. Twenty-three women (8.8%) said yes to this question, three of whom were humanitarian entrants. Of the twenty women who went on to explain what their concerns were, all of these women reported being worried about or having arguments with their husband, son, daughter, and/ or friends. Excessive alcohol use was the most common source of the arguments or concern. Fifteen women mentioned their concerns about excessive alcohol use, often consumed in conjunction with other drugs such as marijuana. Other drugs specifically mentioned as being used by relatives or friends included marijuana, ice and heroin. A further three women said they were worried about their children using drugs but said they had no proof of their children using at the moment. The questionnaire asked respondents if they would use an alcohol or other drug service if they or a family member had a problem with alcohol or other drugs. Just over 71% of women said they would use such a service. In open-ended questions where interviewers wrote down participant's responses, women reported a variety of reasons for why they would not use such a service. The most common one was that

**Khat is a leafy green plant (Catha edulis Forsk., Celastraceae family) that often grows to a large tree in climates such as Perth's. Chewing khat leaves can give an amphetamine-like stimulant effect. Khat use is predominately a male activity although some women use khat (Druginfo Clearinghouse 2003).

the women did not have or would not have a family member with an alcohol and drug use issue. Many women stated this was because of religious reasons, for example, because they were Muslim. Some women said they would prefer to help themselves or seek help from family and friends first. As one woman stated, alcohol and drug use issues were "*a private family matter*". One woman said that she would be ashamed or embarrassed as it was "*not in my culture to seek help regarding alcohol and drug use*". Other responses showed a poor understanding of AOD services in Australia. One respondent said she would not go to an AOD service because she was "*afraid of cold turkey*". Another woman would use an AOD service but was concerned about confidentiality and whether the person accessing the service would be turned into the police. One woman said she would "*try to sort out herself if service too expensive*". Other responses indicated that some women had tried to access AOD services or had thought about it. One respondent reported that her husband "*would not agree to let them help him*" while another woman had not accessed AOD services "*because it (her use) wasn't a big deal*".

7.3.1 Other Sources of Assistance

Asked who else they would talk to if they or a family member had a problem with alcohol and drug use, women gave a variety of responses. The most common response was that women would talk to family members or relatives about AOD issues. Friends were the second most common response, followed by family doctors (GPs), or health service providers at women's health centres, TAFEs or universities. A number of women (n=37) said they would talk to a "specialist", "professional person", or a social worker about this issue. Some women specified that this professional would need to be a woman or that they would prefer a woman professional from their own cultural background. Priests, pastors, church counsellors and other church workers were other sources of help mentioned. Thirteen women said they would not talk to anyone, either about their own alcohol and drug issues or those of a family member.

7.3.2 Using an Interpreter to Talk about Alcohol and Other Drug Issues

Women answering the questionnaire were also asked how comfortable they would be using an interpreter to talk about their own or a family member's alcohol or other drug use issues. Around half (48.4%; n= 121) said they did not need an interpreter.

Nearly 7% (n= 17) of the women felt very comfortable using an interpreter, and just over 31% (n = 79) felt "ok" using an interpreter. Twenty-three women (9%) felt "not comfortable at all" in using an interpreter to discuss these issues. When women were asked to comment on their level of comfort in using an interpreter, issues of privacy and confidentiality were brought up in the open-ended questions. Alcohol and drug issues were described as too sensitive and there were fears that the interpreter might tell someone from their community. Other women said they would prefer to use a family member to interpret. Comments made by the women around interpreter use showed just how sensitive alcohol and drug issues are in many communities. As one woman responded, "*I always keep as a secret about my family's issues*" and another woman said that she wouldn't feel comfortable using an interpreter "*because it is very embarrassing for someone else to hear your problem.*" One woman offered a good summary of the issues around alcohol and drug use and interpreters:

> *"I wouldn't feel comfortable to speak about such issue in front of an interpreter that's from my own country because it might ruin the person's reputation among the community. It's just that everybody knows each other and I wouldn't want such information to leak out."*
>
> Questionnaire Respondent

Some of the women responding to the questionnaire had ideas on how they would prefer to handle issues of privacy and confidentiality whilst using an interpreter. One woman suggested using an interpreter that spoke her language but did not come from the same region or country as she did. Another woman suggested discussing such issues with an interpreter she knew. Another woman who said she would be "ok" using an interpreter preferred to discuss such issues using a telephone interpreter.

Reasons why women were comfortable or ok with using an interpreter also varied and related to a sense that they needed support with communicating with service providers. One respondent stated that she would use an interpreter because she had "*no choice*"; while another wanted to understand what was being said and this was only possible by using an interpreter.

> *'For me, maybe better to have an interpreter because English is not my first language and I don't know I would be able to explain what I want to explain/say"*

7.3.3 Talking to Children about Illegal Drugs

A substantial proportion (41%) of women reported they did not feel confident enough to talk to their children about drugs. For refugee women, confidence was even lower with only 16% of refugee women reporting feeling confident enough to talk to their children about illicit drugs. Despite this low level of confidence, when women were asked to rank their five priority issues with which they wanted information or assistance, information on illicit drugs ranked ninth.

7.4 Accessing Primary Care

In the survey women were asked about access to GPs, Emergency Departments and medication usage, topics that had come up during the qualitative phase of the project both with service providers and newly arrived women.

7.4.1 Difficulty in Getting a GP

Women were asked when they came to Perth how difficult was it to find and get an appointment with a GP (family doctor) and responses of the 264 women who answered this question are summarised in Table 7.7.

Table 7.7 Difficulty in Finding a GP

	All questionnaire respondents N=264		**Refugee Respondents Only N=107**	
	Number	Percentage	Number	Percentage
Easy	187	70.8	86	80.4
Difficult	32	12.1	12	11.2
Very Difficult	17	6.4	8	7.5
No GP yet	28	10.6	1	0.9

The majority of women who found it easy said this was because they used their social networks to find an appropriate GP. These social networks included family members who were already in Perth, friends, and employers. Other women reported finding it easy to find a GP as they spoke English, had found a number of GP practices near their place of residency and/ or used the university medical services where they were studying. Refugee women were more likely than non-refugee

women to report that it was easy to find a GP as settlement service workers had linked them to a GP who most felt was appropriate. For example, only one refugee woman did not have a GP at the time of the questionnaire interview while 27 non-refugee women reported not having a GP. The responses to the open ended question asking women to comment on why finding a GP was difficult gave an interesting insight into the various difficulties women faced. These included lack of information about how the GP system worked in Perth and not knowing anyone who could recommend a "good" or "trustworthy" GP. One woman stated, "*No English and nobody to guide us*". Another woman remarked, *"I just didn't understand the system. I realised it was a huge step to talk to a new GP, trusting a stranger takes a while."* Women reported lack of English as another barrier to finding a GP. This was also true for women who originally had a GP arranged through a settlement service but for various reasons needed to find a new GP. One woman described her situation, *"Language- we were introduced to one (GP) but not happy with her and wanted to change, but didn't know how to."* Seven women remarked that they found it difficult as the environment or culture was so different. A number of respondents commented that they had long waiting times for appointments and this was the difficulty they faced versus finding a GP. Two women mentioned they lacked the support of their husbands to find and get themselves to a GP. As one of these women explained:

> *"When I was living in (a mining town in the North of WA) it was small and it was easy for me, but after I moved to Perth, it is very hard, because it is big city and my husband refused to take me or to help me*."

Three women who had uncertain residency status mentioned their difficulties in getting a GP were due to cost. They had no Medicare card and private health insurance was too costly.

Attending Multiple GPs

The majority of the women (71%) reported to have attended one or two general practices since coming to Perth. Twenty-eight women (12.3%) reported attending three different practices. A small percentage of women (8.4%; n=19) reported attending four or more different practices with the highest number being six different practices. Refugee women appeared to be more loyal in GP attendance with 73% of

the women reported attending only one or two different GP practices since coming to Perth. Three women had visited five different practices.

7.4.2 Communicating with a GP

The majority of women that spoke to their GP in English had English as either their main language or reported that they spoke English very well or well (n=172; 86.4%). A small percentage of women who spoke to their GPs in English said they only spoke some English (n=27; 13.6%). There was no relationship between how well women spoke English and their difficulty in getting a GP. Both refugee and non-refugee women reported using partners, children and friends to help them communicate with their GP (Table 7.8).

Table 7.8 How Newly Arrived Women Communicate with Their GP*

	All Questionnaire Respondents N=268		**Refugee Women Only N=109**	
	Number	Percentage	Number	Percentage
In English	200	74.6	77	70.6
In Own Language	23	8.6	8	7.3
In another language we both speak	4	1.5	1	0.9
Using an interpreter	19	7.1	13	11.9
With help of husband or partner	22	8.2	6	5.5
With help of children	11	4.1	8	7.3
With help of friend	7	2.6	5	4.6

*Multiple responses allowed

Refugee Women

The majority (80.6%) of refugee women who spoke to their GP in English rated their spoken English as either very well or well. Again there were some women that communicated with their GPs in English even though they reported having only some English (n=15; 19.5%).

7.4.3 Emergency Department Attendance

The majority of women (64.8%; n= 105) had not attended an emergency department since arriving in Australia. The percentage of women of the women who had attended an emergency department once was 24.1% (n=39), while 9.3% (n=15) of the women had attended twice. Two women reported attending an emergency department three times (1.2%) since arriving in Australia and one woman (a humanitarian entrant) reported attending an emergency department six times since arriving in Australia. Reasons that women gave for attending an Emergency Department included bleeding, high blood pressure during pregnancy, referral by their GP, injuries as the result of domestic violence, cutting a finger badly or being involved in a car accident. Only two women reported going to an Emergency Department because they didn't have a GP. Eleven women reported attending an Emergency Department because their GP was closed because it was the weekend, after hours or a holiday. Only one woman reported attending an Emergency Department as she was unable to get an appointment with a GP when needed.

Refugee Women

Similarly, the majority of refugee respondents (69.6%) had not attended an emergency department since arriving in Australia and of those that had, the majority did so only once (n=21). Emergency department visits by refugee women were mostly for appropriate emergency care. Two women reported being sent by their GP to their local Emergency Department. Only seven refugee women reported attending an emergency department because their GP was closed as it was Sunday or the middle of the night.

7.4.4 Self-Reported Medication Usage

Service providers interviewed in the qualitative phase of the project suggested newly arrived women frequently used medication for depression, anxiety and sleep. This concurs with what is reported in the literature (Dimopoulos 1999). For these reasons, women responding to the questionnaire were specifically asked about their use of these types of medication. As Table 7.9 shows, only a few women reported taking prescribed medication for depression, anxiety and sleep, but larger numbers reported taking vitamins, herbs or over the counter medications for these conditions. A number of women had been prescribed medication for depression or anxiety by their

doctor but reported that they had not filled the prescription or not taken the tablets for fear of becoming addicted to them.

Table 7.9 Medications Used for Depression, Anxiety or Sleep

Item Taken	Number	Percentage
Taken vitamins or herbs for sadness, memory, stress or worry (n=260)	44	16.9
Taken medication prescribed by a doctor for sadness, memory, stress or worry (n=259)	7	2.7
Taken medications from chemist or herbalist to help sleep (n=257)	14	5.4
Taken medication prescribed by a doctor to help sleep (n=257)	7	2.7
Taken other medications for mental health (n=256)	2	0.8

Of the refugee women who responded to these questions, very few women were taking medication for depression, anxiety or sleep. Nine refugee women reported taking vitamins or herbs for sadness, stress or worry. Only two refugee women reported taking prescribed medication for these same conditions. One refugee woman reported using an over-the-counter drug to help with sleep while the other three women reported using prescribed medication for sleep. Only one refugee woman reported taking prescribed medication for an unspecified mental health condition.

7.4.5 Other Medication

In the questionnaire 13.8% (n=37) of women reported that since coming to Australia they had taken herbs, drinks or medicines to help them lose weight. Of these women, fourteen women were humanitarian entrants.

Fifteen women (5.6%) reported sharing someone else's prescription medication since coming to Australia. Another five women (1.9%), two of whom were refugees, reported sharing medication but were unsure if the medication was prescription medication or not.

7.5 Newly Arrived Women's Choices for Information and Activities

As explained in the methodology chapter, participants responding to the questionnaire were asked to choose their five most important topics from a group of

ten cards. Women were also given the opportunity to suggest other topics. These suggestions were written on an index card and put on to the table or board that was being used to sort the topics. Women were then asked to rank their choices from 1 (the most important to them) to 5 (the least important). Table 7.10 shows the topics women chose and their importance. When women nominated their own topic these were given first preference by over 47% of the women. However, many women found that their choices were covered by the existing topics and did not nominate additional issues for information and/or support. Topics or issues women nominated included: sporting activities for women, women's groups for newly arrived women, opportunities to meet people especially from the same ethnic background, youth groups, information on the health system, driving lessons, information on post traumatic stress disorder and opportunities to learn about WHS and other women's health centres. This latter choice came up a number of times as women's health centres were seen as a point of contact and referral that could assist women in the case of some unforeseen event. One respondent described this as:

> *"Let them (new arrivals) know that there is a women's health service/ clinic in their neighbourhood, to assure them that they have someone to talk to or see in any need".*

Choices women made in the questionnaire on issues of information and/or support were examined for differences in age, spoken English ability, migration category, level of education, patterns in country of birth, and income. Given the large number of different countries of birth of respondents, only broad trends and for some countries can be reported as the sample for each country is very small.

Table 7.10 Newly Arrived Women's Choices for Information and Activities

Information Wanted	Percentage of all women who chose this topic N=268	Percentage of refugee women who chose this topic N=109
How to get work; Information on TAFE and University courses to get qualifications to get work	79.1	78.9
Women's health such as pap smears, breast checks, family planning and contraception	75.4	73.4
Exercise classes for women	66.4	72.5
Eating better on a budget	59.7	60.6
How to get a GP and how to talk to a GP to get the health care you need	53.0	41.3
When you feel very sad, stressed, worried and depressed and support for women who feel like this	44.0	33.9
Family violence, what it is and where to go for help	36.2	46.8
When you feel very sad, stressed, and depressed or very anxious after having a baby and support for women who feel like this	27.2	22.0
Illegal drugs especially for parents	16.8	22.0
Support for women whose husbands or children are drinking too much alcohol	14.9	14.7

Over 50% of the women respondents who wanted women-only exercise classes were under thirty while another 27.8% of women in their thirties wanted women only exercise classes. Exercise classes were particularly requested from respondents from Ghana, Singapore, Afghanistan, Eritrea, Peru, and Liberia.

Women who selected information on eating better on a budget as an issue of importance were more likely to be aged in their twenties and thirties. (χ^2 = 12.690; df =4; p =.013). Unsurprisingly, women on lower incomes were more likely to want this information (χ^2 =10.424; df = 3; p=.015). This choice was particular requested from women from Afghanistan, Singapore and Malaysia.

There were no significant demographic differences in women who considered information on women's health as an issue of importance. However, high

percentages of women from Eritrea, Peru, Singapore, India and Russia wanted information on women's health.

University educated respondents were more likely to want information and support about depression than women from other educational backgrounds, as were women from non-refugee backgrounds (Table 7.11). Unsurprisingly, women wanting information and support with postnatal depression were more likely to be in their twenties and thirties (when women are often having children) than women in other age groups. Four out of the five Romanian women in the survey wanted information and support with post natal depression. Non refugee women appeared slightly more likely to want information on women's health (χ^2 = 3.898, df=1, p=.048)

Table 7.11 Women Wanting Assistance with Depression*

	Not Choosing Assistance with Depression		Wanting Assistance with Depression		Chi-Square Tests
	N	**(%)**	N	%	
Education Level					
Primary School	18	(60.0)	12	(40.0)	χ^2 =11.153, df=3; p=.011
Year 10	18	(69.2)	8	(30.8)	
Completed High School or Other	69	(63.9)	39	(36.1)	
University	39	(42.9)	52	(57.1)	
Total	144		111		
Refugee versus Other Migration Categories					
Refugee	72	(66.1)	37	(33.9)	χ^2 = 12.035; df = 1;p=.001
Non-refugee	63	(44.1)	80	(55.9)	
Total	135		117		

*Numbers do not equal the total number of questionnaire respondents as this section of the questionnaire women ranked a number of choices. Some women did not choose this topic or did not rank five choices.

7.5.1 Information and Activities Requested by Refugee Women

The top three listed activities chosen by refugee women were the same as for women overall namely 1) information on how to get work or how to get qualifications

leading to work through TAFE or university courses, 2) information on women's health such as pap smears, breast checks, and family planning and 3) exercise classes. Refugee women were less likely to select wanting information on how to get a GP and how to talk to a GP than non-refugee women (χ^2 = 12.832, df 1, p=.000).

There were no statistically significant differences between refugee women and non-refugee women about their want for further information and/or support in the following areas: employment and re-qualification, family violence, illegal drugs (for parents), eating better on a budget, support for women whose husbands or children are drinking too much alcohol and exercise classes.

7.6 Providing Information to Newly Arrived Women

The questionnaire was designed to explore the best methods of providing information to newly arrived women. Methods of giving information that were often suggested in the focus groups and interviews were included in the questionnaire and respondents were asked to rate how useful these methods were. These methods included information sessions or talks, articles in the local community newspapers, information on the web, talks or information in English classes or bridging courses, information on ethnic radio, and pamphlets and information sheets. Suggestions for other ways of receiving information were also sought. Tables 7.12 and 7.13 describe the results obtained from the questionnaire.

Table 7.12 Rating of Methods of Providing Newly Arrived Women with Information: All Questionnaire Respondents

All Questionnaire Respondents (%)				
	Very Useful	Useful	Not Useful	Dont' Know/ Refused
Information on the Web (n=249)	47.8	25.7	18.9	7.6
Talks / Information Sessions (n=251)	41.0	41.8	9.6	7.6
Talks in English Classes (n=250)	39.6	38.0	10.4	12.0
Community Newspapers (n=249)	34.5	36.9	22.5	6.0
Ethnic Radio (n=245)	14.7	27.3	33.1	24.9
Information Sheets/ Pamphlets (n=241)	30.3	45.2	15.8	8.7

Table 7.13 Rating of Methods of Providing Newly Arrived Women with Information: Refugee Women Only

Refugee Women Only (%)				
	Very Useful	Useful	Not Useful	Dont' Know/ Refused
Information on the Web (n=95)	34.7	26.3	32.6	6.3
Talks / Information Sessions (n=102)	44.1	43.1	9.8	2.9
Talks in English Classes (n=103)	41.7	51.5	2.9	3.9
Community Newspapers (n=99)	37.4	28.3	30.3	4.0
Ethnic Radio (n=100)	26.0	34.0	27.0	13.0
Information Sheets/ Pamphlets (n=92)	33.7	39.1	21.7	5.4

7.6.1 Information Sessions

Questionnaire respondents rated information sessions or talks as a good medium to obtain information (Tables 7.12 and 7.13). Information sessions in English classes or bridging courses also rated very highly with women respondents. Information

sessions not held in English classes were preferred on the weekend (Table 7.14). Sessions held on weekday mornings were nominated by relatively few women as a good time to meet. Just over 23% of the women (n= 60) said they would need child care to attend information session or activities. A slightly higher percentage of refugee women (just over 25%; n= 26) reported that they would need child care in order to attend sessions at their nominated time and day.

Table 7.14 Best Times for Information Sessions*

	All questionnaire respondents N=268		Refugee Women Only N=109	
	Number	**Percentage**	**Number**	**Percentage**
Saturday mornings	107	39.9	55	50.5
Saturday afternoon	63	23.5	21	19.3
Sunday afternoon	55	20.5	11	10.1
Weekday mornings	37	13.8	10	9.2

*Multiple responses allowed

7.6.2 Pamphlets and Information Sheets

Approximately 75% of respondents found pamphlets and information sheets either very useful (n=73) or useful (n=109). Many of the women commented that this written information was better in their own language. There were no significant differences between refugee and non-refugee women in their rating information sheets and pamphlets as "very useful".

7.6.3 Information on the Web

Nearly 74% of women in the survey found information on the web either very useful (n=119) or useful (n=64). Those who found web based information very useful came from a wide range of countries and had entered Australia in a diverse range of visa categories including humanitarian entrant. Women who found the web very useful ranged in age from 18 to 54 years and there were no significant differences between age groups. Women who reported reading English well or very well were likely to find receiving information on the web very useful or useful (χ^2 =51.501; df=4; p=.000).

7.6.4 Community Newspapers

Because so many women in the qualitative phase of the project suggested community newspapers were a good way to receive information, this option was included in the questionnaire. Obviously, English literacy is required for articles in the local paper to be useful. Newly arrived women who did not read English well did not find this medium useful compared to those who did read English well. (χ^2 = 49.053; df=4; p=.000). There were no significant differences between refugee and non-refugee women in their rating information articles in local community newspapers as "very useful".

7.6.5 Ethnic Radio

Forty two percent of participants found ethnic radio useful or very useful as a medium to get information. Participants gave a number of reasons why ethnic radio was difficult for them to access including not knowing which radio station broadcast their language based program. This may be the reason for high number of "don't know" responses to this question (Table 7.12). Other reasons given for difficulties in accessing ethnic radio included being unavailable to listen to the program at the time of the broadcast, and not having time to listen to the broadcast.

7.6.6 Other Suggestions

Women were asked to suggest other ways to get information out to newly arrived women. One of the most popular suggestions was using social networks such as family and friends to get information out to new arrivals. Friends, especially those in English classes, were a popular suggestion. Other women suggested giving information to ethnic community groups, women's groups and play groups. Other suggestions included giving information out on television programs, in information booklets and in information sheets, especially if these could be given out by DIAC. Final suggestions from women included giving information on arrival at the airport, or providing information in train and bus stations.

7.7 Discussion

Collecting ethnicity data using country of birth, migration category, nominated ethnicity of respondent, primary language spoken and religion yielded an interesting insight into women's often own complex migration histories and/ or those of their

families. For some women respondents their journey to Australia was a series of migrations. For example, one respondent was born in India, migrated to Africa and then migrated to Australia with her African born husband. Some of the complexities of participants' ethnic backgrounds would have been lost had only country of birth data been collected.

7.7.1 The Use of Interpreters and Bilingual Workers During the Project

During all phases of this project, both female interpreters and bilingual/ bicultural workers were used. Female interpreters were used during all phases of the project but particularly in the qualitative phase interviewing and conducting focus groups with community women. All interpreters used in the project were accessed through the Translating and Interpreting Service (TIS). Interpreting fees were paid for using the Interpreter Access Project run through the West Australian Network of Alcohol and Other Drug Agencies (WANADA). Some delays were experienced in getting interpreters for women for interviews due to the lack of a specific language interpreter being available at a time convenient to the woman. Other delays occurred because of the woman forgetting the appointment, the interpreter forgetting or being delayed by a previous appointment, and/ or young children or the woman herself becoming sick and necessitating the appointment to be rescheduled. Flexibility proved to be very important in order to complete the interviews.

The majority of interpreters kept within the interpreter guidelines as specified by the Language Services in Health Care - Policy Guidelines (1998) of the Department of Health in Western Australia and did not add their own interpretation to the women's answers and comments. However, there were some interpreters who interjected during the interview to tell me that some questions were not necessary. This most often happened around alcohol-related questions. For example, one interpreter said the questions around alcohol use were unnecessary for Muslim women or for women wearing a head scarf as these women do not drink alcohol. This occurred despite prefacing the questions with an explanation that all women participating in the survey needed to be asked the same questions for the sake of consistency. Some interpreters did not interpret using the first person, rather prefacing statements with

"she said" or referring to the client in the third person such as "her husband" instead of "my husband." (The reader may note such usage in some of the extracts of interviews and focus groups that appear in this document.)

7.7.2 Bilingual Students

In addition to interpreters, a number of bilingual workers were used in piloting the survey as well as conducting the survey itself. The first group of bilingual workers were students on placement at Womens Health Services who were doing either Certificate level studies or Diploma level studies in Communities Services at Technical and Further Education (TAFE) centres. The students were mature age students and primarily had come to Australia as humanitarian entrants. I trained the students to administer the surveys and then gave them a small number of surveys, usually five, to complete with women from their own communities. When the students had completed the small number of surveys they had been given, they were debriefed and any questions they had answered and any issues discussed. The students were then given the option of being given more surveys to complete with women from their community.

The feedback from this group of bilingual workers was that women in their communities liked doing the surveys. The students noted that it often took a great deal of time to do individual interviews as they had to make the appointment, get there either by driving or by public transport and then do the interview. Often the interviews were one to two hours because the women knew each other and there was often the cultural expectation of sharing food and drink and exchanging news before or after completing the survey. Some of the students interviewed in a group situation where women had gathered for a women's meeting or a party in someone's house or other venue. Some students used the group settings to arrange subsequent individual interview times later in the week while other students did the interviews in a group setting in a quiet space away from the main group. Students noted that women interviewed like this in a group setting could be quite distracted and that there needed to be enough room away from the children to do the interview.

7.7.3 Other Bilingual Workers: Overseas Trained Health Professionals

Another group of bilingual workers was recruited through a professional support group run by Womens Health Services. This group is for overseas trained doctors, nurses, and other health professionals who are permanent residents of Australia and are in the process of requalifying to work in their chosen profession in WA. The majority of the network members are either humanitarian entrants or spousal visa holders and face many barriers to re-qualification as a health worker. Women recruited through this network were doctors, nurses and/ or psychologists. The majority had many years of professional experience in their country prior to coming to Australia. The advantage of using these professionals was that they primarily required training in only how to administer the questionnaire as they already had a good grasp of concepts such as confidentiality and referral. I was more confident that this group of bilingual workers would refer if needed and would handle potential problematic situations better than the students who had only limited client related experience. Given the professional backgrounds of these workers, this group needed far less supervision and support than the student bilingual workers. Some of these workers were also doing post graduate studies themselves so it was useful for them to gain practical experience in surveys. These workers were employed casually on an hourly rate.

For many of the women recruited through this professional network, this was their first paid job in Australia. A great deal of time was spent explaining time sheets, mileage forms, superannuation, electronic payments, the difference between casual and part time work, and other aspects of the Australian employment system. Explaining the Australian employment system was in some cases far more time consuming than training the worker in how to administer the questionnaires and conducting the follow-up supervision!

7.7.4 Community Sector Bilingual Workers

Three bilingual workers were also used who were currently working in the social services area and had good community networks. Similar to the overseas trained health professionals, these workers had an excellent skill base upon which to draw to deal with any potential problematic situations as well as the skills and networks to refer appropriately should the need arise. However, these workers did not have the

time to interview as many women as they originally anticipated due to their heavy work and community commitments.

Overall, using multiple bilingual/ bicultural workers and students was the key to the success of the project. Having a number of different workers meant there was less opportunity for systematic selection bias as the workers were tapping into a broad range of newly arrived women. Training the workers and students, meeting them regularly to discuss issues and concerns, and giving out small numbers of questionnaires at a time and then checking them when they were handed in for potential problems were all strategies used to maintain the quality of the data through out the quantitative phase of the project. At the outset of the project, it was anticipated that many participants would be found through bilingual workers currently employed in the social services sector. However, this was not the case. The use of students and the overseas trained health professionals resulted in far more participants being contacted and completing the survey. The students were unpaid as they were on placement but required intensive supervision. The overseas trained health professionals were paid but required less supervision. The use of these professionals may be an option for other researchers doing cross-cultural work who need to maximize their budget to pay for experienced bilingual workers. Table 4.2 summarises the advantages and disadvantages of using the different types of bilingual workers and interpreters.

7.7.5 The Experience of Using Students and Overseas Trained Professionals

Positives and Negatives for Students of Working Within Their Own Ethnic Community

As part of the experience of doing the interviews, students were asked to reflect on the positive and negative aspects of being involved in a research project such as this. There were regular group discussion sessions with the students covering a wide range of issues such as difficulties in recruiting potential participants, ways of avoiding social desirability bias, and the difficulties of working with members of their own ethnic community. Students also had opportunities to discuss individually their experiences of the interviews. The bilingual workers and students often recruited through their own networks of family, friends, ethnic community members and fellow students who met the selection criteria. The interviewers at times felt that

participants might have been more honest with a stranger as there was less pressure to give a socially acceptable response. However, when discussing social desirability bias in the debriefing sessions, the students felt that on the whole, the women interviewed gave more honest answers with them than they would have done with a stranger as participants may have felt the necessity to preserve the reputation of the group, for example, women engaging in deviant behaviour such as drinking alcohol. In addition, an interviewer from outside a community may not have been able to recruit the woman in the first place to participate in the study.

The students commented that there was a high expectation on them to "fix the system" in which many new arrivals and their families were struggling, often in a much quicker time frame for dealing with issues than the research project had. The community women wanted almost an immediate response to the issues they raised. The students also had to deal with criticism that the survey was largely about alcohol and drug issues and consumption of drugs or alcohol is very much frowned upon by many new arrival groups.

Not all students had good community networks. One student had just come to Australia and knew very few people. She was also very shy and softly spoken so although she trained with the other students she didn't complete any interviews. She didn't know anyone who fitted the selection criteria of the research project and found asking the questions difficult. However, she was interested in the alcohol and drug area due to a family history of drug use and ended up joining the Reference Group as a member of the group.

The feedback from the students showed that the interviews and the experiences they provided were positive and beneficial placement experiences. The interviews highlighted issues that had been discussed previously in the students' course work such as confidentiality, the role of the worker, maintaining boundaries, dealing with ethical issues, and self care. Most students had very good community networks and were able to complete a number of questionnaires. Information was also obtained from women that would not normally have been involved in such a project using the students' networks. The students felt they were doing something useful for

themselves and their communities and that the experience of interviewing was a practical application of their chosen field of study.

From an organisational perspective the student placements were extremely time consuming to supervise and organise. The students needed to have other tasks to do when they were not arranging interviews, interviewing or debriefing. In a strict academic setting this may have been problematic. However, in a not-for profit organisation there are always tasks that need to be done. As an agency, WHS has a good track record of providing student placements, especially for students who have English as a second language who may require extra support and encouragement in order to complete their placement hours. Looking at increasing the opportunities for students to gain exposure and experience in dealing with alcohol and drug issues can assist CaLD women to gain knowledge and experience that could be both used informally and formally within their own communities and could also be used to assist other AOD research projects.

Table 7.15 Positives and Negatives of Different Types of Bi-lingual/ Bicultural Workers Used for This Study

Type of Worker	Negatives	Positives
Interpreters through a professional interpreting service	Expensive Would not recruit women to be interviewed Difficult to get interpreters in some languages Some problems with interpreters answering for clients	Level of fluency in English and the community language had been checked Well organised interpreting service that made booking interpreters easy
Bi-lingual Students	Required intense supervision Limited professional experience on which to draw if client became distressed Potential for social desirability bias as most women surveyed knew students personally Level of language proficiency in community language was uncertain	Gave students experience in their field of study Often had good community networks and found women to interview Students often spoke community languages where there was limited access to interpreters
Overseas Trained Health Professionals	Required some supervision Required intensive assistance with aspects of the Australian employment system Potential for social desirability bias as most women surveyed knew professionals personally	Level of fluency in community language was recognised by an overseas university Good understanding of confidentiality, boundaries, referral processes Good professional experience on which to draw if client became distressed Often had experience in research or were about to undertake research, so good understanding of research protocols Good community networks and found women to interview
Community Sector Bilingual Workers	Were exceptionally busy people so difficult to find time to interview new arrivals Potential for social desirability bias as most women surveyed knew workers	Good understanding of confidentiality, boundaries, referral processes Good professional experience on which to draw if client became distressed Good community networks Required minimal supervision

7.7.6 Tobacco

The results of the survey data confirm the findings of the focus groups and interviews with service providers and community women that tobacco use amongst newly arrived women is low. In Australia there are increasing restrictions on smoking in public places as well as increasingly stronger cultural prohibitions against smoking. These newer attitudes along with strong educational messages about the risk of smoking may influence newly arrived women who are smokers to give up and to influence women who are not smokers to stay non-smokers. As the vast majority of smokers (89.5%; n= 17) reported speaking English very well or well, read English very well or well (84.2%; n=16) and had a high school education or higher, health messages about strategies to stop smoking may not need to be translated into community languages as a priority for newly arrived women. Rather, existing messages for women may just need to be made more inclusive to encompass women of different cultural backgrounds. This strategy would need further exploration as the number of women who reported smoking in this study is small and a larger number of smokers need to be surveyed. However, translations or other types of information in language are still likely be needed for non-smokers who have family and friends that smoke given that many of these women have poor English literacy.

The use of tobacco as a coping mechanism when a woman is stressed or worried is consistent with the findings from the interviews and focus groups with service providers and newly arrived women as well as with the published literature in general and with more migrant specific studies (Ministerial Council on Drug Strategy 2005, Trotter 1997). Service providers working with newly arrived women need to be encouraged to ask their clients about their smoking habits, especially if the women are experiencing a stressful event(s) such as domestic violence. Service providers have a role in supporting women who are using cigarettes as a coping mechanism and helping them cut down or quit when it is appropriate.

Woman smokers who come to Australia often quit or cut down after their arrival. Many service providers cited the cost of cigarettes in Australia compared to other countries in the world as a reason why people cut down or quit after arriving in Australia. However, women in the focus groups and interviews stated that they had learned more about the dangers of smoking since coming to Australia and concerns

about their health, the health of the children or unborn child had been the motivating factor to reduce their tobacco consumption or quit smoking altogether. This finding is supported by the results of the questionnaire which found these same motivating factors were the most common reasons given by women for stopping or reducing their smoking. Stopping smoking during pregnancy is not unique to newly arrived women, and is a relatively common occurrence amongst women from a wide range of ethnic backgrounds and socio-economic status (Torrent et al. 2004, Crittenden et al. 2007, Pletsch & Kratz 2004). Service providers could use the antenatal period as well as the post-partum period to provide information and support to newly arrived women smokers, even if they had quit during their pregnancy, as the literature does indicate that there is a high relapse rate after the birth of the child (Torrent et al. 2004, Pletsch & Kratz 2004).

7.7.7 Alcohol

New arrivals come with their own traditions and values about alcohol. Some of the beliefs and customs are similar to Australia's, while others are quite different. The drinking patterns and behaviours of newly arrived migrants and refugees often become a mix of old and new patterns and behaviours as new arrivals negotiate Australia's drinking culture. Cultural and religious values prohibiting alcohol consumption and/ or negative attitudes towards women consuming alcohol meant that the majority of the women (76.1%) participating in the survey did not drink alcohol confirming the results of the focus groups and interviews with service providers and newly arrived women. Other studies of migrant alcohol use have also reported abstinence or low drinking levels amongst women compared to the mainstream population and subsequent generations (Ames & Rebhun 1996, Bradby & Williams 2006, Caetano 1994, Gilbert 1991). Some of these non-drinking women encountered peer pressure to drink due to Australian norms around alcohol use. Of the women who did drink alcohol, many of these women had experienced changes in their drinking behaviours and patterns after arriving in Australia again confirming the results of the focus groups and interviews with service providers and newly arrived women. There is little academic health literature that specifically explores Australia's alcohol culture and its impact on new arrivals and this is an area of future research.

For the vast majority of women these changes and their current drinking levels posed no short or long term risk to women's health. However, for a small number of women their alcohol consumption was risky or at high risk for their short and/ or long term health. An increase in alcohol consumption and problematic use by a few does not imply a serious alcohol problem by a group. However, as the total alcohol consumption of a given population increases, there is a greater risk for more problematic drinking within that group (Ames & Rebhun 1996). Cultural and religious beliefs may offer a protective factor against alcohol problems. However, these factors do not give total protection against problematic alcohol use. Other known risk factors such as the impact of poverty, discrimination, targeted alcohol advertising, and alcohol availability in a given area may be more powerful than the protective factors offered by cultural and religious beliefs (Ames & Rebhun 1996). Thus, newly arrived women should not be ignored but rather be provided with appropriate information regarding alcohol consumption.

Family Violence

The results of the survey confirmed the views of service providers and newly arrived women that alcohol use by partners often played a role in domestic violence but not necessarily caused family violence. This also concurs with the literature (Leonard 2001). Approximately 17% of the women responding to the questionnaire reported incidents of verbal abuse and just over 21% of women had been put in fear by some one who had been drinking alcohol or taking drugs. Incidents of physical abuse were lower at 4.3% and sexual assault at 5.2%. However, members of the CALD Consumer Reference Group felt that there was a significant under reporting of these incidents and my experience at WHS as a service provider also suggests that the figures of abuse and domestic violence could be higher. The question around being forced to have sex was a particularly difficult question to ask and many interviewers including myself skipped this question on occasion particularly if there was no privacy in the interview area. Although the questionnaire gave examples of verbal abuse (insulted you, yelled or sworn at you) and physical abuse (hit you, pushed you), there are differences between cultures and individuals in what they regard as abuse. A good example of these differences in understanding occurred during the

time of the research project when a client from the domestic violence advocacy program at WHS was interviewed. When asked if her husband had ever physically abused her she replied no. After further discussion it transpired that the husband had never hit her and this was the client's idea of physical abuse. However, her husband had on numerous occasions thrown her to the floor or across the room.

Alcohol Related Violence by Strangers

Issues related to AOD use by others impacting on the safety of ethnic women in public places were not often reported in the literature. The notable exceptions to this were the project report by Working Women's Health and Women's Health in the North (2000) and the study by Ng, Bartu & Sang (1999). Incidents of abuse and being put in fear by a stranger under the influence of alcohol and other drugs were not mentioned by service providers as an issue. Service providers and the literature mainly refer to these types of incidents only in the context of domestic violence. Forty six women reported one or more incidents by a stranger of verbal abuse, physical abuse, being put in fear, or being forced to have sex when they didn't want. Questionnaire respondents gave examples of often quite traumatic events that other people might well have reported to the police. Some of these incidents the woman regarded as "verbal abuse" as the perpetrator(s) did not touch the woman. For example, one woman was waiting in her car with her baby in the back seat while her husband went into a shop. The car was surrounded by a group of youths under the influence of alcohol. The youths proceeded to shake the car back and forth, banging on windows and doors, yelling insults, telling her to take off her headscarf and clothes until the husband came out of the shop and chased them off. She did not report the incident to the police. Other women also described incidents that had clearly impacted on their confidence and feelings of safety. They appeared to lack strategies to deal with these incidents either at the time or afterwards, sometimes because uncertainty regarding what they should or could do or who they could ask for assistance. Other times women were uncertain of what the person was saying to them because they were still learning English. Asking the person to repeat their request was often mistaken as wanting to engage in further conversation or being willing to give money.

Refugee women did not experience more verbal abuse, physical abuse, sexual assault or fear from someone who had been drinking alcohol or taking drugs than other newly arrived women or in comparison to women in the National Drug Strategy Household survey (2005). However, given the reluctance of service providers to talk about alcohol and drug issues with CaLD clients, newly arrived refugee women may lack strategies to deal with such incidents in their new country and may feel particular vulnerable or more fearful after such incidents given many women's past traumatic histories. Similar to other questionnaire respondents who were interviewed, refugee women did talk about quite serious incidents that had impacted on the way they live their lives. For example, one woman, who did not want to describe in detail the particular incident that she had experienced to the interviewer, felt it was no longer safe to walk for exercise in her neighbourhood. For this reason, this woman was particularly keen for a group exercise class in a safer environment. Another woman told of a road rage incident she experienced where her car was rammed a number of times by another driver who shouted verbal abuse at her before speeding away. After this incident she stopped driving for some time. Although she had now resumed driving, she no longer wears a hijab as she feels this makes her too conspicuous and vulnerable to attack. There appears to be a need for workers to provide refugee women with strategies to deal with such incidents as well as discussing prevention strategies with their clients.

Support for Women whose Husbands or Children are Drinking too Much Alcohol

Forty women (14.9%) included support for women whose husbands or children are drinking too much alcohol as one of their priority areas for support and information. Although a relatively small number, these women may find it difficult to access services to get the information and/ or support they require. Although the majority of the surveys were completed by interview, some respondents insisted on filling out the survey form themselves and using the interviewer only if they had a question about the survey itself, for example, what section to go to next. Interviewers noted when participants completed the questionnaires themselves in the comments section of the survey instrument. Interestingly some of the women who filled in the survey themselves disclosed family violence and alcohol abuse by their partner, information that might not have been forthcoming if they had been asked these questions in an

interview situation. The questionnaire did not investigate the drinking habits of the partners or children of the woman respondents and how these had changed since coming to Australia.

7.7.8 Illicit Drugs

The relatively low priority given by respondents to wanting illicit drug information needs to be seen in context with other issues newly arrived women are dealing with such as employment, re-qualification or recognition of existing qualification, finding a GP, and depression to name but a few. Nevertheless, the fact that information on illicit drugs appeared in the top ten items of requested information and activities reflects substantial concern on the part of the respondents given the many other issues facing new arrivals.

Overall a substantial proportion of respondents (41%) did not feel confident enough to talk to their children about illicit drugs. This is a similar percentage of female respondents to that reported by Bertram and colleagues (2003) in their study of five groups of non-English speaking parents. Of the refugee respondents in this project, only 16% of refugee women felt confident enough to talk to their children about illicit drugs. This later figure is in keeping with findings reported by Rowland, Toumbourou & Stevens (2003) in that practitioners surveyed in their study believed that more education was needed for both younger members and older members of CaLD communities around alcohol and drug use. Helping parents to communicate more effectively with young people and manage issues around drug use was a suggested strategy. The low percentage of refugee women feeling confident to talk to their children about illicit drugs is concerning as refugee youth may be at considerable risk for problematic drug and or alcohol use due to traumatic migration histories, interrupted schooling, conflict with parents, and risk of homelessness due to family conflict (Rowland, Toumbourou & Stevens 2003, Sowey 2005).

7.7.9 Primary Care

The majority of women found it easy to find a GP. However, over 18% of the women found it difficult or very difficult to find a GP and other women still did not have a GP at the time of the survey. The difficulties women had in finding a GP concurred with the views of newly arrived women attending the focus groups and

interviews. However, service providers did not mention this as an issue and this issue is rarely mentioned in the literature. That refugee women were less likely to select wanting information on how to get a GP is most likely a reflection of the level of service provided by community health nurses to humanitarian entrants. These nurses ensure that newly arrived refugees have a GP and know how to make an appointment with their GP, and often accompany refugee clients on their first and if necessary subsequent appointments to assist communication between newly arrived families and their new GP. However, no such service is available to women from other migration categories.

Concerns by service providers in the focus groups and interviews of women "doctor shopping" are not supported by the results of the survey. The majority of the women (71%) reported to have attended one or two general practices since coming to Perth. Only a small percentage of women (8.4%; n=19) reported attending four or more different practices with the highest number being six different practices. Considering the transitory nature of new arrivals with over 50% of the respondents reporting moving once or twice since their arrival in Australia, the respondents appear to be quite loyal to their GPs. This is in spite of newly arrived women often having to negotiate a very different primary care system where it would not be surprising for women to try several GPs before finding one with whom they could establish a good rapport and feel comfortable .

There was a small percentage (n=27; 13.6%) of women who spoke to their GPs in English who said they only spoke some English. These women who reported speaking "some" English often had very poor comprehension and fluency, well below the levels needed to comprehend medical explanations and instructions. Some of these women, for example, would not have been able to participate in the project without an interpreter or bilingual worker. Although the numbers were not large, the use of children to provide medical translation for parents is not appropriate for a myriad of ethical and practical reasons. A free national telephone interpreter service for GPs exists through the Translating and Interpreting Service (TIS) but educating and providing incentives for GPs to use such services is necessary.

Eleven women reported attending an Emergency Department because their GP was closed because it was the weekend, at night, or a holiday. This is a small proportion of the 268 women surveyed and suggests that there is not a large issue with emergency departments being used inappropriately for primary care despite concerns by service providers that this was happening. The assistance of community nurses in helping refugee clients to find a suitable GP early in their settlement no doubt contributes to appropriate use of Emergency Department facilities. A number of women in feedback sessions reported that they were unfamiliar with after hours GP services and other services such as Health Direct (a free telephone triage service offered by the West Australian Department of Health). Knowledge of such services amongst newly arrived women could help further reduce the load on Emergency Department facilities. As a result of the information provided, it was recommended that WHS and other service providers working with newly arrived women provide information sessions on the WA health system, how to find a GP, after hours services and other related information for newly-arrived women. WHS currently maintains a GP referral list (updated yearly) for women who are having difficulty in finding an appropriate GP. Again, a recommendation of the research was that this list should be cross referenced with the list of GPs who consult in other languages, and GPs who are "Youth Friendly" and/ or are open to working with AOD issues. Such information could be used to help women find an appropriate GP and be a valuable resource for the information sessions about the WA health system.

7.7.10 Medication Use

An unexpected finding was the low rate of women who reported sharing medication. Many service providers had spoken about their clients sharing medication with family members and friends and this has also been noted in literature (Bolton, Hammoud & Leung 2002). There are a number of explanations for the survey responses differing from perceptions of service providers. The rate of sharing medication was only established by self-report. As the vast majority of the questionnaires were completed by interview, there may have been a bias by women to report on what they saw was the "correct" answer for example, not sharing medication to the interviewer. In addition, service providers tend to work with large numbers of people from very different migration categories, with varying lengths of residency and from a wide variety of cultural and socio-economic backgrounds.

Problems that clients experience are often remembered, however, non-problematic situations are not. Thus, service providers may be remembering and reporting on a small number of problematic situations and not the usual experience. Thus, while sharing medication does occur, in this sample of women it is at a low level and appears to be more common for certain types of medication such as inhalers for asthma.

Given the frequency of which the use of anti-depressant medication was mentioned by service providers and in some of the literature (Bolton, Hammoud & Leung 2002, Dimopoulos 1999, Griffiths, Qian & Procter 2005), it is surprising that only fourteen women reported taking prescribed medication for depression, anxiety or sleep. The low rate of prescribed anti-depression, anti-anxiety and sleep medication amongst this particular group was unexpected. However, this may be due to a response bias as women who were highly anxious or depressed may be unlikely to take part in a study or may not have come to social groups where interviewers often recruited participants. A desirability bias may have also influenced these results as women who were taking such medications may have been reluctant to disclose such information because of the stigma attached to mental health issues. Another factor influencing the reported low rate of prescribed medication use may be the length of time spent in Australia. The literature reports quite high use of benzodiazepines amongst some migrant and refugee groups (Dimopoulos 1999). However, the literature does not mention the length of time women have been in the country before benzodiazepine use starts and then becomes problematic. It could be that problematic use starts after the new arrival period (thus not reported by women in this study) or that benzodiazepines are prescribed less today than in the recent past. The number of women taking over-the-counter medication, herbs or vitamins for depression, anxiety and sleep was substantially higher than those taking prescribed medication for the same conditions. One bilingual interviewer reported that some of the Asian women she interviewed were taking cold and flu tablets to help them sleep, a medication that was not specifically asked about in the survey. Further exploration is necessary into this use of over-the-counter medications.

7.7.11 Priority Areas for Information and Support

The choices women nominated for their priority areas for information and support were interesting. The process of ranking a number of options or choices has been found to elicit honest responses from participants and to be easy to explain, administer and analyse in other studies (Bauer 1995). Although subjective, rank ordering does require respondents to comparatively judge a number of options and make a decision (Bauer 1995). The choices that women made regarding areas of support and information through the ranking process, therefore, has validity (Bauer 1995). In the feedback session for service providers some workers expressed the opinion that topics such as women's health and domestic violence have been done "again and again". However, women responding to the questionnaire indicated that there is a need for such information. Information is best accessed when it is relevant for a person. Thus, some information will need to be repeated regularly to be available as women's circumstances change or as new women arrive in Perth. A cause of concern is the fact that more than one third of the women responding to the survey indicated that they wanted information and support on family violence.

The demographics of newly arrived women who wanted information and support with depression concurred with other studies (Shemirani & O'Connor 2006). Professional women with university education who had established careers in their own country and arrive in their late thirties and forties often find it very difficult to get their qualifications recognised in the host country. These women are often told they must undertake lengthy re-qualifying procedures or "start again". In the meantime, they are often unemployed or engage in work far below their qualification levels. This unemployment and underemployment has been shown to impact on self-esteem and can lead to psychological problems such as anxiety and depression (Bartely, Ferrie & Montgomery 1999).

The statistically significant difference between refugee and non-refugee women in wanting information and support regarding depression and post natal depression is interesting. Considering the traumatic events that many refugee women have experienced, it is somewhat surprising that refugee women rated information on depression seventh on their list of requested information and services and were less likely to select this topic than non-refugee women. This could be a linguistic problem

in the questionnaire itself with some participants being unsure of what was being referred to. Thus, some women may not have selected this option as they were unsure of the meaning. However, the process of the questionnaire development took care to describe depression in terms that appear to carry well across cultures such as "stress", "very sad" and "anxious" as well as using the word "depression" (Tilbury 2007). The selection and desirability biases described above could have also influenced the results or it may be that women who have finally been granted asylum in a new country feel even more optimistic about their future as those who migrate for other reasons.

A surprising finding was the high level of interest in women's only exercise classes by women participating in the focus groups, interviews and questionnaire. As a potential intervention that provides information and support to newly arrived women, exercise classes for women only holds great promise. Exercise is known to help reduce feelings of depression, provides social interaction and opportunities to meet new people, is a socially acceptable activity and offers an ideal opportunity to provide information around a number of health and social issues.

7.7.12 How Newly Arrived Women Prefer to Access Information

Given the diversity of education levels, English language ability, and life circumstances there is no one medium that will suit all newly arrived women. Like any other group of people, some women will prefer one means of accessing information over another. Service providers need to keep this in mind when planning service delivery as there is a tendency to use the same methods again and again to disseminate information such as ethnic radio.

There is also an expectation that men sponsoring female relatives, fiancés, or wives to Australia will orientate these women to the health system. Men notoriously have low rates of access to primary and preventive health care and it is unrealistic to anticipate that they will provide adequate orientation to the health system for newly arrived partners or female relatives. In particular, sponsoring men are unlikely to be proactive in providing information related to prevention in general, and in particularly prevention related to women's health issues.

The preliminary results of the project were surprising to many service providers who attended feedback sessions. Service providers were particularly surprised at the poor rating of ethnic radio and the high rating of web based information. However, the results of the survey concurred with the results of the focus groups and interviews with newly arrived women in this regard. The advantage of web based information is its accessibility at the time when women are available and that it has often been translated into community languages. Web based information also tends to be written less formally often with information appearing in a few short paragraphs per page, making it less daunting to read. The World Wide Web is rarely considered as a medium to provide information to refugee women. However, information via the web was rated by over one third of refugee women as a very useful way to receive information. In comparison, ethnic radio was rated as very useful by 26% of refugee women. For these reasons, it is recommended that alcohol and other drug information as well as information on other issues raised by the project be put on the WHS website and on the websites of other service providers working with newly arrived women. These websites could provide links to translated information or provide information in a more visual format for women with limited literacy. This does not mean that service providers should stop using ethnic radio to reach refugee women but rather expand the repertoire of media to include other mediums such as the web and community newspapers.

The usefulness of community talks as a medium to give AOD information to migrant and refugee women has been noted by other service providers (Dimopoulos 1999). Given the high percentage of women who reported that they find health talks very useful or useful as a medium to gain health information, it is recommended that WHS and similar agencies continues to provide health talks to community groups especially those who are newly arrived or who have a high proportion of ethnic women in their membership. Given the stigma related to alcohol and drug issues, advertising a community talk solely on the issues around alcohol and drugs is unlikely to result in it being well attended. A more successful strategy may be to include AOD information in talks about stress, pregnancy and parenting, parenting teenagers, and/ or in general introductory sessions for women when they first arrive in WA. Falls prevention talks also offer an excellent medium to discuss alcohol and prescription drug issues with older CaLD women as training packages for facilitators

already exist that cover these topics. However, the efficacy of AOD talks to community groups over other mediums needs to be further explored especially in terms of whether there is an increase in knowledge leading to changes in attitudes and behaviours.

Service providers may wish to take note that a high percentage of women may not need child care if information sessions were held at the women's preferred time and day. Service providers often struggle with the monetary cost of child care on a tight budget and appropriately scheduling information sessions may resolve this issue as many women can utilise their own support networks for child care.

Health service providers need to work more closely with settlement services to provide translated health information on a range of topics. In turn settlement services need to display translated health information as their services may be the only place women can access such information. Given the feedback from service providers working with new arrivals that they lack the time to find alcohol and drug information for clients, AOD service providers could provide translated health information to these services. Translated health information and other resources on alcohol and drug issues do exist in many languages. However, these resources are poorly accessed by community members as they are often difficult to find on the web, women may often have low computer literacy and/ or the resources are not displayed or given out in venues where women go. Providing such information to women at venues where women gather is not expensive but does require staffing hours to gather the resources, check the resources for accuracy and currency and provide sufficient copies for groups. During the course of this research many different centres were utilised to conduct focus groups and interview women. The vast majority of these sites had no translated health information displayed or available for women accessing their services. A good example of health information not reaching its intended audience was a comment made by an Arabic speaking woman who had been in Australia for five years, and had been regularly attending a settlement support service to access English classes, information sessions, and other services.

> *"… such information some times they can find but it's in English and that is a major problem. Is it possible such information … important information to be translated into Arabic?"*
>
> Iraqi woman through an interpreter
>
> NW 52

Unlike other new arrival languages, information in Arabic on a wide variety of health topics is readily available yet this woman had apparently never had the opportunity to access this information.

To overcome this barrier, agencies like WHS may wish to consider providing translated AOD information sheets and pamphlets directly to key agencies, English language centres or work sites. Students on placement and/ or volunteers could be used in the time consuming task of gathering and packaging the information in appropriate languages for other agencies.

7.8 Summary

This chapter examines the issues and concerns about alcohol and other drug issues amongst newly arrived women as gathered from the questionnaires. This phase of the project was particularly important to see how common the issues raised in the focus groups and interviews were amongst a broader cross section of newly arrived women. Some of the more interesting points to come out of the questionnaire phase were the use of tobacco as coping mechanisms for some women when stressed or worried and the fact that a strong motivating factor to quit or cut down on tobacco use was to improve women's own health, the health of their children or unborn child. The level of abuse and being put in fear by some one who had been drinking alcohol or taking drugs was a surprise to many service providers with whom the results were discussed. Similarly the high level of interest in women's only exercise classes was surprising to many workers. Although the surprise of some service providers about the findings of the study may indicate institutionalised biases and stereotypes by service providers, it is more likely a reflection of funding arrangements. For many service providers their work with new arrivals is focussed on very specific issues pre-determined by their funders. Service providers are not encouraged by their funders to

extend their questions or service provision beyond these pre-determined issues. Unfortunately, this can result in gaps in service provision.

Expanding the repertoire of ways to disseminate information to newly arrived women to include less traditional mediums such as web based information, community newspapers, and health information as part of English classes was also supported by the findings of the questionnaire. The next chapter examines how information from all phases of the project was used to develop practical strategies for addressing the issues that had been raised.

Chapter Eight

Outcomes of the Project and Future Areas of Research

This research project from the onset was intended to produce findings that could be applied to service provision at WHS but also has wider applicability for service providers elsewhere around programs supporting CaLD women. The professional doctorate approach worked well in this regard as the project had come from questions WHS staff had about working with newly arrived women and many of the findings of the project have helped inform work practices and service delivery at WHS and other agencies. This chapter provides an overview of three of the main outcomes of the project.

8.1 Outcome One: Older Migrants and Alcohol Related Issues

8.1.1 Background

As part of the process of recruiting participants for this research project a number of well-established ethnic community groups were contacted. It was hoped that these more established community groups would know of newly arrived women who might be interested in participating in the study. Although this method of recruitment was not particularly successful, it established contact with key women from a variety of ethnic communities. In explaining the purpose of the research project to these women, alcohol related problems in their own ethnic community were often discussed, usually in relation to these women's own experiences as caregivers in their own families and/ or for older people in their community. The issues commonly raised centred on older people and problematic alcohol use, and were more frequent in communities where the consumption of and/ or making of wine, beer or spirits was part of their cultural tradition. Many of these ethnic groups arrived in Australia after WWII while others came later in the 1980s and 90s. For many of these communities, the family is the central and most trusted resource for handling problems. Family reputation is also important and it is often considered that some matters are best dealt with by family members and the involvement of health professionals may not be considered helpful in some situations (Multicultural Access Unit 1996). This may have been the reason why these women and their families were unaware of services

that they were entitled to and/or services that could assist them, for example with health, medication, alcohol and ageing issues.

Insufficient survey information was collected from the questionnaire from newly arrived women over 60 years of age to substantiate conclusions about the impact of older women's own alcohol use or the impact of others alcohol use on newly arrived older women. However, I had numerous conversations with older women who had been in Australia for many years whilst in the process of recruiting newly arrived women and these clearly indicated cause for concern amongst longer term women migrants. Like new arrivals, these women appeared to lack knowledge of services, had difficulties accessing services and had misconceptions about AOD services.

8.1.2 Women's Role as Formal or Informal Volunteers in the Community

In many communities, a woman's role primarily relates to that of care giver. An extension of this traditional care giving role, especially in the older ethnic communities in Perth, is caring for community members who have no family in Perth or who have no contact with their families for a variety of reasons including the disintegration of family ties. These community volunteers, acting in a formal or informal capacity, support older community members by bringing meals, cleaning their house, taking them to appointments, doing errands and other domestic chores. Through the care giving roles they have in their communities, women often became aware of and need to deal with older people who use medications and/or alcohol hazardously. In general, there is a poor understanding amongst older people of the health risks of heavy drinking and the health risks associated with some medications and alcohol use (Epstein, Fischer-Elber & Al-Otaiba 2007, Fink, Beck, & Wittrock 2001, Mukamal et al. 2007). This is particularly true for older migrants as lack of English fluency may prevent them from accessing appropriate services.

8.1.3 Language Barriers to Service Access

There are substantial language barriers for older members of ethnic communities in accessing mainstream services for assistance with medication and/ or alcohol use. For men and women growing up in many countries in the 1920s to 1940s educational opportunities were limited. Not all older migrants are able to read English or their own language (Multicultural Access Unit 1996). This is true of older women who

grew up in low socio-economic areas where the education of male children was given priority over the education of girl children (Multicultural Access Unit 1996). This means health information and service information in a written format such as posters, information sheets and pamphlets are inappropriate; rather information needs to be in other mediums. Unfortunately, the majority of information in the alcohol and drug area is in the form of printed material.

Many older migrants speak very good English. However, it is common during the ageing process for people to lose language skills (Juncos-Rabadan & Iglesias 1994). As a person ages there is a decline in the ability to find the right word as well as a decline in the ability to repeat complex sentences and stories especially when this requires a person to select and re-organise information (Juncos-Rabadan & Iglesias 1994, Goral 2004). This decline appears to be a normal part of the ageing process where the brain's ability to do complex tasks concurrently in multiple areas of the cortex declines. This decline is not related to other conditions such as Alzheimer's disease (Juncos-Rabadan & Iglesias 1994). Researchers generally agree that later life acquisition of a second language is usually associated with lower ultimate proficiency and that the speed and accuracy with which words are accessed and processed is linked to the age at which that word was acquired (Hernandez & Li 2007). Thus older migrants, not only experience the normal loss of language skills in their primary language but also a decline in the ability to access language acquired later in life. There are several theories currently being explored as to exactly why and how this happens (Goral 2004). However, decline in language skills is generally attributed to cognitive decline, lack of use and need, social isolation, and/ or health problems leading to hearing, vision and memory loss (Goral 2004). This means that service providers either need to be able to consult in community languages or be comfortable with and willing to work using interpreters. One of the key service providers for older people is a GP. Currently in Western Australia there are many GPs who consult in community languages. However, there is not always a good match between the needs of ethnic communities and the availability of GPs who speak a particular community language. For example, there was a GP speaking a community language serving a community in the southern suburbs of Perth but following his retirement no GP was available in this area who can speak this community language. As the research project has shown, there are many GPs who do

not use accredited interpreters when consulting with non-English speaking patients. Often older people will either "make do" or use family members as interpreters, especially adult children, when attending appointments with GPs and other community based health professionals who do not speak their language.

8.1.4 Accessing Services

To access local services for the groups of older migrants I had contact with through the research project, I contacted a number of AOD service providers. I was unsuccessful in gaining service referrals for older migrants, especially for older men. Barriers included service providers' unwillingness to use interpreters due to lack of knowledge and lack of experience and a lack of flexibility in service delivery. Community members needed to come to the premises of the service providers – no outreach or home visiting services were readily available. This was problematic for older community members with mobility issues and/ or who lacked transport and relied on family members or community care givers to take them to appointments. Although there are issues of safety for workers in alcohol and other drug agencies doing home visits, I was surprised at the reluctance of service providers to do outreach work in a community based setting such as an aged day care centre. In part this reflects funding arrangements and inflexibility to extend services beyond contractual requirements, but also the failure to bridge interfaces that are the result in service gaps.

Some service provision was eventually arranged through my professional networks. Considering the difficulties I as a fluent English speaking service provider who had worked in the health sector for many years encountered, it is unlikely that community care givers could successfully engage an alcohol and drug service provider to provide educational or treatment services in a community setting. My experience was similar to that of a health service provider interviewed for the project who found it difficult to get speakers to come out for a program she was running for young ethnic women,

> *"…I know when I was trying to get speakers for …. the young girls program around substance use for young people it was so dammed hard. Not because people weren't wanting to but they weren't allowed*

> *to. It wasn't in their mandate or whatever to come out and give talks and I think yes, they could go to schools but when it comes to something like this, it's very frustrating…"*
>
> Health Service Provider
>
> SP 17

Although some service delivery and contact was established between key community women and an AOD service provider, the outcome was far from ideal. In general, specialist services in the AOD field tend to look only at AOD issues and were reluctant to engage with the multiple and complex issues and service delivery around ageing, especially when working with a client from another language and cultural background. For this client group an integrated primary care approach provided by agencies such as community health centres and women's health centres seems likely to be more useful than specialist services.

There appeared to be a poor understanding of AOD services by community members and harm minimisation was poorly understood. Abstinence appeared to be the preferred model of dealing with problematic drinking. The expectation of some of the key community women was that service providers would solve problematic drinking by just telling a community member to stop drinking. As a result of language barriers, many elderly community members could not access AOD information and support through their GP, nor could community members access services that generally were coordinated through a GP to assist with identifying and managing an older person's medication and/ or alcohol related problems such as a Home Medicine Review.

8.1.5 Once a Leader, Always a Leader Project

Whilst trying to access assistance for older ethnic women, a small pilot project was started by the Ethnic Communities Council in WA in conjunction with a number of other community based service providers including WHS. Raising the issue of alcohol and other drugs with women involved in the pilot project and subsequently including information on alcohol and other drugs in the pilot was a direct result of the needs assessment. Issues and strategies identified by the needs assessment were used in developing the pilot project. These included covering alcohol and other drug

information as part of general health information not as a separate topic and informing women about alcohol issues and services through informal information sessions where questions could be asked. The pilot offered the opportunity to action concerns raised by community women and to provide a more integrated approach to addressing some of the issues older ethnic women were facing around alcohol and medication use. My role in this project involved being on the steering committee that supported the project officer, recruiting community women to participate, finding speakers for a number of the sessions and, in addition, I conducted one of the sessions myself.

8.1.6 Once a Leader, Always a Leader Project Approach

The aim of the pilot project was to identify senior women who were potential or existing leaders in their own ethnic community who could pass on information about relevant health and social services to isolated women. The project did not provide treatment services but did enable opportunities for senior women to improve and refresh their existing leadership skills as well as opportunities for senior women to learn about a variety of social and health services and issues and meet with relevant service providers.

The project had three stages. In the first stage, 32 senior women from a variety of ethnic communities met to discuss their most pressing needs and to recommend the format of subsequent educational workshops on these issues. In the second stage, workshops were held on the topics identified at the first meeting. These topics included information on aged care facilities and services, diabetes, legal issues and legal aid, alcohol, medication, and women's health. Usually each workshop session covered two topics of interest with a lunch break and a discussion period at the end. Lunch was provided for the participants. In the third stage of the project, women leaders were encouraged to talk informally to other women in their communities about how to access services they had learned about. Some women leaders, because of their formal volunteer work in their community, used conventional dissemination strategies such as ethnic radio programs, or arranging for a particular information session to be repeated with their group with an interpreter. However, a more common occurrence was for participants to disseminate the information to other

women through their social, cultural and religious gatherings. The project utilised a strengths based approach that focused on positive experiences and the strengths of participants.

8.1.7 Once a Leader, Always a Leader Participants

Women participating in the pilot project were from a variety of ethnic communities and language groups. These were Serbians, Bosnians, Macedonians and Croats from the Former Yugoslavia, Spanish- speakers from a number of Latin American countries and Spain as well as women from the Greek and Italian communities. Participants' ages ranged from 65 to 86 years. Women participating in the project were very active in their own communities performing different tasks and assisting those in need. Their caring roles included but were not limited to community projects such as weekly ethnic radio broadcasts, fund-raising, and educational activities with children in their communities. Participants' awareness of services varied between women depending on how long they had been in Australia, language skills and family support. The group that had the highest awareness of services was the Spanish- speaking group and some of the former Yugoslav group, both of whom had been in Australia for a considerable period of time. Greek and Italian women appeared to rely on their internal community resources and support systems.

8.1.8 Once a Leader, Always a Leader: Alcohol and Other Drug Workshops

Two workshops specifically addressed alcohol and other drug issues. One was on the safer use of medications delivered by a pharmacist from the Home Medicine Review Program. The pharmacist covered safer use of prescribed medication as well as over-the-counter medication and included information on appropriate storage, medication interactions when taking multiple medications, and sharing medication. Information on how seniors can access the Home Medicine Review program was also provided.

The other AOD specific workshop was on alcohol and ageing that looked at issues related to alcohol consumption as women and men age. Issues covered included alcohol and medication use and safe alcohol consumption levels, especially as people age. Participants were particularly interested in seeing what a standard drink was. The women were all quite surprised at the size of a standard drink and how much smaller it was than they had understood it to be. The group voiced their concerns

about the dangers associated with alcohol use for their grandchildren and other youth in their communities. Alcohol use was also discussed during the workshops on diabetes and women's health in relation to these specific topics.

8.1.9 Lessons Learned from the Once a Leader, Always a Leader Project

An evaluation of the project was conducted by the Ethnic Communities Council of WA. The evaluation of the project focused on whether the approach used by the Once a Leader, Always a Leader Project was feasible. Formally using the social networks of older women from different ethnic background as a means of disseminating information to more isolated older ethnic women is a unique approach. Service providers involved in the project were unsure if this method would work and what factors would be necessary for its success. The evaluation aimed to document factors that would contribute to the success of the workshops and that would need to be replicated by any future organisers. Due to limited resources, the evaluation did not examine the extent to which the workshops changed the attitudes and behaviours in women that participants spoke to. If the project were to be replicated, this would be an important aspect of a future evaluation.

The evaluation showed that senior women make significant contributions to their own ethnic communities and the wider community as carers, friends, volunteer workers, community leaders, organisers and activists (Loncar 2008). Often this role and women's influence are underestimated. Contributing to the success of this project was involving participants in the planning of workshop issues that they were interested in. This meant that the educational workshops were on issues of relevance and concern to the participants. Culturally sensitive issues such as women's health and alcohol issues were able to be discussed because they were not a one off session by an unknown service provider but part of a program. Participants were able to get to know facilitators and each other over a number of weeks which was important before culturally sensitive topics were discussed. Sharing lunch and discussing health issues after the presentation were both useful in helping the group to feel more comfortable in asking questions and raising issues.

Seniors from different cultures and language groups often shared similar barriers to service access, for example not knowing about a service. Becoming aware of such

services was often an interesting revelation for participants, with relief in knowing that they were not the only ones with a particular problem. In many cases, the larger more established communities relied on their own internal resources. However, this could be problematic when an issue is considered shameful or is particularly stigmatized.

As a means of disseminating information to isolated older ethnic women, the project showed that the approach used is feasible and works well in some cases. Some participants were very proactive in disseminating the information they gained through ethnic radio, arranging for speakers to do repeat sessions with their community groups and talking to other women informally about services. However, other participants were more passive due to their personality and/or other issues requiring attention in the participant' life.

8.1.10 Summary

Both the current study and this pilot project have shown that a better understanding of the extent to which older migrants are experiencing medication and/or alcohol related problems and the types of problems they are experiencing is needed. Other information that is needed is an understanding of how older ethnic men and women access GP services, how they communicate with their GP, and the extent to which GPs seeing older ethnic community members are asking about and providing services regarding medication and/ or alcohol related issues. While the current study has shown that most newly arrived women are able to access and communicate with a GP, the situation for older migrants is less clear.

Due to the high stigma AOD issues have in many ethnic communities, and the fact that those most in need of assistance may not be accessing services, a community wide approach may be the most beneficial approach to dealing with older migrants with alcohol and drug use issues. However, even using this approach more information is needed on what type of service delivery is most acceptable and helpful for older people who are drinking problematically. An integrated approach, where information and support on alcohol and medication issues is incorporated into primary care services used by elderly migrants, is likely to be the most successful path forward.

8.2 Outcome Two: The CaLD Women's AOD Project

In late May of 2007 WHS was approached by the WA Drug and Alcohol Office (DAO) as this State government department was keen to fund a 12 month project to address AOD issues in CaLD communities. As a result of the profile developed because of the research project, WHS was encouraged to apply for this funding. A proposal was developed and funded enabling some of the recommendations from the research project to be actioned. The outcomes of the CaLD Women's AOD project are described below. My role in the CaLD Women's AOD project was in developing the project proposal, writing the funding submission, supervising project staff and students, and linking the project to existing services at WHS and elsewhere. Finding a suitably experienced project officer to undertake this project proved to be difficult and for a time I acted a the project officer until a staff person was eventually secured.

8.2.1 AOD Drawings

The number of culturally appropriate images for service providers and community leaders to use to talk about AOD issues in CaLD communities is very limited. The research project showed that visual images were an excellent way to deliver health messages to both migrant and refugee women and could be used to prompt discussion over AOD and other health issues. The CaLD AOD project employed an artist to create twenty drawn images that were placed on a CD. The copyright free images could then be used by WHS and other service providers working with CaLD clients around AOD issues. The images were around the following themes: accessing AOD services, AOD use in general, AOD use and the impact on relationships, and safety for women. Community consultations were used in the process of developing the images. Examples of the images can be found in Appendix Five.

8.2.2 Student Placements

A limited number of AOD services are willing to take TAFE and/or University students from CaLD backgrounds on placement making it difficult for them to find placement positions as these students often need additional support due to language and cultural differences. This reinforces the trend of a largely Anglo-Saxon English speaking workforce in the AOD sector in WA. The CaLD AOD project provided

placement opportunities for four University students from Iranian, Singaporean, Indonesian and Zambian background and one TAFE student from Indonesia that assisted with the project as well as other aspects of service delivery at WHS.

8.2.3 Participation at University Open Days

Following on the recommendation from women at the community feedback sessions, WHS had stalls at three University Orientation Days to provide young women from CaLD backgrounds health and AOD information. These stalls were well attended with 150 to 200 women (with over half from CaLD backgrounds) contacted per event.

8.2.4 Promotion of AOD Training Opportunities

Although the Drug and Alcohol Office in WA offers free high quality workshops on AOD issues these tend to be poorly accessed by service providers, students and volunteers working with CaLD clients. In order to attend such training these groups need to know that the workshops are relevant to their needs. For CaLD students and volunteers the workshops need to be at a pace and a language level that they can understand and feel comfortable with. Students and volunteers may also need practical support to attend e.g. assistance with transport as well as encouragement to attend a workshop on a highly stigmatised topic. The CaLD AOD project facilitated access to three workshops for WHS staff and students working with CaLD clients on AOD issues.

8.2.5 Web Based Information

Given the high percentage of women in the research project who found web based information very useful or useful, the CaLD AOD project set out to provide information about the project itself and AOD information that was easy to read for women who had English as a second language. The topics chosen were based on information gathered in the research project. Three information sheets on AOD issues in English were created as well as information about the project itself and placed on the WHS website (in the information library at www.whs.org.au).

8.2.6 Information Sessions

Due to the high percentage of women in the research project who found talks or information sessions a very useful/useful way of getting information, the CaLD AOD project planned and delivered 7 workshops with women from CaLD communities on various topics related to alcohol and other drugs. One of the most successful sessions was a half day stress management and relaxation workshop that incorporated AOD information as well as an exercise component. Feedback from participants was very positive. WHS plans to hold more of these workshops with community women in the future. Other successful sessions were with two groups of overseas trained nurses enrolled in a bridging program. Feedback from these sessions was again very positive with participants nominating the most useful aspects as:

- the role of the health system and the legal system in working with AOD clients and how these differed compared to the nurses' own countries
- the most common types of alcohol and drug related problems seen by the health services in Western Australia
- treatment options for clients with AOD issues in Western Australia.

Other sessions were less successful and were either cancelled or were less well-attended often due to circumstances beyond the control of the project officer. For example, a workshop was cancelled at a high school with a high percentage of students from ethnic backgrounds due to arson that burnt down the centre of the school. Other sessions for women who were victims of domestic violence were not well attended even though the women had requested the session. However, the women that did attend were eager for more information and support on AOD issues, especially around how parental drug use impacted on children. The experience of working with these particular groups of women demonstrated the challenges of providing services for CaLD clients in the complex nexus of AOD, mental health and domestic violence.

8.2.7 Consumer Reference Group

The research project found that a standing consumer reference group was invaluable in providing practical and timely feedback on issues as well as facilitating access into various communities. There were many tasks undertaken by the Reference Group as a whole and or by individual members that were crucial to the successful completion

of this research. One of the seemingly minor contributions that was of benefit to myself and the project as a whole was the task of defining what is meant by "Culturally and Linguistically Diverse". Although apparently simple, it is fraught with debate and controversy. An entire meeting of the Reference Group was spent considering what different agencies and government departments defined as CaLD and what meaning women in the group associated with this term. Amongst service providers who work with CaLD clients, who is and isn't included in this definition is often determined not by semantics but by funding bodies and internal politics. Having a consumer reference group define this term saved me from "choosing sides" and ensured that the findings of the needs assessment were not discounted by one group or another.

Other important contributions the Reference Group made to the project included the feedback on the preliminary and final results of the project. In addition, a number of the Reference Group members were involved in piloting the questionnaire, recruiting participants for the questionnaire or undertaking work as bilingual interviewers. These contributions were invaluable as it allowed information from women that would not normally have been accessible to be included in the research. Other tasks completed by the Reference Group helped ensure the group's sustainability after the research project was completed such as having a statement of purpose that includes rights and responsibilities of group members and who is eligible to join. These definitions and clarifications are helpful for recruiting new members and keeping the focus of the Reference Group. The CaLD AOD project assisted with the continuation of the Reference Group ensuring ongoing regular meetings and payment for attendees. A small amount of funding was also made available to do activities suggested by the group such as visits to various AOD agencies.

Overall the CaLD Women's AOD project was considered very successful. The main obstacle encountered was employing a project officer who had both experience in working with CaLD communities and some understanding of AOD issues. Due to WA's employment market at the time of the project, most not-for-profit agencies were finding it very difficult to attract and retain qualified staff. WHS found it difficult to attract an appropriately qualified project worker so there were delays in

recruitment. WHS has successfully negotiated another 12 months funding with the Drug and Alcohol Office to continue this project.

8.3 Outcome Three: The Physical Activity Project

There is a growing body of literature on some of the barriers that women from CaLD backgrounds face in accessing physical activity. Lack of English fluency and literacy are not the only barriers. Newly arrived women need to learn how to navigate the "physical activity system" of sporting clubs, gyms and recreation programs and this can be both confusing and intimidating (Velanovski & Karantzas 2006). Being a woman can itself be a barrier. In some cultures, sport is seen as something men do and not women (Taylor & Toohey 1998). Cultural and religious beliefs may mean the need for women only venues and these are often difficult to find (Taylor & Toohey 1998). There are also relatively few role models of CaLD women participating in sport at either the community level or at a national level, especially from new and emerging communities (Cortis, Sawrikar & Muir 2006). Being part of a minority group that has few well known role models can increase CaLD women's feeling of being different, unwelcome and uncomfortable especially in social exercise settings (Cortis, Sawrikar & Muir 2006). These barriers are in addition to the barriers women from low socio-economic groups face including lack of transport, the need for child care, appropriate timing of classes and accessibility for minimal cost or for free.

The original purpose of this research project was not to collect information on physical activity, promote the benefits of physical activity or improve opportunities for newly arrived women to increase their physical activity levels. However, requests for physical activity classes and other opportunities were frequently brought up by participants. Because of the importance that women in the focus groups and interviews attached to exercise classes, it was included as an option in the questionnaire where women ranked information and activities that they would like. Just over 66% of women responding to the questionnaire rated exercise classes in their five most preferred information or activities, with 17.2 % over the women rating exercise classes either as their first or second priority. Women were also given an opportunity to add issues or activities that were important to them as the final

question in the survey. Exercise classes or a variety of sporting activities were often added in this section. The level of interest in physical activity was unanticipated. Similarly, when women suggested disseminating information to newly arrived women through exercise classes and sporting activities, this was another unexpected finding.

Findings from both the qualitative and quantitative phases of the project indicated that newly arrived women were keen to participate in physical activity and did not require further motivation. However, newly arrived women's access to physical activity opportunities was problematic as discussed below and required further exploration before WHS could implement strategies to address this need.

8.3.1 Feedback Sessions with Community Women

I conducted five feedback sessions with community women regarding the results of the project, specifically around the idea of a physical activity pilot. One of the key issues was to confirm what newly-arrived women understood by the term "exercise class". The feedback sessions showed that most women had a similar understanding to what service providers and WHS staff understood by "exercise classes". Women attending the feedback sessions were particularly keen to have sessions that concentrated on exercises for their stomach and thighs. Stretching and relaxation were also seen as useful. Women were asked about cardiovascular exercise and this was described as exercise for women's heart and lungs. Some groups of women wanted this while other groups of women wanted just gentle exercise and stretching without a cardiovascular component.

Barriers to accessing physical activity were also explored in these feedback sessions. The most common need expressed by women in the feedback sessions was the need for a women only environment either for cultural or religious reasons. Another major barrier was the cost of classes or activities as many newly arrived women were on low incomes. Some women who felt comfortable in a mixed gender environment said the barriers for them were primarily not knowing where to go, what to ask for, and how the system worked for enrolling in sporting clubs and activities.

8.3.2 Barriers to Walking as Exercise

Walking is currently being promoted by both government and non-government organizations such as the National Heart Foundation, The WA Premier's Physical Activity Taskforce and the WA Department of Planning and Infrastructure as a low-cost and accessible form of exercise for people in the community. During the feedback sessions with community women, women were asked if incidents involving alcohol use and/ or drug use by strangers had made them feel unsafe or uncomfortable to walk as part of an exercise routine. The majority of the women in the feedback sessions said that they did feel safe going for a walk in their community. However, for a small minority of women, safety concerns following unpleasant incident(s) were the reason they did not walk for exercise.

When barriers to walking for exercise were further explored in the feedback sessions, women often mentioned that they were hindered in going for a walk because they had one or more pre-school age children that they would need to take with them. The weather also had an influence: often it was too cold or wet in the winter or too hot in the summer to walk with the children, even in a pram. If the women had more than one child, often the older child did not want to sit in the pram or was too big for the stroller and would need to walk beside their mother. This made walking for exercise too difficult (and stressful!) for many women. These women felt that exercise classes with a childcare facility were a better option than walking. Newly arrived women are not alone in finding this option appealing. Many Australian born women with young children have found walking too difficult and exercise classes with appropriate crèche facilities a good exercise option.

8.3.3 Description of the Physical Activity Intervention

The Physical Activity Program at Womens Health Services (WHS) is a part of the Community Development Program and is a relatively new addition to the agency's services. Over the years a variety of opportunities to participate in physical activity have been offered to clients at WHS, especially to clients from the Mental Health Community Outreach Project (MHCOP). However, it has been relatively recently that a designated staff member has been employed to co-ordinate physical activity opportunities for clients across the different program areas at the agency. One of the reasons for employing a dedicated physical activity staff person was to address

barriers that different groups of women face in being more physically active. Given the barriers faced by newly arrived women in accessing exercise class and the strong interest by women in participating in classes, a pilot project seemed an appropriate intervention. The pilot project ran out of the WHS Physical Activity Program and offered physical activity to women who were not necessarily WHS clients but were similar to WHS clients in that they experienced similar barriers in accessing physical activity. The pilot project was aimed at women who were new arrivals although women who had been in Australia more than 5 years were not excluded. A series of six new multicultural physical activity classes were piloted in second and third terms of 2007 under the auspices of the WHS' physical activity program. These classes were then evaluated at the end of third term, or just before Ramadan if the classes were being suspended over the Muslim holy month. The classes were set up in conjunction with service providers from a variety of agencies whose clients had expressed an interest in exercise or other types of physical activity classes. Some of the women in these groups had participated in the research project and were extremely keen to have exercise classes. Thus, the provision of a pilot physical activity program was recognition that these women's views and opinions had been heard by WHS. As WHS had already had experience in providing physical activity opportunities to an outside group with ties to WHS, the Spanish Speaking Seniors Association, it was not difficult replicate this model with other outside groups. My role in the pilot physical activity program was in supervising staff and students involved in the pilot and training instructors to work appropriately with clients from diverse cultural backgrounds many of whom had experienced traumatic events and were experiencing mental health issues as a result. I also liaised with the service providers whose female clients had expressed an interest in exercise classes to negotiate venues, class times, advertising the classes and equipment needs. I also linked women and the service providers working with them to existing services at WHS and elsewhere. On occasion I also acted as a relief instructor.

Four venues offered gentle fitness classes ran during the period of the pilot. The number of classes run in each venue varied during the course of the pilot depending on the group and the service providers associated with the pilot. Three classes were multicultural classes with women from many different language groups in the same class, although most women spoke some English. Often those with minimal English

were assisted by those with better English. The fourth fitness class was attended mainly by Indonesian women with a few women from other countries in attendance Appendix Six describes in more detail the classes offered.

There were two additional venues offering gentle yoga classes. The number of classes run in the two venues again varied during the course of the pilot depending on the group and the service providers associated with the pilot. One group was a multicultural group while the other was an Ethiopian women's group (See Appendix).

All the groups except for two were advertised as women's only exercise groups and open to multicultural and other women in the community to attend. For all the classes women were encouraged to give a gold coin donation but otherwise there was no charge to the women for the exercise sessions. WHS either paid for the instructor's fees or the instructors were WHS staff. Two of the groups were only advertised internally to other group members. The first of these closed groups was for women who were starting an Ethiopian women's support group and were members of the local Ethiopian Orthodox church. They chose to do a yoga class. The second group was part of the domestic violence program run by WHS. This group was for women from CaLD backgrounds that were domestic violence survivors attending a weekly peer support group run by WHS. This group chose to do a gentle exercise class for a half hour prior to their peer support meeting.

8.3.4 Considerations in Starting the Classes

Involvement of Other Service Providers

I and other WHS workers liaised closely with the staff associated with the agencies requesting the exercise classes through face to face meetings, e-mail and phone conversations. As the exercise classes became more established there was less need for face-to-face meetings and more contact occurred through e-mail and by phone. Staff members associated with the groups were welcome to participate in the exercise or yoga classes as WHS staff had found in the past that giving staff opportunities to try different activities resulted in them encouraging clients to participate in physical activities that they themselves had enjoyed. This also has had the positive effect of staff becoming more physically active than before.

Privacy

Issues of privacy were important to four groups whose members were mainly Muslim women. Windows in the various venues needed to be covered so women could take off their outer garments. When blinds and curtains were unavailable, shower curtains hung with stick-on plastic hooks attached to window frames proved to be an efficient and low-cost method of ensuring privacy.

Screening questionnaires

Exercise screening questionnaires were completed by women prior to their participation in classes. The screening questionnaire was developed by a final year exercise physiology student on placement at WHS and was modified from commonly used exercise screening questionnaires. Standard screening questionnaires were inappropriate due to their high literacy requirements, so questions were simplified. Questions such as, "Do you have any cardiovascular problems?" or "Do you have a history of ischemic heart disease?" asked on other screening instruments were simplified to "Do you have any problems with your heart?" with a picture of a heart. These simplified questions were better understood by women in the pilot project. Women were usually verbally asked the questions on the screening questionnaire by the instructor or WHS staff member, especially when there was low English literacy amongst the group. Overall, women could understand the simplified screening questionnaire and respond verbally even if they could not read English very well.

Other Issues

As many of the women attending the classes had traumatic personal histories, particular care was taken in making the classes friendly and welcoming. WHS staff understood that for many of these women their ability to commit to regular attendance would be hampered by the many practical settlement concerns facing new arrivals such as finding appropriate housing, work, attendance at English classes, and settling children into schools. Regular attendance at the exercise classes would also be adversely influenced by bad weather as the pilot was occurring over winter and many of the clients used public transport. Ill health of either the woman or her children would also interfere with attendance. For these reasons the classes were run

on a casual basis with women being able to attend as many or as few exercise classes as they would like.

Issues of dress soon became apparent. Muslim women did not always remove their head scarves even though the venues where the exercise sessions were held were exclusive to women only. Instructors needed to be aware that these women would generate body heat more quickly and that these women would also retain more body heat than other participants. Many of the women had not exercised before and often came in street clothes including long skirts, high heels and long head scarves. Many conversations were held with women to encourage them to wear sport shoes and pants. However, many women still came in long skirts. There was more success in getting women to wear sport shoes or at least flat shoes to exercise classes. For the yoga classes footwear was not an issue as these classes were done in bare feet.

Participants were asked whether they wanted the classes with music or without music as in some branches of the Muslim faith, music is considered "haram" or forbidden because it is believed to make people stray from the path of Allah. Three of the four exercise groups requested music with the classes. The fourth group started with music but some group members later requested no music due to religious beliefs.

8.3.5 Recruiting and Training Instructors

Instructors used in the pilot (and in general by WHS) were accredited where possible by a training organisation such as the Fitness Institute of WA. (Some disciplines of physical activity that women expressed an interest in such as belly dancing did not have an accrediting body). Instructors were interviewed by two program managers at WHS. The interview concentrated on the instructor's communication skills, their empathy with the client groups and their openness to working with marginalised groups of women rather than on their physical activity expertise. Instructors were then listed in a "pool" of instructors that WHS maintains. The pool of instructors include teachers who can be called upon to teach a range of activities ranging from fitness classes to self-defence to various types of dance depending on the interest of the women. This pool also acts as a source of relief instructors when teachers are ill or unable to teach a class for other reasons.

Offering further training was a way of enticing instructors to be involved and stay involved with the WHS Physical Activity Program. Information about working in a physical activity setting with clients with mental health, alcohol and other drug, or torture and war-related trauma issues was needed for the instructors. These issues are rarely covered in the more general training instructors receive, even for instructors who had undergone university coursework. An instructor training program was developed and piloted that included information on working with refugee clients and cross-cultural communication in physical activity settings. Evaluations of the pilot training showed that the training was well received by the instructors who attended.

8.3.6 Health Information Provision in the Exercise Classes

As part of the pilot program, health talks were offered to participants. WHS nursing staff gave a health information session on women's health to one group while a dietitian specialising in refugee health gave two talks on Vitamin D deficiency to two groups. These talks were extremely popular and took place after the exercise or yoga class. However, these talks took considerable organisational effort to ensure that the topics were on issues the women were interested in and that the women would be available to stay after the class to listen to the speaker.

In addition, health information was provided to women attending the classes. Pamphlets and information sheets in both English and in community languages on a wide variety of women's health issues including AOD issues were brought to the classes. These proved to be very popular and on occasion led to some interesting discussions. For example, a woman from Somalia who on seeing the information sheet on Khat remarked on how Khat use was detrimentally affecting some families in her community. In the lead up to Ramadan, I provided information on quitting smoking, helping others to quit smoking and passive smoking in English and community languages to the classes. As the vast majority of the women attending classes did not smoke, I felt it was useful to include information on helping others quit and on passive smoking. The information sheets and pamphlets were used as prompts to discuss smoking cessation in the exercise classes that had mainly Muslim women. Other programs have successfully used Ramadan as a cue and motivator for Muslim men and women to quit smoking or cut down on cigarette consumption. These programs have included a campaign run by the South Metropolitan Area

Health Service and the Muslim women's Support Centre in Perth and various QUIT projects in New South Wales. The smoking information prompted a number of conversations with the women. One Muslim woman who smoked found Ramadan very difficult as her beliefs dictated that the use of nicotine patches, gum and other products would be seen as breaking her fast. She, therefore, faced severe nicotine withdrawal symptoms which she found very difficult. The women was reluctant to use the internal support structures of her community due to stigma but did not feel mainstream support services would understand her situation. This case demonstrated some of the complexities faced by ethnic women with regards to AOD use and that providing information can only be one strategy in supporting women with AOD issues and concerns.

8.3.7 Evaluation of the Pilot

As I had been actively involved in setting-up many of the groups and in some cases acted as a relief exercise instructor, an external evaluator was sought to conduct the evaluation of the physical activity program. A fifth year Health Science and Commerce student on a thirteen week placement at WHS undertook this task. I worked closely with the student to ensure appropriate methods of conducting the evaluation were used given the language levels of participants, time constraints, and the reluctance of many of the participants to fill-in forms and give information for fear of services being withdrawn and/or experiences of persecution in their home countries. Informal focus groups at the last session of the series were considered the best method to overcome these issues. These informal focus groups covered a number of points and lasted no more than 20 minutes. Information from instructors as well as WHS staff and service providers associated with the pilot was collected by questionnaire. Recommendations from the evaluation of the pilot project included:

- Providing as many women's health information sessions or talks as possible, within the resource constraints of WHS, while continuing to make written information available.
- Increase promotion and advertising of physical activity classes.
- Maintain WHS staff presence at relevant groups to support, assist site coordinators and attend to women's needs if required.

- Actively seek and act upon opportunities that may arise for collaboration with other community and sporting organisation in accordance with future aspirations of the WHS physical activity program.

These recommendations have been discussed with WHS staff and have been incorporated into the ongoing WHS Physical Activity Program, staff work plans and the WHS planning cycle.

The pilot project had many positive outcomes for both the participants and agencies involved. WHS staff learned a great deal about delivering a physical activity program to newly arrived women using existing women's groups in the community. Community Development Program staff at WHS have incorporated the information gained from the pilot project into ongoing exercise classes for newly arrived women as well as creating other opportunities for physical activity for this group of women. Five of the six exercise classes continued through the rest of 2007 with women from the sixth class being invited to attend any of the other classes. Upon seeing the popularity of the exercise classes, one of the collaborating organisations applied for and received funding to conduct their own exercise classes for women. WHS worked with this agency in early 2008 to assist them in sourcing and training instructors, finding equipment and dealing with other administrative matters such as music copyright. All of the agencies involved with the exercise classes have requested future WHS involvement in providing information sessions to the women as part of an exercise program. A number of strategies have been undertaken by WHS to make exercise sessions and other opportunities for physical activity for newly arrived women more sustainable in the medium to long term. These strategies include using existing WHS staff members who already have an appropriate exercise qualification to teach the exercise classes, encouraging and assisting existing staff to qualify as exercise instructors, and recruiting external instructors who are willing to teach either voluntarily or at less than the current commercial rates. Grant funding to pay for the physical activity sessions has been sought to sustain this approach on an ongoing basis.

After learning about the work done by WHS, the Department of Sport and Recreation (DSR) in WA has indicated interest in helping WHS obtain accreditation

for the training developed for instructors during the physical activity pilot. The accreditation will be through the Fitness Institute of WA. This will enable instructors to get continuing education points for attending this workshop in the future. DSR is also interested in hosting the workshop for instructors and other recreation service providers in the near future to increase awareness of the needs of newly-arrived women and the barriers they face in accessing physical activity.

The pilot project considered many of the obstacles identified in the literature as barriers for CaLD women to participate in physical activity. Although WHS was able to address many of the barriers, such as the need for women only venues and privacy, the pilot project was unable to address some of the larger issues of providing positive role models of CaLD women and assisting women to navigate what seems to them to be the complex and confusing sport and recreation system in WA. Many women in the pilot project reported in the evaluation on the same positive aspects of exercise as identified in the literature, namely, that exercise made them feel happy, more confident and comfortable. Women also enjoyed being with their friends and meeting new women.

The physical and mental health benefits of exercise are well established. Regular physical activity helps in reducing non-communicable diseases that many migrant women suffer from including cardiovascular disease, type 2 diabetes, osteoporosis and breast cancer (Bull 2003). In addition, the mental health benefits of exercise are now more widely recognised as is the interplay between a healthy mental state and improved physical health (Faulkner & Taylor 2005). Studies have shown that walking, jogging, cycling, weights and resistance training all can reduce anxiety and depression (Coalter 2003, Donnelly & Coakley 2002, Faulkner & Taylor 2005). As 44% of the women responding to the survey identified depression as one of their priority health issues, the link between exercise and reduced anxiety and depression may be of particular importance to newly arrived women. Women involved in the research project were particularly interested to know about other ways besides medication that they could use to address feelings of depression and anxiety. In some cases, exercise may be able to offer an effective non-medical intervention to deal with the mental health issues faced by newly arrived women. Exercise may also be a useful intervention given the difficulties some newly arrived women face in finding

an appropriate GP and/ or the difficulties some women experience in communicating effectively with their GP given limited English and the reluctance of some GPs to use an interpreter.

8.4 Summary

The research project has led to improvements in practice at WHS and produced tangible outcomes, namely increased awareness of the alcohol and medication issues facing older migrant women and ways of addressing these issues, the CaLD Women's AOD project, and the expansion of the WHS physical activity program to include more activities for newly arrived women. Such tangible outcomes where research is directly linked to program delivery and evaluation provides strong support for the professional doctorate approach. The pilot projects used retrospective client feedback and process evaluation methods in assessing their success. There are limitations to this type of methodology, however, these methods were the most suitable given the time and resource constraints of the pilot projects. The purpose of these pilots was primarily to test the feasibility of such projects and strategies being conducted in a sustainable manner by a not-for profit organisation. Larger and more thorough process and impact evaluations are now planned to review the efficacy of the approaches used in the pilot. The expanded physical activity program will undergo a more complete process and impact evaluation over an 18 month period starting in late 2008.

Chapter Nine

Project Summary

The main objective of the research project was to identify concerns and issues regarding alcohol, and other drugs experienced by culturally and linguistically diverse women in Perth who had been in Australia 5 years or less, and to trial potential solutions to these common concerns and issues. This objective of the project was successfully met. The project overcame a number of barriers specific to working with CaLD women such as interpreting/translating concepts to a number of cultural and language groups and working with women who had limited literacy either in English and/ or their primary language. As newly arrived women's AOD issues and concerns had not been well documented previously, qualitative methods in the first phases of the project were useful in capturing some of the complex life experiences of new arrivals and how these impacted on women's alcohol and drug issues and concerns (Bolton, Hammoud & Leung 2002, Greenhalgh & Taylor 1997, Stewart et al. 2008). The use of qualitative methods also helped increase the cultural sensitivity of the study and helped inform the design of an appropriate survey instrument. To ensure that the qualitative results of the study could be generalised to a wider group of people, it was necessary to use quantitative methods as well (Flick 2002; Yelland and Gifford, 1995). The mixed methods approach placed additional demands upon those involved in the research project as it required additional data collection, more time to analyse the results and more effort to interpret the data (Stewart et al. 2008). However, the mixed method approach allowed a more complete and accurate picture of participants' experiences to be obtained (Stewart et al. 2008) and the strengths and weaknesses of qualitative research methods were counterbalanced by the strengths and weaknesses of quantitative methods.

9.1 Documenting AOD Concerns

The research project had a number of sub-objectives which were also met. The first of these was to explore and document common AOD concerns and issues of newly arrived women as identified by these women and the service providers working with them. A summary of the most common issues and concerns in the qualitative phases

of the project is outlined in Table 9.1. Discrepant views between newly arrived women and the service providers working with them are outlined in Table 9.2.

Table 9.1 Concurrent AOD Concerns of Newly Arrived Women as Identified by Women and the Service Providers Working with Them

- There were low levels of tobacco use amongst new arrivals
- Smoking was used a coping strategy for stress in women who continued to smoke in Australia.
- There were low levels of alcohol consumption amongst newly arrived women
- For women who drank alcohol, there often had been a change in their drinking pattern in part due to the cultural acceptability of women drinking in Australia.
- Problematic alcohol use caused a number of problems in the family not just domestic violence.
- Problematic alcohol use was co-occurring with abuse by intimate partners.
- Problematic alcohol use did not necessarily cause abuse.
- Women were concerned about their children using illicit drugs and drinking alcohol

Table 9.2 Discrepant AOD Concerns between Newly Arrived Women and the Service Providers Working with Them

Identified by Service Providers	Identified by Women
• Illicit drug use was low amongst new arrivals with more fear of use than use.	• Illicit drug use was low amongst new arrivals but perceived as more problematic, especially for male youth, in Australia than in women's own countries.
• Workers were not providing AOD information to women as it is not seen as an issue for newly arrived women.	• Women would like more AOD information and support.
• **Not identified as an issue**	• Some women found it difficult to find a GP
• Medication issues included sharing of medication and improper use of medication due to poor compliance	• Medication issues were more to do with poor communication between the consumer and health care provider. Communication was hampered by poor use of interpreters and lack of time for detailed explanations by health care provider.
	• Some medication women preferred was unavailable in Australia.
• The use of medication for depression, stress or sleeping problems was common.	• **Not identified as an issue**
• Emergency Department was used inappropriately for primary health care provision.	• **Not identified as an issue**
• **Not identified as an issue**	• Women quit smoking after arrival due to greater awareness of health risks to themselves, their children, and/or unborn child.
• **Not identified as an issue**	• Women had experienced problems with strangers who were under the influence of alcohol and drugs

9.2 Factors Contributing to AOD Concerns and Issues

The second sub-objective of the study was to explore with newly arrived women and the service providers working with them what underlying factors contributed to the AOD concerns and issues of these women. These underlying factors can be examined under the broad categories of the AOD issues about which service providers and newly arrived women were questioned.

9.2.1 Underlying Factors Contributing to Tobacco Use

Negative cultural attitudes towards women smoking is most likely assisting with keeping the prevalence of smoking low amongst newly arrived women. The findings of this project regarding low smoking rates amongst women and proscriptive cultural values around women smoking concurred with the results of other studies (Rissel et al. 2001; Bradby & Williams 2006). In addition, women may be assisted in staying non-smokers because of the changing cultural attitudes in Australia towards smoking. The number of places in which it is acceptable to smoke in public has been reduced and the awareness of the dangers of smoking including passive smoking has been increased. An underlying factor reported as contributing to women continuing to smoke was stress. Questionnaire respondents cited one of the most frequent reasons for continuing to smoke was as a way to cope with stress.

9.2.2 Underlying Factors Contributing To Concerns and Issues Around Alcohol

Cultural and religious values prohibiting alcohol consumption and/ or negative attitudes towards women consuming alcohol meant that the majority of the women participating in the study did not drink alcohol. Other studies of migrant alcohol use have also reported abstinence or low drinking levels amongst women compared to the mainstream population and subsequent generations (Ames & Rebhun 1996, Bradby & Williams 2006, Caetano 1994, Gilbert 1991). Some of these non-drinking women encountered peer pressure to drink or to drink more as a result of Australian norms around alcohol use. As the vast majority did not drink or drank in only very small amounts, the concerns and issues that many women had around alcohol use was the impact of others use of alcohol on them such as offensive or threatening behaviour in public by people under the influence of alcohol. Many women appeared to lack strategies for dealing with this as in their own countries such problems were handled by male relatives or were more hidden from public view. The issues related to AOD use by others impacting on CaLD women's safety and feelings of safety in public places is not well documented in the literature. The link between domestic violence, alcohol use, and the experiences of newly arrived women coming under a variety of migration categories and circumstances is complex and is also not well documented in the literature. However, the role of PTSD as an aggravating factor is highly likely, especially amongst humanitarian entrants.

9.2.3 Underlying Factors Contributing to Low Illicit Drug Use

Cultural and religious values prohibiting illicit drug use, especially by women, were perhaps the strongest factors reported that contributed to a low illicit drug use rate amongst newly arrived women. Service providers also cited the cost of drugs as another barrier to use. The link between PTSD and drug use by young people was cited by service providers as a "cry for help" rather than as a result of peer pressure. The role of PTSD as contributing factor to illicit drug use is highly likely but further research is required to test this assumption.

9.2.4 Underlying Factors Contributing to Problematic Medication Use

Sharing of medication and other types of problematic use appeared to be quite low amongst new arrivals participating in the study. Many of the problems around medication usage that did exist appeared to be a mixture of different models of health interacting, cultural beliefs as well as communication difficulties including language difficulties between health service providers and their clients. An example of this was the expectation by mothers that their child would be given antibiotics immediately for a viral infection.

9.3 Addressing AOD Concerns and Issues

The third sub-objective of the study was to explore and document what newly-arrived women and service providers working with them recommended to address the AOD concerns and issues facing newly arrived women. This sub-objective was achieved through gathering information on what information, supports, and services women wanted and ranking these. Community feedback sessions were also useful to clarify strategies. Some of the choices that were particularly relevant for addressing AOD concerns and issues included:

- Information on how to find a GP and how to communicate effectively with a GP
- Information and support with depression and post natal depression
- Information and support with family violence
- Support for women whose husbands or children are drinking too much alcohol
- Women's only exercise classes and other opportunities for physical activity

Why these particular strategies have been identified as important in addressing AOD concerns and issues is discussed in greater detail below.

Based on the project's findings, there seems to be a poor understanding by both newly arrived women and the service providers working with them of what AOD services are, different types of treatments and models that can be used, who can access them (not just the person with an AOD problem), the costs involved, and whether or not the police will become involved. Many women and service providers assumed that alcohol and drug services were live-in services that promoted an abstinence only model of treatment and care. Describing AOD services as "professional", "specialist alcohol and drug services", as many women described them in response to the questionnaire and generally promoting the existence of AOD services may help increase access for newly arrived women. This strategy was also suggested by Reid and colleagues (2001) and tried in the project conducted by Working Women's Health and Women's Health in the North (2000). However, a more realistic alternative may be to use women's suggestions as to who they would talk to about alcohol and drug issues and provide further skills to this group of people to discuss AOD issues. Providing further skills for GPs and other health service providers working with newly arrived women as well as church workers to talk about AOD issues may be more realistic than expecting women to come to an alcohol and other drug service. These suggestions are supported by other research. For example, in the qualitative study by Reid and colleagues (2001) researchers found that although GPs and religious leaders were likely to be the first choice for discussing illicit drug use either by users or their families, often the quality of the information and support these workers provided showed a lack of knowledge about how to deal with such issues. Training and support for these workers should be considered.

In addition, having a GP with whom a patient can communicate well is a key factor to accessing various aspects of the WA health system, including AOD services. GPs see women for a variety of different health needs and in doing so are in an ideal position to help women deal with drug use issues or known risk factors for problematic AOD use such as depression. Although GPs can work with a woman individually, the GP can also refer a woman to other relevant health care providers and support agencies. This may be crucial for newly arrived women who may not

have a good understanding of the WA health system and/or relevant support agencies.

Information and support for depression and post-natal depression can be considered an AOD prevention strategy due to the strong association in women between depression and problematic AOD use, especially alcohol (Dale & Marsh 2000, Kohen & Hardy 2007). Alcohol dependence increases three fold amongst depressed women compared to women who are not depressed (Kohen & Hardy 2007). It is also know that AOD involvement of alcohol either by the perpetrator and/ or the woman involved in domestic violence situations is not unusual (Dale & Marsh 2000). However, providing appropriate service provision for newly arrived women who request information and support with depression, post-natal depression and domestic violence requires further inquiry. However, the findings of this study suggest that service providers can assist women in helping them make the links between substance use, violence, depression and other life experiences. Service providers can open conversations on these issues in a variety of ways as suggested by women involved in this study: on the web, information sessions, articles in community newspapers, on ethnic radio as well as in one to one counselling sessions. The personal stories of family, friends, and other newly arrived women may be perceived as more helpful than those strategies suggested by service providers. In theorising appropriate service provision with newly arrived women, this factor may need to be taken into account.

The literature and WHS' own experiences has shown that women's only support groups can be a very effective strategy for women experiencing a range of difficulties including AOD issues (Dale & Marsh 2000 , Olff et al. 2007). Support groups are considered a particular effective method of treatment as they can expand a woman's social networks, especially with women who may feel isolated and stigmatized for a number of reasons including domestic violence and/or coping with the double burden of mental health and AOD issues. Programs that offer social support are particularly effective when they consider the practical needs of women such as securing safe and appropriate housing, dealing with employment and welfare issues as well as addressing physical health issues (Dale & Marsh 2000).

Either in groups or individually service providers can also assist women in helping them to make the links between substance use, violence, depression and other life experiences. An important role of workers is providing a safe space for women to disclose their concerns and to explore strategies suitable for them.

9.4 Prevalence of the Issues Raised

The fourth sub-objective was to explore the prevalence of the issues raised by service providers and newly arrived women during interviews and focus groups amongst a broader range of CaLD women using quantitative methods. Table 9.3 and 9.4 provides an overview of the issues raised in the focus groups and interviews with service providers and newly arrived women that were and were not supported by the quantitative results.

Table 9.3 Summary of Issues Raised in the Qualitative Phases Supported by Quantitative Results

Issue	Supported by Data Gathered in the Questionnaire
• There were low levels of tobacco use amongst new arrivals	• Confirmed, survey data showed that 77.2% of women had never smoked.
• Smoking was used a coping strategy for stress in women who continued to smoke in Australia.	• Confirmed, 58% of the women who smoked cited one of the reasons for smoking was managing stress
• Women quit smoking after arrival due to greater awareness of health risks to themselves, their children, and/or unborn child.	• Confirmed, amongst women who cut down or quit smoking awareness of health risks to themselves, their children, and/or unborn child were the most common reasons given for stopping or reducing their smoking.
• There were low levels of alcohol consumption	• Confirmed, survey data showed 76.1% of women do not consumer alcohol
• For women who drank alcohol, there had often been a change in their drinking pattern.	• Confirmed, for those women who drank 28.3% drank less and 31.7% drank more since coming to Australia.
• Problematic alcohol use caused a number of problems in the family not just domestic violence.	• Was not specifically asked about in the questionnaire. Requires further investigation.
• Problematic alcohol use was co-occurring with abuse by intimate partners or ex-partners.	• Confirmed, of the women reporting abuse related to AOD use, physical abuse by partners accounted for 73% of the cases. • Of the women being made to have sex when she did not want to by someone using AOD, partners accounted for 92.3% cases. • Just under one-third of women who reported being put in fear or verbally abused by some one under the influence of alcohol indicated that this was by their partner.
• Women have experienced problems with strangers under the influence of alcohol and drugs (raised by community women and mentioned in limited literature)	• Confirmed, forty six women experienced one or more incidents by a stranger of verbal abuse, physical abuse, being put in fear, or forced to have sex when they didn't want to. 64% of women who reported verbal abuse and over 65% of women being put in fear reported that strangers were responsible for these incidents.
• Illicit drug use was low	• Confirmed, only six women of the 268 women surveyed had used illicit drugs since coming to Australia.

Issue	Supported by Data Gathered in the Questionnaire
• Women were concerned about their children using illicit drugs and drinking alcohol	• 23 of the women surveyed were worried about or had arguments with family and friends about their AOD use. • 41% of women did not feel confident enough to talk to their children about drugs
• Women would like more AOD information and support.	• 16.8% of women chose information on illegal drugs for parents as an area they wished further assistance
• Some women find it difficult to find a GP	• 18.50% of women found it difficult or very difficult to find a GP • 10.6% of women survey didn't have a GP yet.

Table 9.4 Summary of Issues Raised in the Qualitative Phases Not Supported by Quantitative Results

Issue	NOT Supported by Data Gathered in the Questionnaire
Women using multiple GPs (doctor shopping) This was mentioned in literature and by service providers only.	71% of women reported to have attended 1 or 2 general practices since coming to Perth. A very small number (n=19 ; 8.4%) reported attending 4 or more different practices with the highest number being 6 different practices
Women using Emergency Departments inappropriately for primary health care provision. This was mentioned in literature and by service providers only.	The vast majority of reasons for attending Emergency Departments were appropriate. Only one woman reported attending an ED as she was unable to get an appointment with a GP when she needed it.
Medication issues included sharing of medication and improper use of medication. This was mentioned in literature and by service providers only.	Not as wide spread as literature and service providers indicated. Only 20 women reported sharing some one else's medication of which 5 respondents were unsure if the medications was prescribed or not. Often use was described as a one time only event or as an act of forgetfulness e.g. forgot asthma inhaler.
The use of medication for depression, stress or sleeping problems is common. This was mentioned in literature and by service providers only.	Not as wide spread as literature and service providers indicated. Only 16 women reported taking prescribed medication for depression, anxiety, sleep and/or other mental health issues.

9.5 Piloting Projects to Address Issues

The fifth sub-objective was to develop, pilot and evaluate a health promotion program to improve women's knowledge and skills around identified AOD concerns and problems. There were actually three small pilots as described in Chapter Eight. Activity in the three pilot project areas; physical activity, information and support for CaLD women around AOD issues, and information and support for older CaLD women around alcohol and medication use has been incorporated into ongoing WHS service delivery.

9.6 Limitations

Although the main objective of the project was met, recruitment was made more difficult because of changes in government policy. As a result, the approach and length of time for data collection was longer and different than originally anticipated. The findings of the study also have limitations. There may have been under reporting of the prevalence of illicit drug use in this project due to many women's recent migration to Australia and fear of deportation by some. A larger sample of younger women and men under 25, especially those who had experienced family breakdown and were no longer living with their relatives may have given a different picture of drug use amongst new arrivals as there were some anecdotal reports of drug use amongst this group. Although difficulties in finding accommodation, dealing with tenancy issues, the high cost of rent and the general shortage of rental properties were brought up by some service providers as issues for newly arrived women, these were rarely mentioned by the women participating in the project. This could be due to a selection bias as women who have the time, motivation and resources to participate were more likely to have their basic need of shelter met. Those women actively seeking accommodation in Perth's competitive and tight rental market at the time of the research project were probably less likely to participate in the project. Similarly, several service providers spoke of young teenage girls becoming pregnant or arriving pregnant, but this issue was not brought up by community women. This may have been due to younger teenagers not being involved in the study as all women had to be at least 18 years to participate.

Another limitation of the study is not being able to control for the effects of acculturation amongst participants in the analysis of the results. I had assumed that limiting the research to women who had been in Australia five years or less would control for the effects of acculturation. The adoption of behaviour patterns, attitudes, beliefs and customs of the host population by newly arrived women has been theorised to take place over decades and is often talked about as taking place over generations (Gilbert 1991, Caetano 1994). However, there is some evidence from this study that some newly arrived women are acculturating to Australian drug use patterns much more quickly. For example, of those women who drank alcohol and answered the question, 31.7% (n=19) reported drinking more alcohol. One of the reasons given for this was socialising with Australians who drank alcohol and adopting their behaviours and customs around alcohol use. Using an acculturation scale to measure the level of acculturation of participants could have clarified whether reported changes in behaviour were due to women acculturating faster than previously assumed or other factors. Future research in this area would benefit in the use of acculturation scales.

Section 3.4.9 discussed some of the general difficulties and limitations of using focus group and interviews in cross-cultural research, so these issues will not be reiterated here. From a study design perspective, using both interviews and focus groups to gain information from service providers and newly arrived women was not ideal Using just focus groups or just interviews as a means of data collection would have increased the reliability of the information gathered. However, the use of both focus groups and in-depth interviews provided more opportunities for service providers and women to participate in the study. At the design phase of the study it was unknown whether workers and women would openly discuss issues considered to be shameful, private or stigmatising in a group. Some literature did suggest that this could be an issue for this study (Elam & Fenton 2003, Dotinga et al 2004). The concern that women would not want to discuss issues related to depression, AOD use, and the difficulties they were having in a focus group proved to be unfounded. Individual interviews were not the only forum where women discussed such issues. This was an important learning for WHS as the organisation is likely to conduct other needs assessments in the future with CaLD women.

9.7 Changes in Practice and New Knowledge Gained

Using the information gathered from the project, a number of recommendations have been forwarded to WHS. These recommendations are not limited to WHS and can help other organisations make their services more culturally sensitive and accessible to newly arrived women. The first of the recommendations was to ensure newly arrived women were asked about their AOD use as part of their intake information. Although the numbers affected are very small, there are some newly arrived women who are drinking at risky or high risk levels for short and/ or long term harm or who continue to smoke or use other types of drugs problematically. Newly arrived women may not offer such information to service providers without being directly asked, and having the question raised may make it easier for women to bring up their issues and concerns. WHS did ask questions around alcohol and other drug use as part of the intake process into various WHS programs prior to the study. However, in programs where these questions were not normally asked, this information is now being collected. For example, prior to this study the Multicultural Women's Advocacy Service (MWAS) at WHS did not collect information on alcohol and drug use issues experienced by domestic violence clients accessing this service. The current national data base that is mandated by MWAS' funding body had no fields where information related to AOD could be collected. However, information on women attending support groups run by MWAS was collected on a separate database designed by WHS. Acting on the recommendations of this project, MWAS staff are now collecting information on women's own alcohol and drug use as well as the alcohol and drug use by significant others including partners, ex-partners and children. Preliminary data showed that approximately 40% of the CaLD women clients attending the peer support program were either using alcohol and/or drugs problematically or there was alcohol and/or drug use by significant others. WHS envisages that monitoring this information will result in better service provision for these women and their children.

The information gathered as part of this project has revealed an interest in and a need for information around AOD issues by migrant and refugee women. Due to funding arrangements of the various WHS programs, alcohol and drug information has been to seen to be a separate issue from other women's health issues. A more holistic

approach is now underway to incorporate alcohol and drug information as part of the current community talks WHS provides to ethnic women. AOD information can be included in talks on stress and anxiety, healthy lifestyle, employment issues, and driving. Incorporating AOD issues into other health topics may help to avoid issues of shame and stigma often associated with alcohol and other drugs. The strategy of incorporating alcohol and drug use issues into broader health education and prevention activities such as stress management has been recommended by other researchers and workers (Dimopoulos 1999, Gilbert 1991, Working Women's Health and Women's Health in the North 2000).

WHS had been asked in the past to participate in university and TAFE orientation days but had not engaged in these activities in preference to other types of displays and stalls. However, information from the community feedback sessions, as well as students and bilingual workers involved with the project, suggested WHS should be involved in these orientation days as they were good ways of getting information out to young women. It was suggested that the information that WHS should bring to such stalls include alcohol and other drug information, sexual health information, and information on safety for young women who may be living away from home for the first time, including drink spiking, going to night clubs and pubs, safety in catching transport, dealing with verbal abuse by strangers and general safety issues in living alone. Following these recommendations, WHS is now participating in Orientation Days for three of the main universities in Perth and will possibly expand this participation to include the other two universities and some TAFE centres. This approach has been justified by the response to events at the Orientations Days held so far.

9.8 Learnings That May Be of Use to Others

Within, as well as between each ethnic community, people differ in a number of ways. These differences include gender, age, religion, education, reasons for migrating, length of time in Australia, level of acculturation, language and literacy skills in their own language and English, and socio-economic status (Queensland Health 1996). Health promotion with different CaLD communities in WA has largely been based on developing programs for separate language groups. One of the

interesting things during the course of this study was the similarity of issues amongst newly arrived women despite their diverse ethnic and socio-economic backgrounds as well as migration categories. This project has indicated that separate programs for each language group or ethnic group may not always be needed. Programs and services can be developed based on similar needs of women despite different language and cultural backgrounds. However, advertising programs and services may need to be tailored to suit each particular group. Given the diversity of education levels, English language ability, and life circumstances of newly arrived women, even amongst women from the same language or cultural group, there is no one medium that will suit all new arrivals. Like any other group of people, some women will prefer one means of accessing information over another. Service providers need to keep this in mind when planning service delivery as there is a tendency to repeat the use of the same mediums again and again to disseminate information. Clients may prefer new technologies such as the web over older more established media such as ethnic radio because of ease of access at a time and manner that suits them. The needs and responses of minority groups are undoubtedly shaped by the context and environment in which they live. Thus when working with a particular group, service providers should always ask how and when women would prefer to receive information.

Discussing alcohol and illicit drug use amongst migrant and refugee women with service providers and community women had many of the same aspects as discussing domestic violence or torture and trauma issues did ten to fifteen years ago. For many women they would prefer not to acknowledge any possibility of alcohol or other drug use happening in their own lives or those of their family or community members. There was a considerable reluctance to talk about the issues. However, once past this initial reluctance, many women were interested and wanted more information, especially to assist their children to navigate their teenage years and early twenties. For many service providers, providing any alcohol and other drug information or raising the issue with their clients was "not on the radar". However, for those service providers who did ask about alcohol and other drug use, they opened the door for women to talk about their own use or more likely the concerns she had for those in

her family. For this reason, service provider working with CaLD women should be encouraged, trained, and supported to talk to their clients about AOD issues.

Services also need to be sensitive to who interprets for newly arrived women and how interpreting services are accessed for example, over the phone or face to face. Women may have a strong preference regarding who interprets for them, ranging from an unknown interpreter accessed via the telephone to an interpreter known to the woman. Where possible such preferences need to be respected and met.

The use of bilingual students and bilingual health professionals who are in the process of qualifying to work in Australia can be very effective in conducting research in ethnic communities. In general, these students and health professionals appreciate the opportunity to put their skills into practice, have good community networks, and require little training in terms of research issues such as confidentiality and referral procedures. Often their work with a research project can lead to other work in Australia as they acquire an Australian work reference for their resumes that can be difficult to obtain otherwise.

9.9 Benefits of the Research

The research has benefitted WHS in a number of ways. Data on which to base programs and interventions has been gathered. This has been used to gain funding and redirect resources to provide services that have been requested by newly arrived women. WHS has increased its networks within Western Australia and Australia to include programs and agencies that are interested in CaLD women and their AOD issues and concerns. Using information from the study WHS has increased the amount of AOD information it provides to CaLD communities with a focus on providing that information in the mediums that women have requested such as information sessions and on the web. As a result of the study there has been an increase in service delivery in areas requested by participants of the study. For example, exercise classes and other opportunities to participate in physical activity have now been incorporated into ongoing service delivery as opposed to just once off projects. There has also been an increase in services to support CaLD women and their families who have experienced domestic violence, especially for those women

where there are AOD issues intertwined with domestic violence issues. In addition, WHS is now offering more structured and ongoing opportunities for CaLD women as volunteers, student placements and interns. These opportunities allow women to gain practical experience in AOD issues, client service delivery and project management. This will help build the capacity of future service providers to work more effectively with CaLD women around AOD issues and provide CaLD women pathways into appropriate employment.

9.10 Areas for Future Research and Projects

During the course of the project a number of issues were identified that were beyond the scope of the original research proposal. These issues were noted as requiring further exploration in the alcohol and drug and/ or migrant health area.

9.10.1 Employment Issues Faced by Newly Arrived Women: the Role of a Women's Health Service

Employment issues including re-qualification or advice around studying to gain first qualifications came up repeatedly amongst women both in the focus groups and in the survey as an area with which women required assistance. In the survey just over 79% of the women rated information on how to get work and/ or information on and courses to get qualifications leading to work as one of their five priority issues. One-third (35%) of women listed these issues as their number one priority. There has been a great deal of research done on employment issues facing new arrivals that has identified that difficulties in qualification recognition, lack of English fluency, skills mis-match between the skills of new arrivals and those required in the current Australian labour market, lack of professional networks, discrimination and a poor understanding of Australian systems contribute to unemployment and underemployment in new arrivals (Colic-Peisker & Tilbury 2007, Wagner & Childs 2006, Watson 2000, Watters 2001, Waxman 2001). These issues are particularly relevant for women accompanying partners who have work already arranged in Australia and refugee women. The impact of unemployment and underemployment on people's physical, mental and social well-being is well documented and includes lowered self-esteem, depression, anxiety, and increased incidence of ill health (Bartely, Ferrie & Montgomery 1999). However, determining ways that newly

arrived women would like to receive assistance in finding appropriate employment and in gaining required qualifications was beyond the scope of this research project. There are a number of specific programs for migrants and refugees looking for advice and assistance with employment, qualifications and re-qualification. These services include three employment centres located in the Perth metropolitan area that are specifically funded to assist with the employment issues faced by migrants and refugees. Any specific and/ or additional services or support women require that is not being delivered by these specialised employment agencies and other services requires further investigation. The role of a woman's health service in providing such support and how such services or programs would interface and collaborate with existing employment services also needs to be further clarified.

9.10.2 Health Care Access and AOD Issues amongst Overseas Students

While conducting interviews on tertiary campuses and talking to tertiary students, I was told about many incidents involving alcohol use by overseas students. These incidents included drink driving, alcohol being used to mitigate stress and loneliness, and unplanned and/or unwanted sexual activity after alcohol consumption by one or both partners. Many overseas students were unaware of or did not access local or on campus health or counselling services due to a range of factors that included not being unaware of such services, lack of money, shame, embarrassment or fear of "being found out". Overseas students often lack robust social supports, having left family and friends in their country or origin to come to study in Australia. Cultural factors that may have offered protection against or modified risky behaviours in their own country may be missing due to the loss of these social networks, more permissive Australian attitudes towards alcohol use and sexual activity, and a new peer group. For some overseas students there is often a great deal of pressure to do well while other overseas students regarded their time in Australia as a "year off" to participate in an exchange program, to have fun, and/ or learn English. Alcohol use amongst this later group of students seems to be more problematic. Many overseas students are in Australia for considerable lengths of time and may eventually apply for permanent residency. Thus, the issues affecting this group are likely to impact longer-term the broader Australian community. Problematic alcohol and drug use

amongst overseas students and their access to health and support services requires further investigation.

9.10.2 Alcohol and Medication Issues Amongst Older CaLD Women

Experiences during the research project and during one of the pilot projects have shown that there is a need for a better understanding of the extent to which older migrants are experiencing medication and/or alcohol related problems and the types of problems they are experiencing. Other information needed is an understanding of how older ethnic men and women access GP services, how they communicate with their GP, and the extent to which GPs seeing older ethnic community members are asking about and providing services regarding medication and/ or alcohol related issues. More information is needed on what type of service delivery would be the most acceptable and helpful for older people who are using medications and/or drinking problematically.

9.11 Conclusion

The professional doctorate approach worked well in achieving the objectives of this project. WHS as well as other service providers now have a substantial body of evidence on which to base programs and services for newly arrived women, especially around alcohol and other drug issues. This document is the most detailed report of the needs assessment. Subsequent papers will be on specific aspects of the needs assessment and available on the WHS website or in academic journals. Different aspects of the project have also been presented at conferences through out the research period. The aim of all the documents and information about the project is to make the results accessible and useable to groups and organisations in order to enhance service delivery with newly arrived women.

Learning about the range of attitudes and experiences newly arrived women have had around alcohol use has been one of the most interesting aspects of the project and also the most challenging. Hearing about women's experiences of alcohol related violence perpetrated either by strangers or by intimate partners is never easy. However, this challenge was balanced by the encouragement of those service

providers and community women who offered practical suggestions that could help women whose lives are being negatively impacted by AOD use. The needs assessment has received a great deal of interest from community groups and government agencies in Western Australia. The research has brought academic knowledge and scholarship to enhance community development practice with newly arrived women.

Bibliography

ADF DrugInfo Clearinghouse 2004, 'CLD projects and programs in the drug and alcohol field', Obtained through personal communication from Library@adf.org.au.

The Australian Institute of Health and Welfare 2005. 2004 National drug strategy household survey; First results, (Drug statistics series no. 13).The Australian Institute of Health and Welfare, Canberra.

Druginfo Clearinghouse 2003, *Khat fact sheet for workers*, Number 2.9. viewed 26 July 2008, <*http://www.druginfo.adf.org.au/druginfo/fact_sheets/khat_sheets/khat.html*>.

Adamson, J & Donovan, JL 2002. 'Research in black and white', *Qualitative Health Research,* vol. 12, no. 6, pp 816-25.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders*, 4th edn, American Psychiatric Association, Washington DC.

Ames, G M & Rebhun, LA 1996. 'Women, alcohol and work: interactions of gender, ethnicity and occupational culture', *Social Science Medicine*, vol. 43, no. 11, pp. 1649-63.

Anand, SS 1999. 'Using ethnicity as a classification variable in health research: perpetuating the myth of biological determinism, serving socio-political agendas, or making valuable contributions to medical sciences?', *Ethnicity and Health*, vol. 4, no. 4, pp. 241-244.

Australian Alcohol Guidelines: Health Risks and Benefits 2001. National Health and Medical Research Council, Canberra.

Barata, PC, Gucciadi E, Ahmad, F, & Stewart DE 2006, "Cross-cultural perspectives on research participation and informed consent', *Social Science and Medicine,* vol.62, pp. 479-90.

Bartely, M, Ferrie, J, & Montgomery SM 1999.,'Living in high-unemployment economy: understanding the health consequences', in *Social Determinants of Health,* ed. M Marmot & RG Wilkinson, Oxford University Press, Oxford, pp.81–104.

Bauer, I 1995, 'Rank-ordering: a suitable method for nursing research', *Australian Journal of Advanced Nursing*, vol. 13, no. 1, pp. 32-6.

Bernstein, D 2002, 'World refugees', *The Age*, July 24, viewed 26 July, 2008, <http://www.theage.com.au/articles/2002/07/24/1027332400229.html>.

Bloch, A 2007. Methodological challenges for national and multi-sited comparative survey research. *Journal of Refugee Studies,* vol. 20, no. 2, pp. 230-47.

Bertram, S, Barbir, N, Ball, J, & Carroll, T 2003, *National Illicit Drugs Campaign: Evaluation of Phase One*, Department of Health and Aged Care, Sydney.

Bevan, K 1997. 'Reflections on one year of consumer participation at the Transcultural Mental Health Centre', in B Ferguson & D Barnes (eds), *Perspectives on Transcultural Mental Health*, Transcultural Mental Health Centre, Parramatta, NSW, pp. 22-31.

Bolton, P, Hammoud, S, & Leung, J 2002. 'Issues in quality use of medicines in two non-English speaking background communities', *Australian Journal of Primary Health*, vol. 8, no. 3, pp. 75-80.

Bradby, H 2003. 'Describing ethnicity in health research', *Ethnicity and Health*, vol. 8, no. 1, pp. 5-13.

Bradby, H & Williams, R 2006. 'Is religion or culture the key feature in changes in substance use after leaving school? Young Punjabis and a comparison group in Glasgow', *Ethnicity and Health*, vol. 11, no. 3, pp. 307-24.

Browne, G & Courtney, M 2006. 'Are we there yet?" consumer participation in mental health services', *Australian Journal of Primary Health*, vol. 12, no.1, pp. 8–13.
Brownlea, A 1987. 'Participation: myths, realities and prognosis', *Social Science and Medicine*, vol. 25, no. 6, pp. 605-614.

Bull, F C 2003, *Review of best practice and recommendations for interventions on physical activity. A report for the Premiers physical activity taskforce on behalf of the evaluation and monitoring working group*, Western Australian Government Perth, Western Australia.

Caetano, Raul 1994. 'Drinking and alcohol-related problems among minority women', *Alcohol Health and Research World*, vol.18, no. 3, pp. 233-41.

Chen, J, Bauman, A, Rissel, C, Tang, KC, Forero, R, & Flaherty, B 2000. 'Substance use in high school student in New South Wales, Australia, in relation to language spoken at home', *Journal of Adolescent Health*, vol. 26, pp. 53-63.

Coalter, F 2003, 'The social role of sport opportunities and challenges', in S Campbell & B Simmonds (eds), *Sport, active recreation and social inclusion*, The Smith Institute, Edinburgh, United Kingdom, pp. 39-58.

Colic-Peisker, V & Tilbury, F 2007. Integration into the Australian labour market: The experience of three "visibly different" groups of recently arrived refugees. *International Migration*, vol. 45, no. 1, pp. 59-85.

Consumer Focus Collaboration 2001, *The evidence supporting consumer participation in health*, viewed on 1 February 2007,
<www.participateinhealth.org.au/clearinghouse/Docs/evidence.pdf>

Cordwell, L 2005. 'Advancing consumer participation in primary health: the case of a Victorian primary care partnership', *Australian Journal of Primary Health*, vol. 11, no.2, pp. 38-44.

Cortis, N, Sawrikar, P, & Muir, K 2006, *Participation in sport and recreation by culturally and linguistically diverse women,* Social Policy Research Centre, University of New South Wales, Sydney, NSW.

Crittenden, KS, Manfred, C, Cho, YI, & TA Dolecek, TA 2007. 'Smoking cessation processes in low-SES women: The impact of time-varying pregnancy status, health care messages, stress, and health concerns', *Addictive Behaviors*, vol. 32, pp. 1347–66.

Culley, L, & and Rapport, F 2007. 'Using focus groups with minority ethnic communities: researching infertility in British South Asian communities', *Qualitative Health Research*, vol. 17, no. 1, pp. 102-12.

Dale, A and Marsh, A 2000, *Evidence based practice indicators for alcohol and other drug interventions: Literature review,* Best Practice in Alcohol and other Drug Interventions Working Group, Perth.

Dar, K, Chaudhry, ZA, Mirza, I, & F Alam F 2002. 'Ethnicity, patterns of substance misuse and criminality: a comparative study of white and Asian patient populations in West London', *Journal of Substance Use,* vol. 7, pp. 244-50.

Dawson, MT 2004. 'The role of consumer participation in Victorian primary care partnerships', *Australian Journal of Primary Health,* vol. 10, no. 2, pp. 134-43.

De Jong, JA, Valentine J, & Kennedy N 1998. "Implementation and evaluation of substance abuse prevention programs in culturally diverse communities: An introduction', in J Valentine, J De Jong, & N Kennedy (eds), *Substance abuse prevention in multicultural communities*: Haworth Press Inc , New York pp. 1-6.

Department of Immigration, Multicultural and Indigenous Affairs 2005, *Population flows: Immigration aspect 2003-2004.* : Department of Immigration, Multicultural and Indigenous Affairs, ACT, viewed 8 February, 2005, <http://www.immi.gov.au/statistics/publications/popflows2003_4/index.htm.>.

Department of Immigration and Citizenship, 2008, 'What is the Settlement Grants Program: Clients and Service Providers?' viewed 2 May, 2008, <http://www.immi.gov.au/living-in-australia/delivering-assistance/settlement-grants/what-sgp-providers.htm>.

Department of Immigration and Multicultural and Indigenous Affairs, 2003, 'Statistical Focus: 2001 Classification of Countries into English Proficiency Groups' viewed 9 May, 2009, <http://www.immi.gov.au/media/publications/statistics/ep-groups/ep.pdf>

Dimopoulos, L 1999, *Benzodiazepine (Minor Tranquilliser) Usage: Improving the Provision of Services and Information to People of Language Other than English Background*, TRAIN RITE Pty Ltd, Oakleigh, Victoria, Australia.

Dona, G 2007. 'The microphysics of participation in refugee research', *Journal of Refugee Studies*, vol. 20, no. 2, pp. 210-29.

Dotinga, AR, van den Eijnden, JJM, Bosveld, W, & Garretsen, HFL 2004. 'Methodological problems related to alcohol research among Turks and Moroccans living in the Netherlands: Findings from semi-structured interviews', *Ethnicity and Health*, vol. 9, no. 2, pp. 139-51.

Donnelly, P & Coakley, J 2002, *The role of recreation in promoting social Inclusion*, The Laidlaw Foundation, Ontario, Canada.

Elam, G & Fenton, KA 2003. 'Researching sensitive issues and ethnicity: Lessons from sexual health', *Ethnicity and Health*, vol. 8, no.1, pp. 15-27.

Epstein, E, Fischer-Elber, K, & Al-Otaiba, Z 2007. 'Women, aging and alcohol use disorders', *Journal of Women and Aging*, vol. 19, no.1-2, pp. 31-48.

Epstein J, Saunders, B, Kilpatrick, D, & and Resnick, H 1998. 'PTSD as a mediator between childhood rape and alcohol use in adult women', *Child Abuse and Neglect*, vol. 22, no. 3, pp. 223-34.

Faulkner, GEJ & Taylor, A H (eds) 2005, *Exercise, health and mental health: Emerging relationships.* Routledge, New York, USA.

Fink, A, Beck, JC, Wittrock, MC 2001. 'Informing older adults about non-hazardous, hazardous and harmful alcohol use', *Patient Education and Counseling*, vol. 45, pp. 133-41.

Finn D. 2009, Personal communication April 29th.

Flaskerud, J & Nyamathi, AM 2000. 'Attaining gender and ethnic diversity in health intervention research: cultural responsiveness versus resource provision,' *Advances in Nursing Science*, vol. 22, no. 4, pp. 1-15.

Flick, U 2002. *An introduction to qualitative research*, 2nd edn, Sage Publications, London.

Gibbs, L, Kealy, M, Willis, K, Green, J, Welch, N, & Daly, J 2007. 'What have sampling and data collection got to do with good qualitative research?', *Australian and New Zealand Journal of Public Health*, vol. 31, no. 6, pp 540-44.

Gilbert, MJ 1991. 'Acculturation and changes in drinking patterns among Mexican-American women', *Alcohol Health and Research World*, vol. 15, no. 3, pp. 234-38.

Goral, M 2004. 'First-language decline in healthy aging: implications for attrition in bilingualism', *Journal of Neurolinguistics*, vol. 17, pp. 31–52.

Green, J, Willis, K, Hughes, E, Small, R Welch, N, Gibbs, L, & Daly, J 2007. 'Generating best evidence from qualitative research: the role of data analysis', *Australian and New Zealand Journal of Public Health*, vol. 31, no. 6, pp. 545-50.

Greenhalgh, T & Taylor, R 1997. 'How to read a paper: Papers that go beyond numbers (qualitative research)', *British Medical Journal*, vol.315, pp. 740–3.

Griffiths, M, Qian, D, & Procter, NG 2005, *Beyond words: Lessons on translation, trust and meaning*, Multicultural Mental Health Australia, Australian Department of Health and Ageing, Canberra.

Health Outcomes International 2005, *Consumer and Carer Involvement in Co-morbidity Treatment Planning Project, Literature Review*. Australian Government Department of Health and Ageing, ACT.

Hernandez A & Li, P 2007. 'Age of acquisition: Its neural and computational mechanisms', *Psychological Bulletin*, vol. 133, no. 4, pp.638–50.

Howat, P, Maycock, B, Cross, D, Collins, J, Jackson, L, Burns, S and James, R 2003. 'Towards a more unified definition of health promotion', *Health Promotion Journal of Australia*, vol.14, no. 2, pp. 82–5.

Jacobsen, K & Landau L, 2003. Researching refugees: some methodological and ethical considerations in social science and forced migration. *New Issues in Refugee Research* - Working Paper No 90. Geneva: Evaluation and Policy Unit, UNHCR.

Jonas, HA, Dobson, AJ, & Brown, WJ 2000. 'Patterns of alcohol consumption in young Australian women: Socio-demographic factors, health-related behaviours and physical health', *Australian and New Zealand Journal of Public Health*, vol. 24, no. 2, pp. 185-91.

Juncos-Rabadan, O & Iglesias, F 1994. 'Decline in the elderly's language: Evidence from cross-linguistic data', *Journal of Neurolinguistics, v*ol. 8, no. 3, pp. 183-90.

Kalunta-Crumpton, A 2003. 'Problematic drug use among 'invisible' ethnic minorities', 2003. *Journal of Substance Use*, vol. 8, no. 3, pp. 170-75.

Karantzas-Savva, E & Kirwan, A 2004. 'Ethnic community stakeholders as partners in primary and secondary diabetes prevention', *Australian Journal of Primary Health*, vol. 10 no. 3,
pp. 61–6.

Kaplan, I 1998. *Rebuilding Shattered Lives.* Parkville, Victorian Foundation for Survivors of Torture Inc, Victoria.

Kavanagh, A, Daly, J, & Jolley, D 2002. 'Research methods, evidence and public health', *Australian and New Zealand Journal of Public Health,* vol. 26, no. 4, pp. 337-42.

Kaysen D, Dillworth, T, Simpson, T, Waldrop, A, Larimer, M, & Resick, P 2007. 'Domestic violence and alcohol use: Trauma-related symptoms and motives for drinking', *Addictive Behaviours*, vol. 32, pp. 1272-83.

Khat Fact Sheet for Workers 2003, Australian Drug Foundation, Drug Info Clearinghouse, Melbourne, viewed 18 November 2007, <http://www.druginfo.adf.org.au/article.asp?ContentID=khat.>

Koehn C & Hardy C 2007, 'Depression and problem substance use in women', in N Poole & L Greaves (eds), *Highs and lows: Canadian perspectives on women and substance use*, Centre for Addiction and Mental Health, British Columbia, pp. 129-41.

Krauss, BJ, Goldsamt, L, Bula, E, & Sember, R 1997. 'The white researcher in the multicultural community: Lessons in HIV prevention education learned in the field', *Journal of Health Education,* vol. 28, no. 6, pp. 67-71.

Language Services in Health Care - Policy Guidelines 1998, Department of Health, Perth, Western Australia.

Leask, J, Hawe, P, & Chapman, S 2001. 'Focus group composition: A comparison between natural and constructed groups', *Australian and New Zealand Journal of Public Health*, vol. 25, no. 2, pp. 152-4.

Leonard, K 2001. 'Domestic violence and alcohol: what is known and what do we need to know to encourage environmental interventions?' *Journal of Substance Use*, vol. 6, pp. 235-47.

Llewellyn-Jones, L 2001. 'Sharing Power: Principles for Community Participation in Health Promotion', *Australian Journal of Primary Health,* vol. 7, no. 1, pp. 97-100.

Loncar, N 2008. *Once a Leader, Always a Leader*, Ethnic Communities Council of WA, Perth.

Marsh A 2008, 'Co-occurring post-traumatic stress disorder and drug disorders', in S Allsop (ed), *Drug use and mental health; effective responses to co-occurring drug and mental health problems*, IP Communications, Pty, Ltd, Melbourne, pp. 150-164.

MacAndrew, C & Edgerton, RB 1969, *Drunken comportment: A social explanation*, Aldine Publishing Company, Chicago.

McDonald L & Sayger T 1998, 'Impact of a family and school based prevention program on protective factors for high risk youth', in J Valentine, J De Jong, & N Kennedy (eds), *Substance abuse prevention in multicultural communities.* Haworth Press Inc, New York, pp.61–86.

McLean, CA & Campbell, CM, 2003. 'Locating research informants in a multi-ethnic community: Ethnic identities, social networks and recruitment methods', *Ethnicity and Health*, vol. 8, no. 1, pp. 41-61.

McKenzie, JF & Smeltzer J 2001, Models for health education and health promotion programming', in *Planning, implementing, and evaluating health promotion programs: a primer,* Allyn and Bacon, Sydney.

Ministerial Council on Drug Strategy 2005, *National Tobacco Strategy 2004-2009*. Commonwealth of Australia, Canberra.

Mukamal, KJ, Robbins, JA, Cauley, JA, Kern, LM, & Siscovick, DS 2007. 'Alcohol consumption, bone density, and hip fracture among older adults: the cardiovascular health study', *Osteoporosis International*, vol. 18, pp. 593-602.

Multicultural Access Unit 1996, *Culture and Health Care: Culture, Settlement Experiences and Life style of non-English Speaking Background people in Western Australia.* Health Department of Western Australia, Perth, WA.

Murphy-Lawless, J 2002, *Fighting Back: Women and the Impact of Drug Abuse on Families and Communities,* The Liffey Press, Dublin.

Nathan, S 2004. 'Consumer participation: the challenges to achieving influence and equity', *Australian Journal of Primary Health*, vol. 10, no.3, pp.15-20.

National Centre for Education and Training on Addiction (NCETA) Consortium 2004. *Alcohol and other drugs: A handbook for health professionals,* Australian Government Department of Health and Ageing, Canberra.

National Resource Centre for Consumer Participation in Health 2004, Information series: consumer participation on committee, viewed 17 April 17, 2006, <www.participateinhehalth.org.au/clearinghouse/docs/infoseriescommittees.pdf. >.

Ng C, Bartu A, & Sang, D 1999, *Alcohol and drug Use among the Vietnamese in Western Australia: Health risks and service use,* Edith Cowan University, Perth.

Nutbeam, D & Harris, E 1998, *Theory in a nutshell: A practitioner's guide to commonly used theories and models in health promotion*, National Centre for Health Promotion, Sydney.

Oakley, A, Wiggins, M, Turner, H, Rajan, L, & Barker, M 2003. 'Including culturally diverse samples in health research: A case study of an urban trial of social support', *Ethnicity and Health*, vol. 8, no. 1, pp. 29–39.

Olff M, Langeland, W, Draijer, N, & Gersons, B, 2007. 'Gender differences in posttraumatic stress disorder. 2007. *Psychological Bulletin*, vol. 133, no.2, pp. 183-204.

Osorio, R, McCusker, M, & Salazar, C 2002. 'Evaluation of a women-only service for substance misusers', *Journal of Substance Use*, vol.7, pp.41-9.

Office of Multicultural Interest 2003-2008. *Office of Multicultural Interests* ,*Western Australian Diversity Statistics*, Office of Multicultural Interest, Perth, viewed 2 May, 2008, < http://www.omi.wa.gov.au/omi_stats.asp>.

Phan, TT & Fitzgerald, MH 1996, *Guide for the use of focus groups in health research*, Transcultural Mental Health Centre, North Parramatta, NSW.

Pitchforth, E & van Teijlingen, E 2005. 'International public health research involving interpreters: a case study from Bangladesh', *BMC Public Health*, vol. 5, pp. 71.

Pletsch, PK & Kratz, AT, 2004. 'Why do women stop smoking during pregnancy? Cigarettes taste and smell bad', *Health Care for Women International*, vol. 25, pp. 671–79.

Polgar, S and S Thomas, S 1995, *Introduction to research in the health sciences*, Churchill Livingstone , London.

Prochaska, JO, DiClemente, CC, & Norcross, JC 1992. 'In search of how people change: Applications to addictive behaviors', *American Psychologist*, vol. 47, no. 9, pp. 1102-14.

Queensland Health. 1996, *Alcohol and Other Drug Use and People from Non-English Speaking Background: Policy Discussion Paper*, Queensland Health, Brisbane.

Ragin, DF , Ricci, E, Rhodes, R Holohan, J, Smirnoff, M & Richardson, LD 2008. 'Defining the "community" in community consultation for emergency research: Findings from the community VOICES study,' *Social Science and Medicine*, vol. 66, pp. 1379-92.

Reid, G, Crofts, N & Beyer, L 2001. 'Drug treatment services for ethnic communities in Victoria, Australia: an examination of cultural and institutional barriers', *Ethnicity and Health*, vol. 6, no. 1, pp. 13-26.

Rissel, C; McLellan, L, Bauman, A, & Tang, KC 2001. 'How Arabic and Vietnamese youth in Sydney perceive tobacco use', *Health Promotion Journal of Australia*, vol. 12, no. 3, pp. 223- 27.

Rohr-Rouendaal, P 1997, *Where there is no artist, Development drawings and how to use them*. Intermediate Technology Publications, London.

Rowland, B, Toumbourou, JW, & Stevens, C 2003, *Preventing drug-related harm in communities characterised by cultural and linguistic diversity. Prevention research and evaluation report number 8*, Drug Info Clearinghouse, West Melbourne, Victoria, Australia.

Sargent, P, Maher, L, Higgs, P, & and Crofts, N 2001. 'Initiation to injecting drug use among Indo-Chinese young people', *Health Promotion Journal of Australia*, vol. 12, no. 3, pp. 242-47.

Shemirani, FS & O'Connor, DL 2006. 'Aging in a foreign country: Voices of Iranian women aging in Canada', *Journal of Women and Aging*, vol. 18, no. 2, pp. 73-90.

Sowey, H 2005, Are refugees at increased risk of substance misuse?, 1st edn, Drug and Alcohol Multicultural Education Centre: Sydney.

Sowey, H 2007, *The African companions' project*. Drug and Alcohol Multicultural Education Centre, Sydney.

Small, R, Yelland, J, Lumley, J, & Rice, PL 1999a. 'Cross-cultural research: trying to do it better 1. Issues in study design', Australian and New Zealand Journal of Public Health, vol. 23, no. 4, pp. 385-89.

Small, R, Yelland, J, Lumley, J, Rice, PL, Cotronei, V, & Warren, R 1999b. 'Cross-cultural research: trying to do it better 2. Enhancing data quality', Australian and New Zealand Journal of Public Health, vol. 23, no. 4, pp. 390-5.

Smith, BC 1998. 'Participation without power: subterfuge or development?', *Community Development Journal*, vol. 33, no. 3, pp. 197-204.

Smith D, Davis, J & Fricker-Elhai, A 2004. 'How does trauma beget trauma? Cognitions about risk in women with abuse histories', *Child Maltreatment*, vol. 9, no. 3, pp. 292-303.

Sozomenou, A, Mitchell, P, Fitzgerald, MH, Malak, A, & Silove, D 2000. Mental health consumer participation in a culturally diverse society 2nd edn, Australian Transcultural Mental Health Network. Sydney, NSW.

Sterk, C 1999. 'Building bridges: community involvement in drug and HIV research among minority populations, in MR De La Rosa, B Segal, & R Lopez (eds), *Conducting drug abuse research with minority populations: advances and issues.* Haworth Press, Inc, New York.

Stewart, M, Makwarimba, E, Barnfather, A, Letourneau, N, & Anne Neufeld, A 2008. 'Researching reducing health disparities: Mixed-methods approaches', *Social Science and Medicine,* vol. 66, pp.1406-17.

Stewart, P 2007, 'Treating problem substance use and post traumatic stress disorder concurrently', in N Poole & L Greaves (eds), *Highs and lows: Canadian perspectives on women and substance use,* Centre for Addiction and Mental Health , Toronto, pp. 201-9.

Stewart, SH 1996. 'Alcohol abuse in individuals exposed to trauma: A critical review', *Psychological Bulletin,* vol. 120, no. 1, pp. 83 to 112.

Stone, L 1992. 'Cultural influences in community participation in health', *Social Science and Medicine,* vol. 35, no. 4, pp. 409-17.

Straussner, S 2001. 'Ethnocultural issues in substance abuse treatment: An overview', in S Straussner (ed.), *Ethnocultural factors in substance abuse treatment,* Guildford Press, New York, pp.3-28.

Taylor, T & Toohey, K 1998. 'Perspectives on sport: Voices of women from non-English speaking backgrounds', *The ACHPER Healthy Lifestyles Journal,* vol. 45 no. 1, pp. 5-9.

Temple, B 2002. 'Crossed wires: interpreters, translators, and bilingual workers in cross-language research', *Qualitative Health Research,* Vol. 12, no. 6, pp. 844- 54.

Tilbury, F 2007. ''I feel I am a bird without wings': discourses of sadness and loss among east Africans in Western Australia', *Identities: Global Studies in Culture and Power,* vol. 14, no. 4, pp. 433 – 58.

Torrent, M, Sunyer, J, Cullinan, P, Basagana, X, Harris, J, Garcia, O, & Anto JM 2004. 'Smoking cessation and associated factors during pregnancy', *Gaceta Sanitaria*, vol. 18, no. 3, pp.184-89.

Towers T 2008, 'Responding to co-occurring drug use and complex post-traumatic stress disorder', in S Allsop (ed), *Drug use and mental health; effective responses to co-occurring drug and mental health problems,* IP Communications, Pty, Ltd, Melbourne, pp. 259-277.

Trotter, L 1998, 'Survey of smoking beliefs and behaviour in Greek and Chinese communities', in L Trotter & R Mullins (eds), *QUIT Evaluation Studies No 9, 1996-1997,* Centre for Behavioural Research in Cancer, Anti-Cancer Council of Victoria, Melbourne, pp. 107-109.

Tsianakas, V & Rice, K 2005, *Gender advocacy framework. Gender impact assessment: Alcohol,* Women's Health Victoria, Melbourne.

United Nations' Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984, Office of the High Commissioner of Human Rights, viewed on 2 May, 2008, < *http://www2.ohchr.org/english/law/cat.htm>)*

United Nations High Commissioner for Refugees 1951, *Convention and Protocol Relating to the Status of Refugees*, United Nations High Commissioner for Refugees, Geneva.

Velanovski, S & Karantzas, E 2006, *Engaging culturally and linguistically diverse communities in physical activity: A discussion paper*. Victorian Centre for Culture Ethnicity & Health , Melbourne, Victoria.

Wagner, R & Childs, M 2006. 'Exclusionary narratives as barriers to the recognition of qualifications, skills and experience a case of skilled migrants in Australia,' *Studies in Continuing Education*, vol. 28, no. 1, pp. 49-62.

Walt, G & Rifkin, S 1990, 'The political context of primary health care', in P Streefland & J Chabot (eds), *Implementing Primary Health Care*, Royal Tropical Institute, Amsterdam, pp. 13-20.

Watson, I 2000, 'Migrant and long term unemployment', in S Bertone & H Casey (eds), *Migrants in the new economy: Problems, perspectives and policy*, Workplace Studies Centre, Melbourne.

Watters, C 2001. 'Emerging paradigms in the mental health care of refugees', *Social Science and Medicine*, vol. 52, pp. 1709-18.

Waxman, P 2001. The economic adjustment of recently arrived Bosnian, Afghan and Iraqi refugees in Sydney, Australia', *International Migration Review*, vol. 35, no. 2, pp. 472-505.

Wen, LM, Hua, M, & Chris Rissel, C 2002. 'Changes in smoke-free home status in an immigrant Lebanese community in Sydney, Australia', *Australian and New Zealand Journal of Public Health*, vol. 26, no. 1, pp. 78.

Western Australian Health and Wellbeing Surveillance System 2006, Computer assisted telephone interview (CATI) survey, Department of Health, Perth, Western Australia.

Whiteside-Mansell, L, Crone, C, & Conners, N 1999. 'The development and evaluation of an alcohol and drug treatment program for women and children', *Journal of Substance Abuse Treatment*, vol. 16, no. 3, pp. 265-75.

WHS Strategic Plan 2008-2010, 2008. Womens Health Services, Perth.

Working Women's Health & Women's Health in the North 2000. *'Nobody ever asked me if I wanted to know': An alcohol and drug health promotion project with culturally*

and linguistically diverse working women', Working Women's Health, Melbourne, Victoria.

Yelland, J & Gifford, SM 1995. 'Problems of focus group methods in cross-cultural research: a case study of beliefs about sudden infant death syndrome,' *Australian Journal of Public Health,* vol. 19, no. 3, pp. 257–63.

Yick, AG, Berthold, SM 2005. 'Conducting research on violence in Asian American communities: methodological issues', *Violence and Victims*, vol. 20 no. 6, pp. 661-78.

Zandes, S 2003. 'Ethnic community group leaders' views on passive smoking in their community', *Health Promotion Journal of Australia,* vol.14, no.2, pp.119-22.

Zakus, JDL & Lysack, C 1998. 'Revisiting community participation', *Health Policy and Planning,* vol.13, no. 1, pp. 1-12.

Every reasonable effort has been made to acknowledge the owners of copyright material. I would be pleased to hear from any copyright owner who has been omitted or incorrectly acknowledged.

Appendix One

Womens Health Service's Consumer Reference Group Statement of Purpose

The Reference Group meets to:

1. Learn and share ideas and viewpoints

2. Educate ourselves about
    a. alcohol and other drug (AOD) issues
    b. Services available
    c. our responsibilities as residents of Australia

3. Acknowledge and respect the role of mothers and fathers and the importance of culture

4. Provide information and direction to Womens Health Services on alcohol and other drug issues and concerns of CaLD women and their families

What we do

1. We invite guest speakers and visit agencies to educate ourselves and others

2. Support ethnic women and their families with alcohol and other drug issues and concerns

3. Support young women to counter negative peer group pressure

4. Promote non-judgemental support and respect for women and their families

5. Welcome and celebrate cultural diversity.

What do we hope to achieve?

1. Empower culturally and linguistically diverse women by promoting confidence, education, job opportunities, and self esteem especially for:
    a. Women in prison
    b. Isolated women
    c. Senior women

2. Give ideas to service providers about how to work with women and their families from culturally and linguistically diverse backgrounds

3. Improve understanding of cultural diversity

Who can Join:

- Women who are 18 years old or more from a CaLD background*.
- Women interested or concerned about drug and alcohol issues in their family or community
- Women who are willing to learn
- Women who are willing to commit to our statement of purpose
- Please be aware that are meetings are in English

Responsibilities of Joining the Group

- Respect confidentiality
- To be respectful and non-judgemental about people's choices and opinions
- Attend meetings regularly (Tell us in advance if you can't come to a meeting).
- Share your views and experiences with the group

***Culturally and linguistically diverse (CaLD) background**

Refers to where the language spoken at home is a language other than Australian English and/ or where the cultural and social customs are different from the range of Australian cultural and social customs. This term excludes Aboriginal and Torres Strait Islander backgrounds.

Appendix Two

Focus Group and Interview Questions for Service Providers and Community Leaders

1. Who are the main groups of newly arrived women you work with? (Prompt humanitarian entrant, migrant, spouse, country of origin, level of English)

2. I'd like to ask you about issues faced by newly arrived women and smoking. Some of the issues these women face could be because of their own smoking, smoking by a member of their family or general Australian attitudes and practices towards smoking. So, thinking about the newly arrived women you work with, what are some of the issues around smoking that these women face?

3. I'd like to ask you about issues faced by newly arrived women and prescription medicines. Some of the issues these women face could be because of their own use of medication, medication use by a member of their family or general Australian practices about prescription medicines. So, thinking about the women you work with who have come to Australia in the last five years, what are some of the issues around prescription medicine that these women face? (prompt anti depressants, tranquillisers, antibiotics)

4. I'd like to ask you about issues faced by newly arrived women and alcohol. Again some of the issues these women face could be because of their own alcohol use, alcohol use by a member of their family or general Australian attitudes and practices around alcohol. What are some of the issues around alcohol that these women face?

5. I'd like to ask you about issues faced by newly arrived women and illicit drug use. Again some of the issues these women face could be because of their own drug use, drug use by a member of their family or general Australian attitudes and practices around illicit drugs. Thinking about the recently arrived women you work with, what are some of the issues around illicit drugs that these women face?

6. What do you think are the most culturally appropriate ways to address the issues we have been discussing? (prompt different strategies for different types of drugs?)

7. Do you think in role as … (community worker, teacher, etc) that you could talk to women and answer their questions about alcohol and drug issues? (prompt if this would be appropriate in relation to their role)

8. If yes, what would help you talk to women and answer their questions about alcohol and drug issues? (prompt training, resources, time..)

9. If yes, what resources, if any, are you using to discuss alcohol, tobacco, and other drug concerns with women at present? Show examples of common pamphlets, posters, etc in language and in English that participants can identify.

10. What other service providers do you mainly refer to about alcohol and other drug issues?

11. Alcohol and other drug concerns are just one of the many health issues that newly arrived women are faced with. What other health concerns do you think women would give as a priority?

12. What is the best way to give you feedback about this project ? (e-mail, letter, short report, newsletter, etc)

Appendix Three

Focus Group Questions and Interview Questions for Community Women

How long have you been in Australia?

Where are you from?

What language do you speak at home?

What are you doing now? (student, working, home duties, etc)

When you move to a new country there are many changes to the way we live that can affect our health.

Exercise
What changes have you made in the way you exercise since coming to Australia?

Smoking
Do you smoke? Any one in your family smoke? (If no skip)

People often change how much they smoke when they come to Australia. Have you (and/ or family member) changed how much you smoke since coming to Australia?

Alcohol
Do you drink alcohol? Any one in your family? (If no skip)

People often change how much, when they drink and what they drink alcohol when they come to Australia. Have you (and/ or family member) changed the way you drink or what you drink since coming to Australia?

GP Access
When you come to a new country you have to find a new doctor, a GP.
Have you found a new doctor yet?
Do you speak to that doctor in English?
Do you get enough time to talk to the doctor about your health problems?

Prescription Medication
Prescription Medicines (medicines that you need to get with a special note from the doctor at the chemist) are often very different from country to country. Have you had to use any prescription medicine since coming to Australia?

Some women find coming to a new country very stressful and they are given medication to help with sleeping, or because they feel very sad or because they are anxious. Have you had any of these tablets?

Health Information
What is the best way to get health information out to newly arrived women such as yourself/ yourselves?

What things are the most important?
Can you put these cards into three groups from most important, somewhat important to not very important for you. (The cards have words and pictures and the woman put them onto a board with three different categories marked with stars (three stars most important, two stars somewhat important, one star least important. The women don't have to agree with each other.)

Exercise Classes for women
Swimming classes/ lessons for women
Bike trips for women (can also be about learning to ride a bike)
Walking groups for women
Information about where to exercise near where you live e.g. clubs, fitness centres
Information on eating better
Food shopping on a budget
Supermarket tours
Help losing weight – information and groups
Help stop smoking – information and groups
Where to get foods from your country in Perth
Information on how to get a GP and get the most out of a GP
Information on sleeping better
Information on antidepressants, anti-anxiety medicine, "stress tablets"
Information on alcohol
Information on family or domestic violence, what it is, where to go for help
Activities to help women relax like pampering days, massage, and meditation
Information on family planning and contraception
Information on infections women can get from sex
Information on illegal drugs like speed
Information on marijuana
Information on pap smears and breast checks
Information on depression/ postnatal depression, what it is, what to do, where to get help
Parenting in a new country

There are three blank cards what health topics or issues should we put on those? Where do they go?

Would you like me to give you information on what this research project found out?

Appendix Four

Womens Health Services Questionnaire for Newly Arrived Women

Please ensure the respondent is

1. **A woman 18 years or older <u>and</u>**
2. **Is a permanent resident of Australia or intending to get her PR <u>and</u>**
3. **Has been in Australia <u>5 years or less</u>**

Please tell the participant the following information:

- This questionnaire is to help Womens Health Services plan services for women who have just arrived in Australia.
- The information you tell us is confidential.
- You do not have to answer all of the questions you are asked. If you do not want to answer a question, tell me to skip to the next question.
- If you do not understand the question, please ask me to explain.
- Curtin University is helping us with this questionnaire. This project has been approved by the University's Ethics Committee.
- If you do not want to answer any questions, this will not affect services provided to you by Women's Health Services or Curtin University.
- The questionnaire will take about 20 to 25 minutes to complete. To thank you for your time we will reimburse you $10 for your time and we have a small gift for you.
- If you would like more information about the project, please contact Susan Lee or her Supervisor, Dr. Sandra Thompson. The contact details are below.

Sue Lee
Women's Health Services
PO Box 32, Northbridge, WA 6865
suelee@whs.org.au
Phone: 9227-9032

Dr. Sandra Thompson
Centre of International Health
Curtin University of Technology
GPO Box U1987, Perth, WA 6845
Phone: 9266-3985

☐☐☐ **Survey Number** **Match name _____**

1. What is your postcode?

☐☐☐

2. How old are you? (Please write the numbers on the line – Refuse is 99)

☐☐

3. How long have you been in Australia?

☐☐ **Months**

(2 years = 24 months; 3 years = 36 months; 4 years = 48 months; 5 years = 60 months)

4. Which migration category did you come to Australia under?

1. Refugee/Humanitarian Entrant
2. Student Visa
3. Fiancé Visa
4. Spousal/ partner Visa
5. Other family visa e.g. child; parent of a person migrating or already a resident
6. Skilled migrant including employer sponsored
7. Business Development migrant (to run a business in Australia)
8. New Zealand citizen
9. Other

5. Where were you born?

_____

6. Where are your parents and family from? (ethnicity)

_____

7. What is the main language you speak? (the language you grew up speaking)

_____

8. What is your religion?

_____

9. Are you mainly (read out options and circle one)

1. Working full-time for pay
2. Working part time for pay
3. Working part time for pay and studying part time
4. A full-time student
5. A full-time student and working part time
6. A part-time student only
7. Unemployed or looking for work
8. Doing home duties full-time
9. Retired or on a pension
10. Refused

10. What is your approximate family income before tax for the past 12 months? (include student allowances, etc) (Read options and circle one.)

1. Under $20,000
2. $20,000 - $50,000
3. Above $50,000
4. Don't know/ not sure/ can't remember
5. (Refused)

11. What is the highest level of education you have completed ?

1. Some of primary school
2. Finished primary school
3. Year 10 or below
4. Year 12 or below (High School Certificate)
5. Trade/ Apprenticeship/ TAFE or Technical Certificate
6. Bachelor Degree
7. Post-Graduate Degree
8. Other (Specify) _____
9. (Refused)

12. How well do you speak English? (Read out)

1. English is my main language
2. Very well
3. Well
4. Some
5. None at all

13. How well do you read English? (Read out)

1. Very well
2. Well
3. Some
4. None at all

14. Who lives with you in the house or apartment you are living in now?

1. No one else

2. Husband/ Defacto/ Partner

3. Sons (please specify ages)

☐☐

☐☐

☐☐

☐☐

☐☐

☐☐

4. Daughters (please specify ages)

☐☐

☐☐

☐☐

☐☐

☐☐

☐☐

5. Relatives (specify) _____

_____

_____

6. Friend

7. Housemate

8. Tenant

9. Other (specify) _____

_____

15. What is the most useful way for you to get the information you need as a woman new to Australia?

	not useful	useful	very useful	don't know	Refused
	1	2	3	4	5
Information Sessions or talks					
Articles in the local community newspaper					
Information on the Web					
Talks or information in English classes and bridging courses					
Information on Ethnic radio					
Pamphlets and information sheets					
Telephone information services					

16. What other ways can you suggest to get information out to newly arrived women? Code manually

17. What are the best times for you to go to information session/ talks or activities?
(circle all that apply)

1. Weekday mornings between 9:30 and 11:30 am
2. Weekday afternoons between 1 and 2:30 pm
3. Weekday evenings 5:30 to 7pm
4. Weekday nights after 7:00 pm
5. Saturday mornings 10 to 12
6. Saturday afternoons 1:30 to 3
7. Sunday mornings 10 to 12
8. Sunday afternoons 1:30 to 3

18. Do you need child care on these days in order to go to the information session, talks or activities?

1. Yes
2. No
3. Don't know/ maybe

19. Does any one in your household smoke?

1. Yes
2. No (skip to 21)
3. Refused

20. Who? (e.g. relative, friend, tenant**) _____**

21. Which of the following best describes you? (read out and circle one)

1. I smoke daily
2. I smoke occasionally
3. I don't smoke now but I used to (Go to question 23)
4. I've tried it a few times but never smoked regularly (Go to question 23)
5. I've never smoked (Go to question 25)
6. Unsure/ don't know/ can't remember
7. Refused

22. Why do you smoke? (Read Out and circle all that apply)

1. I enjoy smoking
2. Smoking helps me when I am stressed or have lots of problems and worries
3. Smoking helps me manage my weight
4. Smoking helps me fit in and feel more comfortable with my Australian friends and family
5. I am addicted to nicotine
6. Smoking is not as bad for my health as people say
7. Other (please write in) _____

23. Have you stopped smoking or cut down on your smoking since coming to Australia?

1. Yes, Continue
2. No, Go to Question 25
3. Refused, Go to Question 25

24. If yes, why? Manual coding

Show standard drink diagram

25. In the last 12 months have you drunk more than 1 standard drink of alcohol in any one month?

1. Yes, continue
2. No, Skip to Question 30
3. Refused

26. Since coming to Australia, on average how often did you have an alcoholic drink of any kind? (Read out and circle 1 response)

1. Everyday
2. 5 to 6 days a week
3. 3 to 4 days a week
4. 1 to 2 days a week
5. Less often
6. Refused

27. On a day that you have an alcoholic drink, how many standard drinks do you usually have? (see the coloured Standard Drinks Guide)

1. 13 or more drinks
2. 11 - 12 drinks
3. 7 - 10 drinks
4. 5-6 drinks
5. 3-4 drinks
6. 1-2 drinks
7. Refused

28. Compared to when you drank alcohol in your own country, since coming to Australia, are you drinking

1. about the same amount of alcohol
2. drinking less alcohol
3. drinking more alcohol
4. Refused

29. Why do you think this is? (Manual Coding)

The next few questions are about things that may have happened to you. Please remember that your answers are confidential. You can skip a question if you would like.

30. Since coming to Australia, has any one who has been drinking alcohol or taking drugs (Mark one response for each row)

	1.Yes	2. No	3.Refused
Verbally abused you (insulted you, yelled or sworn at you)			
Physically abused you (hit you, pushed you)			
Put you in fear (made you scared)			
Made you feel uncomfortable or embarrassed			
Made you have sex when you didn't want to			

If all no, skip to Question 33

31. Who was the person who did this to you?

Read Across ⇨	Verbally abused you (insulted you, yelled or sworn at you)	Physical Abused (hit you, pushed you)	Put you in Fear (made you scared)	Made you feel uncomfortable or embarrassed	Made you have sex when you didn't want to	Refused
	1	**2**	**3**	**4**	**5**	**6**
Spouse or partner						
Parent						
Child						
Brother or sister						
Other relative						
Other house/ flat resident						
Current boy/ girl friend						
Former spouse/ partner/boy/girlfriend						
Work/school/university mate						
Friend						
Other person known to me						
Stranger/ Person not known to me						
Refused						

32. In general, at the time(s) these incidents took place, had you also been drinking alcohol or taking drugs?

1. Yes, alcohol only
2. Yes, other drugs only
3. Yes both alcohol and other drugs
4. No, neither alcohol nor other drugs
5. Refused

33. When you came to Perth how difficult was it to find and get an appointment with a GP (family doctor)? (Read out options)

1. Very difficult
2. Difficult
3. Easy
4. I don't have a GP yet **(probe why and then skip to question Q36)**

34. Why/ Comment? Manual coding

35. Many doctors in Perth work together in the same practice. How many different family practices have you gone to for your health since coming to Australia?

☐☐

36. How many times have you needed to go to the Emergency Department at the hospital for your own health since coming to Australia?

☐☐ **(Skip to Question 38 if none)**

37. Why did you go to the hospital rather than to your family doctor? (Manual code)

38. I talk to the GP (Read out and circle all that apply)

1. In English
2. In my own language
3. In another language we both speak
4. Using an interpreter
5. With the help of my husband or partner
6. With the help of my children
7. With the help of a friend

39. How many times have you moved house since coming to Australia?

☐☐

40. Why have you moved? (Probe has she stayed in the same suburb) **(Manual Code)**

41. Since coming to Australia, have you taken any herbs, drinks, tablets or medicine to help you lose weight?

1. Yes (Continue)
2. No (Skip to Question 43)
3. Refused (Skip to Question 43)

42. If yes, where did you get these from?

1. Herbalist, health food store, grocery store, etc
2. Chemist (non-prescription)
3. Doctor (prescription)
4. Other: (write in) _____

43. Since coming to Australia, have you ever used someone else's prescription medicine when you were feeling unwell ?

1. Yes, Continue
2. No (Skip to Question 46)
3. Not sure if the medicine was prescribed or not, (Continue)
4. Refused (Skip to Question 46)

44. Since coming to Australia, which medications originally prescribed or recommended for <u>someone else</u> have you used.?
(Read Out and Mark all that apply)

1. Pain killers/Analgesics
2. Antibiotics
3. Tablets or Capsules for Anxiety, Nerves or Depression
4. Tablets or Capsules to help you sleep
5. Asthma Medications
6. Herbal and alternative medicines, vitamin and mineral supplements, etc
7. Others
8. None in the since coming to Australia
9. (Refused)

45. Why did you use other people's prescription drugs? (Manually code)

46. Some women take vitamins, herbs or medicines to help them feel less sad or anxious, to help their memory or to help them feel less stressed or worried. Since coming to Australia have you taken (tick the appropriate box)

	1. Yes	2. No	3. Refused
Vitamins or herbs to help you feel less sad, to help your memory or to help you feel less stressed or worried			
Tablets or capsules prescribed by a doctor to help you feel less sad, to help your memory or to help you feel less stressed or worried			
Tablets or capsules from a chemist or herbalist to help you sleep			
Tablets or capsules prescribed by a doctor to help you sleep			
Other medications for your mental health			

If all NO, Skip to Question 48

47. How long have you been taking these medications? (Tick the appropriate box)

	Less than one month	1 month to less than 3 months	3 months to less than 6 months	6 months or more	1 year or more	Don't know
	1	**2**	**3**	**4**	**5**	**6**
Vitamins or herbs to help you feel less sad, to help your memory or to help you feel less stressed or worried						
Tablets or capsules prescribed by a doctor to help you feel less sad, to help your memory or to help you feel less stressed or worried						
Tablets or capsules from a chemist or herbalist to help you sleep						
Tablets or capsules prescribed by a doctor to help you sleep						
Other medications for your mental health						

The next few questions are about drugs.

- We ask these because the information will be very useful to us to plan programs and services for women.
- Please remember that your answers are confidential and we won't identify your information in any way.
- If you do not want to, you do not have to answer a question. Just ask me to skip to the next question.

48. Do you feel you know enough about illegal drugs to be confident that you can talk to your children about them?

1. Yes
2. No
3. Don't know
4. Don't have children/ children not here/ children too young
5. Refused

49. Since coming to Australia have you been worried about or had any arguments with family or friends about <u>their</u> use of alcohol, marijuana, khat or other drugs ?

1. Yes
2. No (skip to Question 51)
3. Refused

50. If yes, what were you worried about or what was the argument about?
(Manual coding)
Drug

Who is using family, friend…

Problem

51. Have you used Marijuana/ Cannabis since coming to Australia?

1. Yes (continue)
2. No (skip to Question 53)
3. Refused

52. Since coming to Australia, how often have you used Marijuana/ Cannabis?

1. Every day
2. Once a week or more
3. About once a month
4. Every few months
5. Once or twice a year
6. Other (write in response) _____
7. Refused

53. Have you used any other drugs since coming to Australia such as: amphetamines, speed, ice, barbies, downers, ecstasy, heroin)

1. Yes (continue)
2. No (skip to Question 56)
3. Refused

54. What drugs have you used?

1. _____
2. _____
3. _____
4. Refused

55. How often did you use these drug(s)? (Read out options and tick boxes that apply)

	1st Drug	2nd drug	3rd drug
In the last 12 months			
In the last month			
In the last week			
More than 12 months ago			
How did you take this drug? (smoked, sniffed, swallowed, injected, etc)			
Refused			

56. Would you use an alcohol or drug service if you or a family member had a problem with alcohol or drugs?

1. Yes (Skip to Question 58)
2. No (continue)
3. Refused

57. If no, why not? (or other comments)

58. Who else would you talk to about this issue?

59. How comfortable would you be using an interpreter to talk about your own or a family member's alcohol and drug issues? (Read out options and circle one)

1. Don't need an interpreter
2. Not comfortable at all
3. Okay
4. Very Comfortable
5. Refused

Comments: **Manual Code**

60. There are 10 cards with information and activities that are important to many women who have just come to Australia. There is one blank card to add a topic or activity that you think is important. (Write their activity down).
Please choose the 5 most important cards for you.
Please rank the cards in order of importance
(Can have equal weights. If she doesn't want to rank write 99)

	Choice (please tick)	**Rank**
1. Information on when you feel very sad, stressed, worried and depressed and support for women who feel like this		
2. Information when you feel very sad, stressed, and depressed or very anxious after having a baby and support for women who feel like this		
3. Information on how to get a GP and how to talk to a GP to get the health care you need		
4. Information on women's health such as pap smears, breast checks, family planning and contraception		
5. Information on how to get work; Information on TAFE and University courses to get qualifications to get work		
6. Information on family violence what it is and where to go for help		
7. Information on illegal drugs especially for parents		
8. Information on eating better on a budget		
9. Support for women whose husbands or children are drinking too much alcohol		
10. Exercise classes for women		
11. Their choice_____		

61. Is there anything else you would like to tell us that you think would help newly arrived women?

Thank You for helping us with our questionnaire!

For interviewers only

62. Surveyed by: **_____**

63. Where did you do the interview? _____

64. Was this interview conducted in (circle all that apply)
1. English only

2. English and a community language (specify language) _____

3. Only in a community language (specify language) _____

4. Using an interpreter

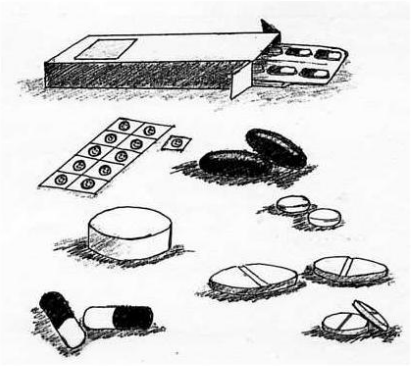
5. Using a bilingual worker

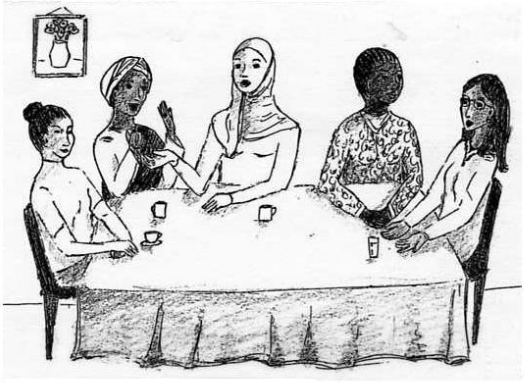
6. Other (please write in) _____

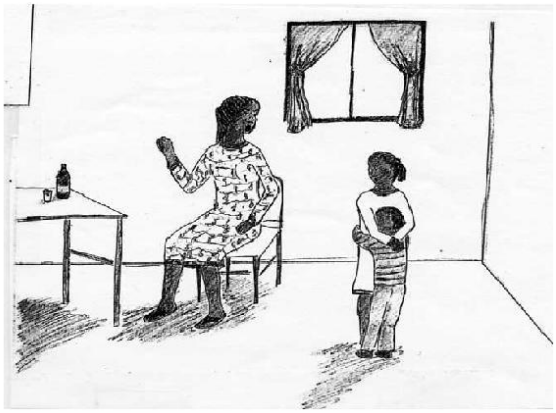
65. Comments by interviewer:

Appendix Five

AOD Drawings







Appendix Six

Classes Run During the Physical Activity Pilot Project

Class Description	Participation
Multicultural Women's Advocacy Service's (MWAS) This group of women were from one of the domestic violence peer support groups run by MWAS. The women met prior to the support group to engage in simple exercise, comprising mainly stretching and relaxation without visualisation. The complex issues facing these women needed to be taken into account when conducting the exercise class.	***Women Who Attended*** A large diversity of backgrounds was represented by the women attending this group including, Chinese, Macedonian, South American, Congolese, and Belarusian. The closeness and understanding between the women could be sensed within the group, even when there was a new face. ***Average Attendance*** Attendance by this group was closely associated with the presence of Mala, the Community Service Worker responsible for the group's coordination. While Mala was on holidays attendance rates declined considerably. The class attendance list comprised nine women in total. Average attendance was four women.
Gosnells Multicultural Parenting and Maternal Wellbeing Community Relations Integration Project This class was initiated in association with the Gosnells Multicultural Parenting and Maternal Wellbeing Community Relations Integration Project, which aims to contribute to improved migrant and refugee maternal well-being. A large increase in migrant and refugee settlement has transpired in the Gosnells area; however supporting services and infrastructure have not increased in response to the growth of these communities. The Multicultural Parenting and Maternal Well-being Project was in its infancy, consequently this was the first time WHS had worked with this group.	***Women Who Attended*** Class participants were from a variety of backgrounds; however women from Somalia formed the majority. A history of torture and trauma was an important consideration, as many of the women were humanitarian entrants, as was privacy and cultural appropriateness in relation to the Muslim faith. Proficiency in English varied considerably between participants, so too the age ranges, with one of the regular attendees in her 80's. ***Average Attendance*** The class attendance list comprised 13 women in total. Many of these women participated in the class once only, however there were three women who attended regularly. Attendance rates remained low throughout the term, with four women on average participating in each class.

Communicare ***(An agency that provides settlement services to newly arrived humanitarian entrants)*** This group could almost be considered a mainstream gentle exercise class, comprising a close network of regular attendees with greater fitness, strength and coordination in comparison to the other multicultural women's groups. This group has been running for a longer period of time, facilitated by the highly organised Communicare staff and continued support of a Communicare volunteer. Three instructors were used by the group this term. The sense of assurance, ability and willingness exuded by the women as a group was further demonstrated in the array of different exercises performed with them, including the use of weights and fit balls, martial arts moves and participant led exercises.	***Women Who Attended*** Participants were predominantly Indonesian; however other language groups included Somali and Arabic. In general the English language proficiency of the women was very good. All women were quite strict Muslim; consequently privacy was an important consideration. Culturally appropriate clothing did not restrict exercise as women came suitably dressed and all exercise was performed with music. ***Average Attendance*** The class attendance list comprised 25 women in total. Many of these women only participated in the class on one or two occasions; however there was a group of approximately six women who were regular attendees. Attendance rates tended to decline later in the term as many women became ill with several viral infections that were around Perth at the time. The same viral infections also resulted in the researcher, WHS staff and instructor sickness as well! Average class attendance was nine women.
East Victoria Park Family Centre This group was still relatively new for WHS. The women were fairly strict followers of the Muslim faith and there had been debate concerning the appropriateness of using music while exercising. Yoga without music was agreed to by the women as a suitable form of exercise. WHS presence at this group was considered important early on in relation to referral, as there was an instance when one woman arrived at the end of the class specifically for domestic violence assistance. The group's enthusiasm for women's health information talks was evident during the two women's health workshops presented during the term by WHS staff.	***Women Who Attended*** A diverse array of language groups were presented by the women attending this class including Arabic, Somali, Farsi and Dari. Women had varying levels of English proficiency. Despite the diversity of backgrounds all women were supportive of each other and it was evident that a stronger social relationship between regular attendees had formed. ***Average Attendance*** The class attendance list comprised 23 women in total. Attendance rates varied quite considerably for this group, falling to four women during one week and reaching as high as 14 in another. Overall, eight women participated in the class on average.

The Gowrie ***(An agency that provides settlement services to newly arrived humanitarian entrants)*** This group was very new, beginning on the 3 August 2007 only. The women participated in sewing classes together, which were held prior to the exercise class, and it was evident that quite a close social rapport had formed within the group. The majority of the women were from refugee backgrounds, consequently issues related to torture and trauma were highly likely. Depression and anxiety were identified as issues affecting the group.	***Women Who Attended*** The group comprised predominantly Somalian women; however other languages spoken included Arabic, Tigrinyan and Swahili. English language ability varied considerably amongst the group. Some women watched the class but still took translated health information when it was offered. ***Average Attendance*** The class attendance list comprised 18 women in total. While a number of these women only participated in the class once, there was a group of approximately seven regular attendees. Average class attendance was nine women.
Ethiopian Women's Group This group was formed with the help of the Association for Services to Torture and Trauma Survivors (ASeTTS), and the Department for Child Protection (DCP), out of the Orthodox Ethiopian Church. The majority of women were from refugee backgrounds; consequently issues related to torture and trauma were highly likely. Depression was identified as a concern for this group. The women requested yoga as their preference for exercise Internal tensions and politics within the community, bearing no relation to WHS, saw attendance rates decline towards the end of term and suspension of the exercise class temporarily.	***Women Who Attended*** Participants were all Ethiopian women, most of whom had small children. Strong social supports, relationships and loyalty were evident amongst the group. ***Participant Evaluation*** Participant feedback was not collected in light of the class being suspended temporarily.

Appendix Seven

Articles and Conference Presentations related to the Project

Presentations

Mark Liveris Health Science Research Students' Seminar at Curtin University. November 2007. Title of Presentation: *Alcohol, Tobacco & Other Drug Concerns of Newly Arrived Women in Perth*

Working Out What Works: 16th Western Australian Drug and Alcohol Symposium. September 2007. Title of Presentation: *Alcohol & Other Drug Concerns of Newly Arrived Migrant and Refugee Women: Are service providers in touch?*

Beyond the Boundaries Conference. September 2006. Title of Presentation: *Establishing a Client Reference Group with Culturally and Linguistically Diverse Women: Philosophical and Practical Considerations*

'Broadening the Horizon': The 2nd WA Transcultural Mental Health Conference. March, 2006. Title of Presentation: *Alcohol, Tobacco & Other Drug Concerns of Newly Arrived Women in Perth*

Articles

Lee S, S Thompson, and D Van Doorn.2007. Effective Community Health Research with Newly Arrived Migrant and Refugee Women. *The Community Psychologist.40 (2); 49-53.*

Lee S, S Thompson and D Amorin-Woods. One service, many voices: enhancing consumer participation in a primary health service for multicultural women. *Quality in Primary Care*. Submitted for publication September 2008.