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Hard Edges:

The Reality for Women Affected by Severe and Multiple Disadvantage

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HERIOT WATT UNIVERSITY

I·SPHERE
Institute for Social Policy, Housing and Equalities Research

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List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
B&B	Bed and Breakfast (hotel)
BPD	Borderline Personality Disorder
CAFCASS	Children and Family Court Advisory and Support Service
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPN	Community Psychiatric Nurse
DA	Domestic Abuse
DSM	Diagnostic and Statistical Manual (of Mental Disorders)
EUPD	Emotionally Unstable Personality Disorder
GDPR	General Data Protection Regulations
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MDT	Multi-Disciplinary Team
NFA	No Fixed Abode
NHS	National Health Service
SMD	Severe and Multiple Disadvantage
VAWG	Violence Against Women and Girls

Executive Summary

Key points

- Many aspects of women's routes into and experiences of severe and multiple disadvantage (SMD) – here defined as the co-occurrence of homelessness, substance use, and offending behaviour – are highly gendered.
- Experience of violence – especially sexual violence and domestic abuse – is horrifyingly prominent in the life histories of women affected by SMD. For many, such experiences have been extreme and/or endured over long periods, typically since childhood.
- It is critical that the severity of trauma that these women have sustained and its impact on service engagement is adequately acknowledged in policy and practice. Their susceptibility to being targeted by predatory men in the longer term should also be recognised (including after they have been rehoused and/or engaged with treatment).
- The combination of SMD experiences heightens barriers to services. Difficulties accessing support are exacerbated where these intersect with other social categorisations such as being from a minoritised ethnic group, having a longstanding physical illness or disability, or experiencing neurodivergence (e.g. Autism).
- Women affected by SMD will often go to extreme lengths to conceal or downplay the severity of their circumstances. Many are fearful of using services and/or the potential consequences of disclosing vulnerabilities. Their need for support often goes unnoticed until they are in a crisis situation.
- Many professional stakeholders have invested intensive effort in attempts to break down the barriers that women (and men) experiencing SMD face in recent years. Progress has however usually hinged on the goodwill of committed individuals at the local level rather than being symptomatic of broader systems change.
- Pockets of good practice in the provision of effective trauma-informed and gender-informed support do exist. Their availability is very uneven, however. Furthermore, most mainstream services cater for one SMD domain only, hence women are frequently shunted between services that are poorly equipped to meet their needs.
- There is an urgent imperative for stakeholders across relevant sectors – mental health and social services in particular – to share both responsibility and risk in responding to the needs of women affected by SMD. Until this happens vulnerable women will remain caught in a pernicious cycle of exclusion and exploitation.

Background

A small but growing body of research has recently cast light on and contributed to an escalation of policy interest in the extreme social and economic costs of 'severe and multiple disadvantage' (SMD) in the UK. A key stimulus to debates in this field was the *Hard Edges* body of research, commissioned by Lankelly Chase Foundation and conducted by Heriot-Watt University, which used administrative data to develop a profile of SMD in England and Scotland. The first *Hard Edges* study revealed that coalescence of different domains of disadvantage – particularly homelessness, substance misuse, and criminal offending – can have profoundly negative impacts on the quality of life and service experiences of those directly affected (Bramley et al., 2015). A second study observed that consideration of mental ill-health and domestic abuse in addition to the other domains gives fuller recognition to a range of complex needs and experiences which tend to affect women to a greater extent (Bramley et al., 2019).

Those initial studies also reported that the vast majority of adults experiencing the most extreme of those manifestations of SMD are men. This finding prompted Lankelly Chase Foundation to

commission a third, explicitly gender-focussed, study which was conducted by Heriot-Watt University in collaboration with DMSS Research. Using household survey data, that revealed key differences in the way that men and women experience SMD, with experience of interpersonal violence and abuse and/or poor mental health being especially prevalent features in the lives of women (Sosenko et al, 2020). Other recent contributions to debate in this area have called for yet further attention to be paid to the gendered manifestations of SMD, and the experiences of women in particular (e.g. Agenda and Changing Lives, 2023). Funded by the Oak Foundation, this study responded by generating rich empirical evidence which might be used to inform the development of interventions with potential to prevent, ameliorate and/or resolve SMD experienced by women.

Research questions, remit and methods

The research was underpinned by the following questions:

- How (if at all) does the combination of different types of disadvantage influence service responses and women's experiences of these?
- When and why do women with experience of SMD first seek help from support services?
- What if any opportunities to support women with experience of SMD are 'missed'?
- What factors facilitate and/or inhibit their access to and engagement with support services?
- How do women perceive and experience the services available to them?
- What are the implications for the commissioning, design, and delivery of support services?

In order to maintain a clear remit, the study used the same parameters employed in the original *Hard Edges* studies, that is, it focussed on women with current or recent experience of two or more of the following three domains of SMD: homelessness, substance misuse, and offending behaviour. Like the preceding studies it was premised on an understanding that the extreme nature of SMD lies in the multiplicity, interlocking nature, and cumulative impact of these issues, rather than necessarily in the severity of any one of them; also that these core domains are distinct from other types of social disadvantage in large part because of the degree of dislocation from societal norms and stigma associated with these intersecting experiences (Bramley et al., 2015). Women's experiences of domestic abuse and poor mental health, along with a wide range of other adversities, were nevertheless also explored in detail in recognition of the prevalence and significance of these other issues in shaping their life experiences and opportunities.

In terms of methodology, a qualitative approach and case study design were employed. Four areas were chosen, one of which was located within each UK jurisdiction. These included: Belfast (Northern Ireland), Glasgow (Scotland), Stoke-on-Trent (England), and Swansea (Wales). Across these, a total of eight agencies which support women affected by SMD were recruited to support the study. Agencies were purposively sampled to include representation across relevant sectors – including homelessness, substance use, criminal justice, and violence against women and girls (VAWG) – as well as providers of both women-only and mixed-sex services.

Data collection and analyses were conducted in two phases. The first phase involved the following activities across case study areas and agencies:

- in-depth interviews with 60 women with current or recent lived experience of SMD;
- focus groups involving 26 frontline staff in agencies supporting women affected by SMD; and
- participant observation wherein a research team member 'hung out' and interacted informally with staff and service users over an extended time period.

In the second phase, preliminary findings were shared with key stakeholders representing a broad range of sectors, including homelessness, criminal justice, substance use, VAWG / domestic abuse, and health and social care. These participants were asked to reflect on how the main priorities and

'asks' identified in phase one might be responded to and what if any factors may facilitate and/or inhibit the design, operationalisation and/or roll-out of any such response. These conversations were conducted at both local and national levels comprising:

- a local roundtable consultation in each case study area involving a total of 14 individuals; and
- key informant interviews involving 14 individuals with strategic roles shaping policy and practice at national level in one or more UK jurisdictions.

Key findings

The study's findings as regards women's routes into and experiences of SMD can be summarised under five key themes, each of which is outlined below.

Gendered routes into and experience of SMD domains

Many aspects of women's routes into and experiences of individual SMD domains were highly gendered. Regarding homelessness, women often moved in and out of situations of homelessness and/or different manifestations of it at frequent intervals. Experience of hidden homelessness, and sofa-surfing in particular, was almost universal. Such arrangements sometimes involved an exchange of sex for somewhere to stay. Street homelessness was much less common, and when experienced typically involved sleeping rough accompanied by a male partner or, if alone, hidden from public view (e.g. in derelict buildings or walking through the night rather than bedding down). These experiences further highlight the limitations of mainstream definitions of rough sleeping which focus exclusively on the most visible manifestations of rooflessness. It was also notable that the capacity of traditional women's refuges to accommodate individuals affected by SMD is limited given the scale and nature of their support needs and refuge providers' prerogative to protect other residents (including children).

For most interviewees with lived experience, substance use dated back to their early teens, beginning with drinking and/or recreational drug use, and subsequently escalated to involve more harmful substances and/or riskier means of consumption. The women were usually introduced to 'harder' drugs by partners or other peers. Many were consuming drugs in extremely risky ways. Power inequalities associated with the tendency for some women to rely on their partner to administer (inject) drugs was a source of extreme concern for frontline staff and stakeholder interviewees. Problematic drinking and the use of drugs was always employed as a form of self-medication, that is, to cope with historic or current trauma.

Involvement in criminal offending was almost always caused by women's substance use, with interactions with the justice system typically initiated by the possession of illicit substances, acquisition of money to fund an addiction (e.g. shoplifting, drug dealing), or disruptive or violent behaviour exhibited when under the influence of drugs or alcohol (e.g. breach of peace, assault). Prison was often described as a space of respite from extremely harmful (and in some cases life threatening) lifestyles and persistent domestic abuse. That said, most of those who had experienced incarceration had served (in some cases multiple) short sentences and tended to be released back into the same circumstances with insufficient support. This perpetuated a cycle of repeat homelessness, substance use, and deterioration in physical and/or mental health.

Influence of compound disadvantage on experiences and service responses

The co-occurrence of those three core SMD domains, which are typically accompanied by experience of poor mental health and/or domestic abuse, severely compounds the challenges individual women face. For some, their disadvantage is further exacerbated by the intersectionality of other social categorisations or identities, such as being from a minoritised ethnic group, having a longstanding

illness or physical disability, and/or experiencing neurodivergence (e.g. Autism, Attention Deficit Hyperactivity Disorder). These domains of disadvantage and individualised attributes coalesce in myriad different ways, but almost always with the same outcome of heightening barriers to mainstream support services.

Recent years have witnessed increased recognition of the inter-relatedness of these disadvantages in policy debate. This has catalysed the investment of intensive effort and deliberative multi-agency working in attempts to overcome the barriers women affected by SMD face in many areas. That said, many of the successes in this regard are symptomatic of the goodwill of highly committed individuals rather than evidence of tangible systems change. Some mainstream services continue to operate as if oblivious to the existence and/or effects of such inter-relationships. The failure of mental health services to adequately support women experiencing dual diagnosis (i.e. both substance use and mental health issues) was singled out for particularly severe criticism in this regard. Local and national-level stakeholders are increasingly impatient (and in some cases irate) regarding the lack of political action to break down longstanding barriers associated with dual diagnosis.

A perceived increase in the number and proportion of women affected by SMD who are receiving Personality Disorder diagnoses was also highlighted as an issue of significant concern. Anxieties regarding the volume of such diagnoses within this population are founded on scepticism regarding the veracity of many (but not all) such diagnoses, implication that blame for a recipient's extremely difficult circumstances lies in personal deficit or dysfunction (thereby detracting attention from structural causes), and the associated restrictions to support (i.e. tendency for people with a Personality Disorder diagnosis to be denied access to some services). Even where specialist Personality Disorder support pathways are available at the local level, these tend to be unsuitable for women experiencing homelessness or living what many practitioners describe as 'chaotic lifestyles'.

Missed opportunities and critical junctures for intervention

The overlaps in disadvantage reported by women with lived experience were typically exacerbated by the absence or inadequacy of support when they first experienced difficulties. For the vast majority, experience of disadvantage and trauma could be traced back to childhood, with accounts of sexual abuse, physical abuse, emotional abuse, neglect, and/or so-called family dysfunction looming large in almost all women's narratives. Experience of sexual violence or domestic abuse in adulthood was universal amongst interviewees with lived experience of SMD; some of this was extreme and/or endured over prolonged periods. In this vein, exploitation by men was a prominent feature in women's life histories and experiences of homelessness, substance use, and offending.

Trauma associated with the loss of children was another key theme in women's narratives. Child removal was a source of extreme and sustained trauma for many women, but also (if/where children had not been adopted but were living in kinship, foster, or residential care arrangements) a source of hope and motivation to recover given the potential for (re)establishing contact. Trauma caused by miscarriage or stillbirth, and difficulties triggered by (sometimes severe) post-natal depression, were also prevalent features in a number of women's accounts.

Some women recalled being familiar with and sometimes (but not always – see below) willing to seek help from services for people facing homelessness or domestic abuse (i.e. council housing departments and/or women's refuges) given their family's experience of these issues during childhood. These women therefore tended to acquire (at least some) assistance comparatively sooner in their life trajectory than others. Others, however, were less familiar with or were fearful of engaging with services and tended to seek assistance only when they had exhausted every other option perceived to be available to them (by sofa surfing or exchanging sex for somewhere to stay for

example) or the decision about whether to access help was taken out of their hands (e.g. they were sectioned, arrested, or child protection processes had been triggered).

The study has drawn attention to numerous missed opportunities for intervention during the lives of women affected by SMD. Most participants with lived experience asserted that more (or different types of) support at critical junctures in their lives would have prevented the accumulation of further disadvantages and/or reduced the severity of their effects. Key amongst the critical junctures and 'red flags' indicative of potential windows of opportunity were: disruptive behaviour at school (especially when severe enough to lead to exclusion); problematic drinking during or prior to early teenage years; the point of leaving care; the transition from child/adolescent to adult mental healthcare; liberation from prison; and the threat or actual removal of children.

(In)visibility of circumstances and inhibition regarding support

The study lends further weight to existing evidence suggesting that the support needs of women affected by SMD are rarely obviously and/or immediately visible to service providers at the first point intervention would have been beneficial. Rather, the difficulties these women are dealing with often only come to providers' attention when they are in a crisis situation, and in more extreme cases not until involuntary intervention is triggered (see above). Some women will go to extreme lengths to conceal or downplay the severity of their circumstances. A number of their actions, such as remaining in abusive relationships or exchanging sex to retain access to shelter and/or drugs to name but a few examples, can expose them to additional risk and perpetuate their experience of SMD.

Fears regarding support services are extremely widespread, and some women actively avoid seeking or accepting offers of help for long periods of time. The tactics of invisibility employed and inhibition experienced as regards engagement with support are often founded on concerns regarding the potential ramifications of disclosing vulnerabilities for current or future access to children. In short, women affected by SMD do not want social services to know if/when they are struggling with issues such as addiction relapse, suicidal thoughts, or domestic abuse for example. Some are subject to coercive control and are forcibly prevented or more subtly deterred from accessing support by their partner. Further to this, attempts to disguise homelessness are often motivated by a wish to reduce the risk of being targeted by predatory men, especially by those women experiencing its most extreme manifestations (i.e. rough sleeping).

Prior negative experiences in support services such as homeless hostels resulting from the intimidating and/or antisocial behaviour of other residents (particularly but not only men) present additional barriers for many women. Some are sceptical regarding the likely effectiveness of services given that previous interventions had made little or no positive difference to their circumstances. Shame and stigma further compound many women's reticence to disclose their circumstances or seek help from wider social networks (e.g. family) and/or public authorities. Most are acutely aware of the extent to which their lives deviate from societal norms and assume that they will be judged by professionals and members of the public (including their own family in many cases) in stigmatised ways. On this issue, stakeholder interviewees argued that women affected by SMD appear to be disproportionately susceptible to accusations of being deliberately difficult ('acting up') despite the fact that their responses to extreme distress are entirely understandable.

Perception and experience of services available

The accounts of women with lived experience, together with staff and local/national stakeholders, indicate that there are pockets of localised good practice across the UK wherein women affected by SMD are provided with effective trauma-informed support. A number of services were also noted to

offer explicitly gender-informed support, albeit this was considered less well established and/or widespread. The availability of such support was likened to a postcode lottery, however, and the sustainability of such services reported to be under constant threat given the preponderance of short-term funding cycles. The limited availability of these services, and tendency for many statutory services to cater for one SMD domain only (e.g. homelessness, or substance use, or mental health), mean that experience of feeling 'shunted' between services was extremely widespread. This issue was especially acute for women affected by co-occurring substance use and mental health issues.

Participants' detailed accounts of their routes into and through service networks indicate that many women have little if any control over the timing, point of entry, and appropriateness of responses. Critically, the likelihood of receiving a genuinely helpful intervention tends to depend on the capacity, expertise, and/or attitude of service gatekeepers and case managers, as well as the local availability (or absence) of services offering support appropriate to an individual's needs. All of these factors have a strong influence on, for example, the appropriateness of referrals, a woman's willingness to disclose current or past trauma, and whether accommodation provided serves to actually protect her from or (further) expose her to risk of harm.

All that said, participants highlighted a number of ingredients that they deemed to be effective in promoting service engagement and increasing the likelihood of positive outcomes for women affected by SMD. These broadly echo those endorsed in prior research on and good practice guidance for extremely excluded populations (e.g. Luchenski et al., 2018; NICE, 2022). They included: the maximisation of choice as regards accommodation and treatment type; use of minimal access and eligibility thresholds; allowance for 'sticky' support with few if any requirements regarding 'engagement'; emphasis on outreach; utilisation of navigators; operationalisation of relational approaches; flexibility enabling rapid response; and provision of long-term support which extends well beyond periods of crisis.

Implications for service design and delivery

Key implications for the commissioning, design, and delivery of services are as follows:

1. There is an urgent imperative for stakeholders across relevant sectors to *share both: a) responsibility for responding to the needs of women at risk of or affected by SMD, and b) any risks associated with doing so*. Critically, the primary locus of responsibility for action needs to be shifted from the individual women affected – who have been heinously harmed and let down repeatedly throughout their lives – to the policy makers and practitioners charged with redressing inequality and injustice. This will require clear leadership from central and devolved governments, and commitment from all sectors, including health and social care whose input has (with the exception of some localised initiatives) been woefully insufficient to date. Other stakeholders are mindful of the immense pressures these sectors are under, but the cold hard fact is that until such time as responsibility and risk is more equitably shared, women affected by SMD will remain caught in a pernicious cycle of exclusion and exploitation.

2. It is incumbent on commissioners at national and regional/local levels to create an enabling environment which both *requires and sufficiently resources providers to design and deliver services that are appropriately trauma- and gender-informed*. Pockets of good practice which is sensitive and responsive to gendered trauma do exist and should be emulated much more widely. Moreover, there is a strong call for more provision of women-only services targeting this population, as well as the further embedding of gender-informed practice across relevant sectors (in both women-only and mixed-gender services) more generally. On this issue, there

is a particularly acute need to more effectively equip frontline staff to understand and respond to domestic abuse and gender-based violence, as well as the psychological effects of child removal. The promotion of existing toolkits might usefully support this endeavour[1].

3. Greater *recognition of the severity of trauma and (relational) injury that women with experience of SMD have sustained and impact on their ability to make use of support services* is required. So too is greater appreciation of the magnitude of the 'ask' being made of such women, given that what is typically framed as recovery is, for many, tantamount to discovery (of self-worth, identity, purpose, trust, and so on). There is a clear need to challenge systemic tendencies which 'punish' women affected by SMD, if for example they self-medicate with illicit substances when denied treatment for mental health problems, succumb to relapse (when doing so is a recognised stage in the recovery process), and/or (re)enter abusive relationships when they often remain a target for predatory men even after their homelessness is resolved and/or they are making progress on their recovery journey. Related to this is a prerogative to ensure that the needs of these women are not deprioritised because their behaviour does not evoke sympathy to the same extent as survivors of other forms of trauma (e.g. neglected children or people sustaining a life-changing spinal injury).

4. There is clear appetite amongst women with lived experience and professional stakeholders for a *shift of emphasis from crisis intervention toward prevention*, albeit few are optimistic about the likelihood of this eventuating in the current context of severe funding constraints. The issue of resource limitations aside, study findings indicate that investment might most valuably be targeted at key critical junctures and/or indicators of disadvantage (listed above) which commonly present windows of opportunity for earlier intervention. The need to focus policy attention on young women and girls exhibiting signs of distress is clear. A widespread wish for social services to play a greater role in interventions is notable, especially when young women leave care and mothers are at risk of having their children removed. That said, sight should not be lost from initiatives targeting perpetrators of domestic abuse and violence against women and girls more generally given their pivotal role in the causation and perpetuation of SMD experienced by women.

5. This is accompanied by a call for *greater recognition and utilisation of the expertise of voluntary sector agencies, and frontline support workers in particular*, in responding to the needs of women affected by SMD. Of note here is their reputation for comparatively greater awareness of individual clients' circumstances and success in engaging and remaining in relationships with those who are often deemed to be especially 'hard to help' vis-à-vis other (particularly statutory sector) professionals. This expertise, it was widely noted by interviewees, is often undervalued in multiagency forums. Moreover, study findings echo wider calls regarding the importance of adequate support and remuneration for frontline practitioners who work with women affected by SMD given the specialist skills required, intense day-to-day demands of the job, and risk of exposure to vicarious trauma.

Consideration of the above issues will place policymakers, commissioners, and support providers on a much better footing to be able to prevent, ameliorate, and resolve SMD affecting women.

[1] Examples of existing resources include: AVA's guidance in relation to the removal of children from mothers facing domestic and sexual violence and abuse (AVA, 2022); St Mungos' toolkit regarding the provision of support for homeless couples (St Mungos, 2020; and Scottish Government toolkit regarding the provision of trauma-informed support (Scottish Government, 2021b).

1. Introduction

A small but growing body of research has recently cast light on and contributed to an escalation of policy interest in the extreme social and economic costs of 'severe and multiple disadvantage' (henceforth abbreviated as SMD) in the UK (Bramley et al., 2015, 2019; Moreton et al., 2021; Revolving Doors, 2021; Watts et al., 2022). Recent contributions to these debates have called for particular attention be paid to the gendered manifestations of SMD, and the experiences of women affected in particular (Agenda and AVA, 2017, 2023; Sosenko et al., 2020). Funded by the Oak Foundation, this study adds to the evidence base in this field by providing rich qualitative insights into women's experiences of SMD and the perspectives of professional stakeholders who work with or devise policies affecting them.

1.1 Background to the study

A key stimulus to debates in this field was the *Hard Edges* body of research, commissioned by Lankelly Chase Foundation and conducted by Heriot-Watt University, which used administrative data to develop a profile of SMD in England and Scotland (Bramley et al. 2015, 2019). The earliest study in this corpus of work revealed that coalescence of different domains of disadvantage – particularly homelessness, substance misuse, and criminal offending (referred to as 3-dimension SMD) – can have profoundly negative impacts on the quality of life and service experiences of those directly affected (Bramley et al., 2015). Later work observed that consideration of mental ill-health and domestic violence and abuse in addition to the other domains mentioned above (referred to as 5-dimension SMD) gives fuller recognition to a range of complex needs and experiences which tend to affect women to a greater extent (Bramley et al., 2019). These reports, along with subsequent commentaries commissioned by Lankelly Chase (Revolving Doors, 2021), reflect on the ways in which poverty, structural disadvantage and trauma interact to generate and perpetuate SMD.

The initial *Hard Edges* studies also reported that the vast majority of adults experiencing the most extreme manifestations of (3-dimension) SMD are men (Bramley et al., 2015, 2019). This finding prompted Lankelly Chase Foundation to commission a further, explicitly gender-focussed, study which was conducted by Heriot-Watt University in collaboration with DMSS Research. Entitled *Gender Matters*, that concluded that there are key differences in the way that men and women tend to experience SMD (McNeish et al., 2016; Sosenko et al, 2020). Using household survey data, the Gender Matters study showed that experience of interpersonal violence and abuse, and/or poor mental health, are especially prevalent features in the lives of women facing SMD. It also indicated that compared to their male counterparts, women experiencing SMD are more likely to report a range of specific vulnerabilities; they are for example more likely to have no qualifications, to be dually diagnosed (with mental health and substance misuse issues), to be victims of domestic violence or abuse, and to have experienced significant adversity in childhood (McNeish et al., 2016).

Importantly, all of these *Hard Edges* studies were premised on an understanding that the extreme nature of SMD lies "in the multiplicity and interlocking nature of these issues … and their cumulative impact, rather than necessarily in the severity of any one of them" (Bramley et al., 2015, p.11). This body of work also argued that the three core domains of SMD are distinct from other types of social disadvantage in large part because of the degree of dislocation from societal norms and stigma associated with these intersecting experiences (Bramley et al., 2015). Further to this, the Gender Matters study observed that stigma associated with perceived behavioural 'transgression' or 'deviance' of women who experience a combination of homelessness, substance and/or involvement with the criminal justice system was particularly acute given their departure from gendered social norms (McNeish et al., 2016; Sosenko, et al., 2020).

1.2 Existing evidence regarding individual domains of disadvantage

Whilst explicit focus on the overlaps between multiple domains of disadvantage is arguably relatively recent in both policy and academic circles, a pre-existing body of research has drawn attention to the gendered dimensions of both routes into and experiences of individual domains.

Work on women's homelessness, for example, has argued that it is often 'hidden', in the sense that it is not visible either on the streets or in official statistics (ONS, 2023; Scottish Government, 2023). Evidence suggests that women often actively conceal their homelessness and/or only seek assistance from formal services when they have exhausted alternative informal options to secure housing (Bretherton and Mayock, 2021; Jones, 1999; Reeve et al., 2006). Recognition of these tendencies prompted the recent advent of a rough sleeping census for women in London given dissatisfaction with traditional techniques used to measure street homelessness (Bretherton and Pleace, 2018; Young and Hodges, 2022). Furthermore, existing scholarship consistently documents the links between domestic abuse and the causation of homelessness experienced by women, as well as homeless women's disproportionate susceptibility to gender-based violence, including sexual exploitation (Bimpson et al., 2021; Reeve et al, 2006).

Regarding substance use, existing evidence indicates that women are less likely than men to use illicit substances (albeit that there is less difference between genders during adolescence) but are more likely to use pharmaceutical drugs non-medically (United Nations, 2004). Females are less likely than males to drink in problematic ways, but the gender gap in problematic drinking is reducing and alcohol poses a greater risk to women's physical health at lower consumption levels than men (Institute Alcohol Studies, 2020; White, 2020). It also suggests that, in comparison with men, women may become dependent more quickly, engage in riskier consumption behaviours, and have higher mortality rates if they inject drugs (Meyer et al., 2019; Tuchman, 2010). Moreover, women with substance use problems generally report lower levels of education, employment and/or income than men, are more likely to be living with a partner with a substance use problem, and be responsible for the care of dependent children (United Nations, 2004). Experience of gender-based violence is also higher amongst women who use substances as compared with those who do not (Moir et al, 2022).

Existing evidence also indicates that there are notable differences regarding the extent to and ways in which women and men interact with the criminal justice system. Critically, women are significantly less likely to engage with the justice system in the first place: women comprise only 4% of the prison population in all four UK jurisdictions (Department of Justice, 2021; Ministry of Justice, 2022; Scottish Government, 2022), and account for a minority (15%) of all arrests in England and Wales (Ministry of Justice, 2022). Compared to men, on average women commit less serious offences, present less risk to other people, and serve shorter sentences if imprisoned (HM Prisons and Probation Service, 2018). Women who commit crime also tend to be more vulnerable than men, for example being more likely to have experience of domestic abuse, to have been diagnosed with mental health problems, to be care experienced, or have experienced abuse or witnessed violence in the home as a child (Light et al., 2013; Ministry of Justice, 2022; Williams et al., 2012).

Research in this general field has also demonstrated that experience of trauma, which often dates back to childhood, is widespread amongst both men and women affected by SMD (Cockersell, 2018; Fitzpatrick et al., 2013; Maguire et al. 2009; Theodorou et al., 2021). The sources and consequences tend to be different for women and men, however, with women disproportionately reporting experience of domestic abuse, sexual violence and/or forced separation from dependent children (AVA, 2022; Scott and McManus, 2016). Commentators also often point to a tendency for stigma and/or shame to be heightened for women affected by SMD given the deviation of their experiences

and behaviours from norms regarding social constructs such as womanhood and/or motherhood (Kreis et al., 2016; Meyer et al., 2019).

Furthermore, it is frequently argued that mainstream interventions to redress homelessness, substance misuse, and/or criminal offending usually cater poorly for women given that they are, for the most part, designed for men (Agenda and Changing Lives, 2023; Bretherton and Mayock, 2021; We Are With You, 2021). Research also indicates that many women-specific services, most notably residential provision for survivors of domestic abuse and sexual violence, lack the capacity or expertise to respond to the complexity of support needs and/or challenging behaviours that women affected by SMD often present with (Bramley et al., 2019; Sharpen, 2018).

Taken together, such issues and insights from the body of research referred to above have led to an escalation in calls for the promotion of more gender-informed, as well as trauma-informed and culturally responsive services and policies to meet the needs of women affected by multiple disadvantage (Agenda and AVA, 2021; Agenda and Changing Lives, 2023; McCormark et al., 2019, 2022; Morris and Webb, 2021). This study was commissioned with the intention of adding to the evidence base informing such an endeavour.

1.3 Aim, research questions, and remit

The study aimed to generate rich empirical evidence which could be used to inform the development of interventions that have potential to prevent, ameliorate and/or resolve SMD experienced by women.

It was underpinned by the following research questions:

- How (if at all) does the combination of different types of disadvantage influence service responses and women's experiences of these?
- When and why do women with experience of SMD first seek help from support services?
- What, if any, opportunities to support women with experience of SMD are 'missed'?
- What factors facilitate and/or inhibit their access to and engagement with support services?
- How do women perceive and experience the services available to them?
- What are the implications for the commissioning, design, and delivery of support services?

In order to maintain a clear remit, the study uses the same parameters employed in the original *Hard Edges* studies, that is, focusses on women with current or recent experience of two or more of the following three domains of (3-dimension) SMD: homelessness, substance misuse, and offending behaviour. Women's experiences of domestic abuse and poor mental health were explored in detail during interviews (see below), in recognition of the prevalence and significance of these other aspects of (5-dimension) SMD in shaping their life experiences and opportunities.

Participants were also invited to discuss a wide range of other experiences – including those referred to in some existing work as 'secondary disadvantages' (e.g. Sosenko et al., 2020) – and which often but do not always accompany the domains of disadvantage focussed on above. These include, just by way of example, having a learning or physical disability, selling or exchanging sex, being a migrant, being a Gypsy/Traveller, and/or having lost children to the care system (see Sosenko et al., 2020).

1.4 Report outline

This report consists of seven further chapters. Chapter 2 describes the methods employed in the study. Chapter 3 documents women's routes into and experiences of each of the three primary

domains of (3-dimension) SMD (i.e. homelessness, substance use, and offending). Chapter 4 discusses their experiences of the other two forms of (5-dimension) SMD, that is, domestic abuse and poor mental health. In Chapter 5, focus turns to women's experiences of support services, particularly their routes into, around, and/or avoidance of service networks. Chapter 6 highlights the attributes of services which participants deemed to have worked well, while Chapter 7 reflects on key lessons for practitioners and policy makers. The final chapter, Chapter 8, draws together the study's key conclusions and recommendations.

2. Methods

This chapter describes the methods employed in the study. It begins by outlining the qualitative case study methodology and case study selection process. This is followed by an account of methods used in the data collection process, which was conducted in two key phases, such that the findings of the first stage informed what was focused on in the second. The penultimate section provides a brief account of the analysis process before the approach to research governance and ethics is discussed.

2.1 Case study approach and selection

A qualitative case study approach was employed so as to allow for the generation of rich empirical data illuminating contextually specific issues as well as those that are shared across different service types, sectors, and/or geographic areas. Four different local authority areas, one of which was located within each UK jurisdiction, were chosen. Across these, a total of eight agencies which support women affected by SMD were selected and recruited to support the study.

The first stage of the case study selection process involved bespoke analysis of quantitative data captured by Heriot-Watt University for the *Hard Edges* studies (see Chapter 1). This enabled identification of a number of local authority areas recording large numbers of women with experience of SMD. From this, a short-list of up to three local authority areas within each country was drawn up and a 'map' of services available to women affected by SMD in each developed via a detailed review of service directories and websites. This process ensured that a sufficient cross-section of service types and target groups was represented across the areas selected. The final case study areas chosen included: Belfast (Northern Ireland), Glasgow (Scotland), Stoke-on-Trent (England), and Swansea (Wales).

In each area, a short-list of preferred potential case study agencies and substitutes was created. Two agencies that support women facing SMD were then invited to support the study by hosting an in-person fieldwork visit and facilitating the recruitment of staff and service user participants. The final selection of services was developed with a view to maximising the research team's chance of coming into contact with women experiencing a range of different combinations of disadvantage domains. The target group and type(s) of services provided by each are summarised in Table 1 below.

Table 1: Case study agency characteristics

Location	Service ID	Primary focus / target group(s)	Type of service(s) provided	Women only or mixed
Belfast (Northern Ireland)	B-1	Homelessness	Temporary/ supported accommodation	Mixed
	B-2	Homelessness + substance use + criminal justice	Temporary accommodation, outreach, needle exchange, floating support	Mixed
Glasgow (Scotland)	G-1	Criminal justice	Residential programme / alternative to custodial sentence	Women only
	G-2	Homelessness	Supported accommodation	Women only

Stoke-on-Trent (England)	St-1	Homelessness + sex work	Temporary accommodation, drop-in, outreach	Women only
	St-2	Homelessness + substance use + criminal justice + domestic abuse/ VAWG	Co-ordinated support on drop-in or outreach basis	Mixed
Swansea (Wales)	Sw-1	Domestic abuse/VAWG	Drop-in, floating support	Women only
	Sw-2	Substance use	Drop-in, outreach, needle exchange	Mixed

As noted in Table 1, half of the selected agencies offered women-only services; the others provided services accessible to both men and women. Some of the mixed-sex services had one or more dedicated women's worker(s). One operated a project targeting young people (16-25 years) only, but the others supported women aged 18 and older. Each participating agency was offered £300 as a gesture of thanks for supporting the study.

2.2 Phase one data collection

The first phase of data collection involved a series of in-person visits to case study agencies and remotely held focus groups, conducted between May 2022 and April 2023, to seek contributions from women with lived experiences of SMD and staff members who work with them on a daily basis.

2.2.1 Interviews with women with lived experience of SMD

A total of 60 women with current or recent lived experience of SMD – defined as concurrent experience of two or more of homelessness, substance misuse, and/or offending behaviour (see Chapter 1) – contributed to the study via an in-depth interview. Numbers recruited via each of the case study agencies are portrayed in Table 2.

Table 2: Number of interviews with women with lived experience

Location	Service ID	No. interviewees
Belfast	B-1	10
	B-2	7
Glasgow	G-1	9
	G-2	10
Stoke-on-Trent	St-1	4
Swansea	Sw-1	10
	Sw-2	10
TOTAL		60

All of these interviews were conducted in person during fieldwork visits. Almost all were conducted privately as one-to-one interviews, but one or more support workers were present in the case of three interviews at the request of the interviewee or in adherence with the host agency's joint working protocols for clients deemed to present a high level of risk. Two other interviews were conducted in pairs at the request of the interviewees (who were fellow hostel residents and/or friends).

Each woman with lived experience was given the option of participating in either a timeline interview or a more standard semi-structured interview as per their personal preference. Those opting for the former were invited to draw a timeline of life events and/or service interventions which were then used to facilitate conversations about the impact of various services (positive and negative, intended and unintended), critical junctures in their life histories, and any 'missed opportunities' and/or successful points of intervention. Those choosing the alternative option participated in a standard semi-structured interview covering the same subjects but without generating a timeline. Slightly more than half (n=35) of interviewees elected to draw a timeline.

Interviews averaged 48 minutes duration, but ranged between 21 minutes and 2 hours in length. Copies of participants' timelines were provided for women who requested one. All women with lived experience of SMD who participated in an interview were given a £20 gift card as a gesture of thanks for their contribution.

The ages of women ranged from 19 to 76, with most aged between early 20s and late 40s. One identified with a non-binary gender identity and expressed a preference for they/them personal pronouns; none identified as transgender. The vast majority were British nationals, with only five having moved to the UK from other countries (all of which were located in western Europe or northern Africa). A total of five women reported being from a Black or minoritised ethnic group.

2.2.2 Participant observation

Participant observation was conducted during fieldwork visits insofar as was practically feasible within each service. This involved a member of the research team spending extended periods of time 'hanging out' and interacting informally with the women using the services and staff members supporting them. This enabled researchers to build relationships and rapport with the women with lived experience with a view to inviting them to participate in interviews (see above). It also offered opportunities for the researchers to acquaint themselves with core issues which were investigated in greater depth during interviews and focus groups (see below).

The range of activities that researchers observed and/or participated in were wide ranging and included by way of example: observing interactions in drop-in and needle exchange reception areas; accompanying support workers on scheduled casework outreach sessions off-site in clients' supported accommodation or settled housing; joining outreach workers on street outreach shifts; attending a women's group meeting in a substance use treatment service; joining residents and staff on supervised walks outside a secure residential rehabilitation programme; and contributing to informal conversations with staff in between their casework meetings and/or on scheduled breaks.

For ethical reasons, participant observation was conducted overtly, meaning that care was taken to ensure that all individuals in attendance were aware of the researcher's presence, affiliation, and reason for visiting the service. Detailed notes from observations were written up as field notes at the end of each day after the researcher had vacated the service premises.

2.2.3 Focus groups with frontline staff

In addition, a series of focus groups was conducted with frontline support workers across the case study areas. Seven such discussions were held, involving 26 individuals in total, as summarised in Table 3. Participants included representatives of the case study agencies (see above) along with staff from other services in the area, including amongst others: homeless hostels, street outreach, drug and alcohol treatment programmes, criminal justice social work, floating housing support, sex worker outreach, and specialist inclusion health nursing. All but one of these sessions was conducted

remotely via videoconference after the fieldwork visit; the other in person during the visit. Each focus group was of two hours duration.

Table 3: Staff focus group location and participant numbers

Location	Focus group ID.	No. participants
Belfast	FG-B1	7
	FG-B2	1*
Glasgow	FG-G1	4
	FG-G2	2
Stoke-on-Trent	FG-St1	4
Swansea	FG-Sw1	6
	FG-Sw2	2
TOTAL		26

*There were a number of last-minute apologies from individuals who had committed to attend this focus group, hence this conversation was conducted as a one-to-one interview

These conversations sought their perspectives on the types and timing of interventions that do and do not 'work' for women affected by SMD and the factors they consider to facilitate and/or inhibit women's engagement with support and the attainment of positive outcomes. Vignettes – hypothetical but 'realistic' cases – were used as a tool to facilitate focus group discussions. The vignettes used, which were developed after fieldwork visits and interviews with women with lived experience so as to ensure they were as realistic as possible, are provided in Appendix A. A few focus group participants disclosed (unprompted) that they had lived experience of SMD and drew on both personal and professional experience.

2.3 Phase two data collection

The second phase of data collection, conducted in June/July 2023 following analysis of phase one data, included consultations with key stakeholders in each of the case study areas and interviews with national key informant interviews.

2.3.1 Local area consultations

Preliminary findings from initial analysis of the interviews with women with lived experience, staff focus groups and participant observation were shared with key stakeholders in each case study area via a series of local stakeholder consultations. These were conducted via videoconference and involved a total of 14 individuals (three in Belfast, four in Glasgow, three in Stoke-on-Trent, and four in Swansea). Local area consultations were all of 90 minutes duration.

Attendees included senior representatives operating at the strategic level representing relevant local service providers, campaigning organisations, and commissioning bodies. A broad spectrum of sectors was represented, including homelessness, criminal justice, substance use, violence against women and girls (VAWG) / domestic abuse, and health and social care.

Participants were asked to reflect on the headline findings from earlier stages of the study and suggest how they and/or other strategic stakeholders might most effectively respond to the priorities and 'asks' articulated by women with lived experience and frontline staff. They were also asked to comment on any (political, economic, socio-cultural etc.) factors that might inhibit or facilitate the design, operationalisation and/or roll-out of any such response at the local level.

2.3.2 National key informant interviews

In addition, a series of in-depth semi-structured individual interviews was conducted with a total of 14 national-level key informants toward the end of the study to seek the insights of those operating at the highest strategic levels of policy and practice across all four UK jurisdictions. Key informant interviewees included representatives in policy making, commissioning, campaigning, and service provider roles with a national (or UK-wide) reach. They represented a wide range of sectors including: housing/homelessness, criminal justice, VAWG/domestic abuse, health and social care.

These conversations focused on the same list of preliminary findings as the local stakeholder consultations described above. They were also conducted via videoconference and lasted between 60 and 90 minutes. Of the total 14 key informant interviewees, five were based in England, three in Northern Ireland, three in Scotland, and three in Wales.

2.4 Data analysis and reporting

All interviews and focus groups were recorded with the permission of participants and professionally transcribed verbatim. Consent for the visual reproduction of timelines was obtained from women who constructed one. Pseudonymised interview transcripts, timelines, and field journal notes were coded and analysed thematically with the aid of a combination of manual coding and NVivo qualitative data analysis software.

Where interview excerpts are quoted, timelines reproduced, field note extracts shared, or individual case examples documented in later chapters, limited demographic or other detail is provided in attributions so as to preserve participant anonymity. Quotations have been edited lightly in places to remove details that might potentially identify an individual or agency. Any such edits are indicated with ellipses and/or square brackets. Where used, names are pseudonyms.

Pseudonymised individual case examples are documented in Boxes interspersed throughout the report. These were purposively selected with a view to illustrating the breadth and impacts of participants' experiences. Details regarding demographic characteristics have been omitted or altered very slightly within these in such a way that the overall narrative remains unaffected. Where included in an original timeline, the names of other people have also been redacted to ensure that participants are not identifiable.

Some quotations and case examples include personal accounts of experiences which some readers may find distressing. These include, but are not limited to, detailed descriptions of sexual violence (including rape), self-harm, miscarriage, and suicidal thoughts/attempts.

2.5 Governance and ethics

A project advisory group comprising representatives of service provider and campaigning organisations and academics with expertise in relevant subjects was convened by the Oak Foundation. It included representatives from all four UK jurisdictions and women with lived experience of SMD.

The group met at key points during the study to comment on research design, advise on case study selection, provide feedback on draft research instruments, facilitate contact with key gatekeepers, comment on preliminary findings, and offer advice regarding dissemination.

Ethical approval for the study was obtained from Heriot-Watt University's School of Energy, Geosciences, Infrastructure and Society Research Ethics Committee prior to data collection.

2.6 Conclusion

This chapter has outlined the methods used in the qualitative study of women's experiences of SMD, which involved detailed case studies in Belfast (Northern Ireland), Glasgow (Scotland), Stoke-on-Trent (England), and Swansea (Wales). Overall, it consisted of: in-depth interviews with 60 women with lived experience; focus groups involving a total of 26 frontline staff; consultations involving 14 local stakeholders representing a wide range of housing, health, social care and related sectors; and in-depth interviews with 14 national key informants. These conversations were complemented by participant observation within each of the eight participating agencies across the four locations. Findings from the analysis of the rich empirical data generated are reported in the following chapters. Each analytical chapter draws upon data from the full range of sources described above.

3. Experience of Homelessness, Substance Use, and Offending

This chapter documents women's routes into and experiences of each of the three primary domains of (3-dimension) SMD, these being homelessness, substance use, and involvement with the criminal justice system.

3.1 Homelessness

Participants with lived experience of SMD had experienced a wide range of forms of homelessness, and often recalled having moved 'in and out of' homelessness and/or different manifestations of it at relatively frequent intervals over a prolonged period. For most, first experiences of homelessness dated back to their teens or 20s, most commonly after leaving care, leaving home after a relationship breakdown with parents/carers, or after a relationship with an intimate partner ended (see also Chapter 5).

Experience of what is often referred to as 'hidden' homelessness (see Chapter 1) was extremely common. Key amongst these was sofa-surfing, with almost all participants with lived experience reporting that they had stayed with friends or family members (or acquaintances thereof) on one or more occasions. These stays were normally short-lived, with women staying until they perceived that they had outstayed their welcome or were asked to leave. Some moved on because they did not feel safe. On this latter point, a number noted that they had been exploited by members of the host household when sofa surfing.

> *I ended up giving up my flat because of rent arrears … [then] I was staying with one of my friends, and … I just kept getting robbed all the time. Sitting around me until my money was gone, then they didn't want me in their flat then. (Woman with lived experience, Swansea)*

A number of frontline staff and stakeholder interviewees observed that what women affected by SMD describe as sofa surfing or staying with friends often involves an exchange of material goods (e.g. food or drugs) or sex.

> *I know for a fact she's [client is] going to turn up at someone's house and go, 'I've got this for tea. I've got this, this and this.' As long as she's coming with something - no matter what it is - they'll have her in. The day she hasn't got no money or the day she doesn't come back with nothing, 'That's it. You're not coming in. Go.' (Frontline staff, Stoke-on-Trent)*

> *They will link into sofa surfing, which often means there's some kind of trade involved, sex work involved in that. (Frontline staff, Belfast)*

On this latter point, a small number of women with lived experience described entering unwanted sexual relationships with men, or exchanging sex, for somewhere to stay and/or to facilitate access to drugs. Frontline staff interviewees emphasised that women engaging in these forms of 'survival sex' do not always perceive themselves to be either homeless or sex workers.

> *I was sofa surfing for years, staying between guys, just going with guys because they were drug dealers, staying with them. I was also sleeping in the streets through this time. (Woman with lived experience, Glasgow)*

Box 1: Case example – Isla

Isla is now in her late 30s. One of her earliest and most vivid childhood memories was of urinating herself, surrounded by broken glass, after witnessing her father 'batter' her mother. She explains that her mother had mental health issues and was a Valium addict, and her father a physically abusive alcoholic. Her father died when she was nine years old, after which time her mother started drinking heavily, was physically and verbally abusive toward and neglected Isla and her older sister. Isla was bullied badly at school because she never had any clean clothes to wear.

Both she and her sister were taken into care after Isla "fell apart" one day and told a teacher about what was happening at home. Her teacher contacted social services and Isla describes being in and out of foster homes for most of her childhood. She recalls sneaking into her sister's bed at night because she felt alone and scared. Isla describes being 'treated like a pure slave' and subject to bullying within one particularly awful home. She started selling sex when in her early teens because she 'didn't think sex was a thing' after having been sexually abused by a friend's father who lived in the same tenement from the age of 9 into her early teens.

Isla moved into a rented flat with her first 'proper' boyfriend when she was 17. She says of the relationship, "It wasn't great, but I thought I loved him", despite him cheating on and occasionally being violent toward her. She became pregnant and describes being deeply traumatised when her baby was stillborn. She was put into a 'safehouse' soon afterwards because her partner assaulted her, leaving her with black eyes and broken ribs. She was first introduced to heroin in the safehouse, and reports that she smoked it for the best part of 12 years "because it took the pain away". She funded her drug use via sex work and reflects that "I hated myself for that".

She spent several years sofa surfing and "going with" men who dealt drugs to secure a place to stay and maintain access to drugs. She slept rough sometimes and also stayed in night shelters on occasion during this period. The local street outreach team and council housing department helped to secure her temporary, and subsequently settled, housing. Isla has had some engagement with a psychiatrist and has been diagnosed with Post Traumatic Stress Disorder (PTSD). She understands that further diagnostic assessments will be conducted when she is sober given that some of her behaviours may be symptomatic of paranoid schizophrenia or bipolar disorder. She has had a couple of court notices for breaching the peace, assault, and theft, but has never been in prison.

Isla had a child whom she cared for herself for a short time whilst 'clean', but experienced a relapse and voluntarily signed her daughter's care over to a family member thinking that doing so was in her child's best interests. She did try to "jump through hoops for social work" to retain regular contact but her drug use worsened after her daughter's removal and her ability to retain contact compromised. She began using in riskier ways by injecting (rather than smoking) heroin. Isla then succeeded in completing a residential rehabilitation programme but relapsed shortly after being housed in an area known to be "full of crack and alcoholics". She began drinking heavily and later started injecting cocaine when living there, funding her substance use via sex work once more.

At the point of interview, Isla was back in residential rehabilitation after a criminal justice social worker referral, with renewed determination to succeed after being gang raped whilst sex working. She concludes, "This has to be it for me because I can't go out there and start using again. I'll end up … murdered or … killing myself to be honest." The prospect of seeing her daughter is a key motivation, but she notes that "I need to find Isla before I can be a mother". She thinks that Housing First may be a good option going forward. But she also emphasises the scale of the challenge ahead given that: "I kind of feel dirty, and used and abused … I don't even know what I like and what I want … I'm just sort of dead inside. I'm numb. Taking away the drugs and that, it's actually harder".

A lot of women engaged in survival sex don't see themselves as a sex worker … They're doing something in exchange for a basic necessity, i.e. somewhere to sleep for the night or something to eat. (Frontline staff, Stoke-on-Trent)

A minority of the women with lived experience had been street homeless, typically because they were actively avoiding or had been banned from local homeless hostels because of rule infringements.

I've slept rough a few times … Doorways mostly or if I found a quiet place, I'd go there. I'm still doing it on and off. Just because the hostels are suffocating for me … Just if people are shouting at each other. It just activates me if they're fighting, I just have to get out of there. (Woman with lived experience, Belfast)

I'd phoned housing, and … the only advice they could give me was to go to the [name of hostel] … I went outside, and there was a lot of people, and it was just quite scary, to be honest with you. Everybody was under the influence, and people were shouting and fighting and just thought, 'Oh, I'm not going in there' … I couldn't stay there. (Woman with lived experience, Glasgow)

Some recalled having walked all night or having 'hidden away' in derelict buildings when street homeless to reduce the risk of being assaulted when bedded down and/or attracting unwanted attention from people (men in particular) who they feared would exploit their vulnerability.

I spent one night floating about the city centre, and it was quite scary … I spoke to a few homeless people and stuff like that as well, but I just kept walking about. Every time I tried to sit on a bench, I'd sit down, and I just couldn't sleep … I was just walking about, and I was absolutely shattered. (Woman with lived experience, Glasgow)

I was walking the streets of the town all night. No sleep … Just walking. (Woman with lived experience, Glasgow)

One participant described 'fortifying' herself with alcohol and/or other drugs in order to cope when sleeping rough.

I used to sleep in closed shops. I've slept in car parks … I was trying to get away from domestic violence as well, so I was dead scared of guys at the time. I thought, 'Do you know what? Just get yourself full of drink, full of everything, and get out on that street' … I couldn't have slept if I wasn't intoxicated. I had to be. (Woman with lived experience, Glasgow)

Frontline support workers and national stakeholder interviewees often commented that the tactic of concealing their street homelessness was a particular barrier to service access, especially where commissioned services were funded to support 'verified' rough sleepers only, as was noted to be the case in Stoke-on-Trent for example.

The definition of someone who's … rough sleeping, that camping down for the night in the city centre. I've come across hardly any … women who've done that … Because most of the women, on the nights where they've had nowhere to go, they will walk round the streets. It's very intermittent … They may not be rough sleeping every night. So even the definition within itself can be a real barrier, because for us to get women verified, they have to be camping down for the night. (National stakeholder, domestic abuse / VAWG sector)

> I caught up with [name] … who looked in a terrible state … She had apparently been on a monkey dust binge and was now coming down. She had been sleeping rough and told me that she could not get a place in a hostel as she was 'unverified'. Staff members confirmed that she is not considered to be sleeping rough as she has not been seen bedding down in any doorway … or other places that are counted in … returns to the government. She mainly sleeps in 'friends' places (in exchange for goods/services) or in derelict buildings. (Field notes, Stoke-on-Trent)

A few women with lived experience recalled having slept rough with a (male) partner. One described the presence of her partner as a protective factor which reduced the risk of harm. She felt extremely vulnerable when he was imprisoned and she subsequently slept rough alone.

> *Me and my man slept under the bridge at the [name of river] … It wasn't a life. I had nae option. I had to do what I had to do, do you know what I mean? … Then he got the jail … Aye, and I was like, I wasn't sleeping. I kept looking behind my back. Anybody came towards me, I got to the stage I was carrying … a knife. (Woman with lived experience, Glasgow)*

In contrast, another woman noted that the abusive nature and volatility of her relationship at the time exacerbated her vulnerability when street homeless. The threat her partner posed had continued even after she moved into a hostel.

> *I was with someone at the time [when sleeping rough]. That made it even worse I would have to say, because he was a psycho. It was horrible … Then I was in a hostel … and he was barred from there because he was an arsehole, and so they [staff] told me, 'He's not allowed in, just don't go out', because he would come in and pound them, and break the door down and shit like that. I just hid from him, fuck's sake. I had to because he was going to fucking kill me. (Woman with lived experience, Belfast)*

Experience of stays in temporary accommodation was extremely common. Whilst some had positive experiences of hostels or other forms of congregate supported accommodation, the majority described hostels as frightening places, especially where they catered for both men and women (see also Chapter 7). A few had been sexually exploited by male residents when living in a hostel.

> *I was in a hostel in [name of area] for a year … One day I refused to sleep with … this fella, and he made up all sorts of lies … He phoned the social workers going, 'She's on coke. Aye, she's drinking. She's sleeping with a fella in the hostel.' (Woman with lived experience, Belfast)*

> *I was in a hostel in [name of area]. I was in the [name of hostel] as well, so I couldn't sleep in any of that, so that was when I was sleeping in the town, because it was terrifying … Somebody got stabbed outside my door. I'd never seen anything like that before. (Woman with lived experience, Glasgow)*

Box 2: Case example – Siobhan

Siobhan chose to draw her timeline "backwards". She was around 30 years of age at the time of interview and living in her own independent tenancy. Her infant son was living in the care of one of her siblings. She described the prospect of being able to see him as her main source of hope for the future: "If anybody will help me, it'll be the child, like". She was nevertheless unsure when, if ever, that might happen given that her family continued to "shun" her because of her drug use. Siobhan was looking forward to marrying her fiancé in the not-too-distant future.

She had recently been discharged from hospital following treatment for abscesses on her brain which were caused by injecting cocaine ('pure' as it is known locally) into her neck and face over the previous six months. She had initially smoked it but progressed to injecting over time. She was injecting in her neck and face because the veins in her arms and groin were very badly damaged during eight years of prior heroin ('gear') use: "I basically have no veins left", she explains. Her drug use escalated dramatically when the father of her son overdosed fatally before their baby was born. "Taking pure is helping me deal with that", she notes.

Acutely aware of the risks involved with her drug use, Siobhan reflects that "I couldn't tell you how many of my mates I've buried" and "I was really close to death and like I say six months later … I am doing exactly the same thing that put me in the hospital in the first place". This chain of events, she concedes, "is very fucked up". She describes dealing with her addiction as a "full-time job" and emphasises that "when you're an addict you don't give a fuck about yourself … whether you live or die, whatever". She adds that boredom is a contributing factor to her high levels of daily use. She reports having been frustrated when seeking help for her addiction in the past when told that there was a waiting list for treatment. A delayed offer, she argues, "is no use to an addict".

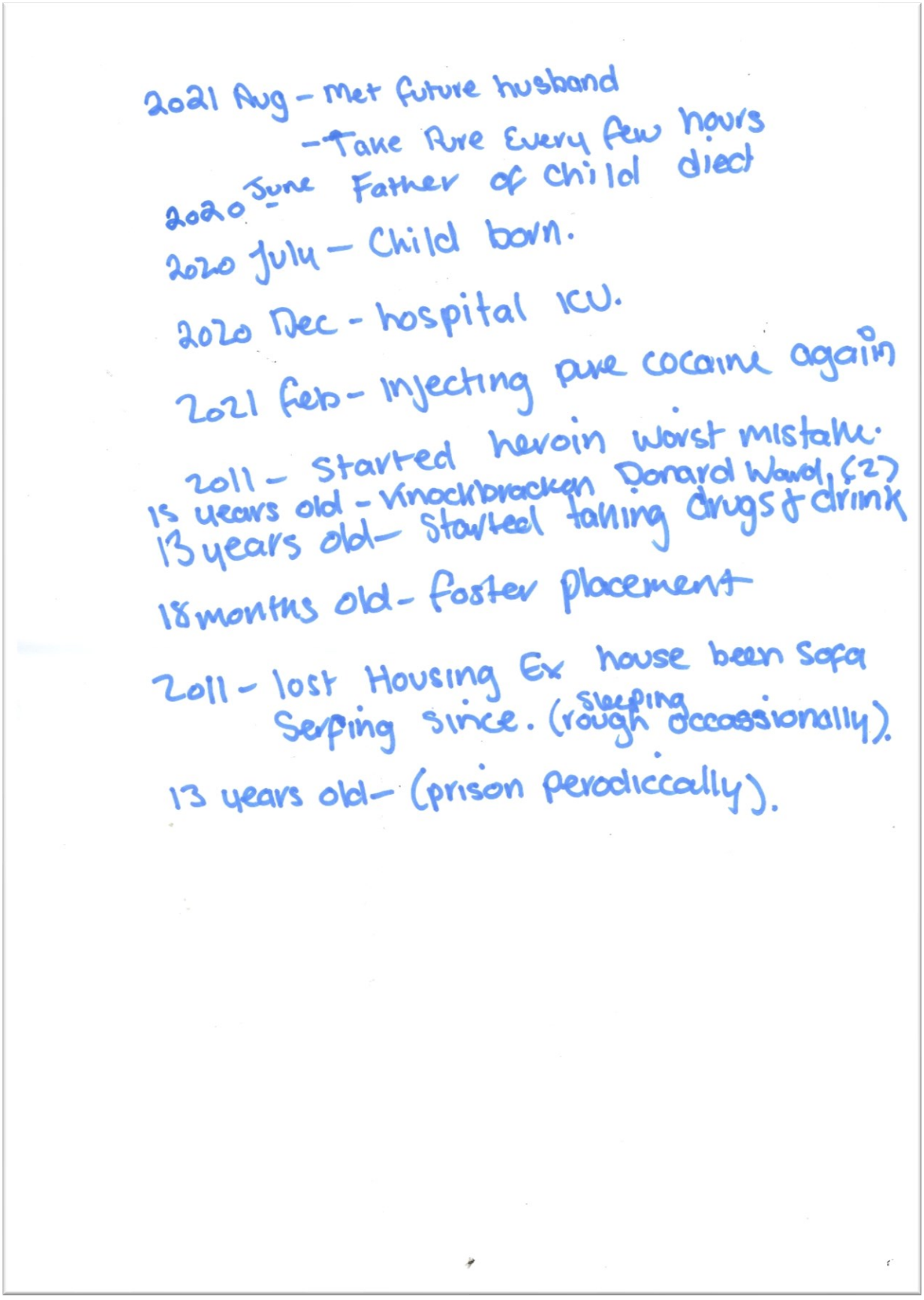
She began drinking at the age of 13, then "followed the crowd" by moving onto opiates in her late teens, despite having done well at school. Her drug use then "just progressively got worse". Siobhan has an extensive criminal record, with all her offences being drug-related in some way: "Either I've been off my head on drugs, or I've needed to sell certain things for money for drugs, or I've bought drugs with that money." Siobhan has been imprisoned a number of times. She deemed probation helpful in that "it kept me out of trouble with the police" but notes that "it didn't address any of my issues". She describes "begging on the streets" at times to fund her drug use.

Siobhan had a social housing tenancy in her early 20s but lost that and has been homeless more or less ever since. She sofa surfed "a lot" during that time, and has also slept rough on occasion, including when she was pregnant. Siobhan stayed in a number of hostels which "served their purpose" in terms of getting her off the street, but she observed that the keyworkers appeared to be overwhelmed and tended to focus their attention on (other) residents who were "ready to change". At one point she was offered temporary accommodation outside the city but that was unsuitable as it meant she could not access her (supervised swallow) methadone prescription.

She reports that she has a personality disorder and "probably other things". She self-harmed from a young age and frequently needed hospital treatment given the severity of her cuts. She spent time in a psychiatric ward when she was 15 but says that her history does not seem to have opened doors to mental health support as an adult: "Mental health is shocking here … there is no help".

Siobhan reports that she was "brought up with social, in the system" after first placed in foster care at the age of 18 months. She "hates" social workers given her experience as a child and because letters from social services regarding her son portray her as "a monster". Of social services, she concludes that "You can't fight the social; end of … You need to befriend them – and I can't do that!"

Figure 1: Siobhan's timeline



A number of women with lived experience reported that their use of substances increased when living in hostels due, in part, to being surrounded by other people who were using, but also in some cases because of boredom.

> *I didn't use substances until I became homeless … I've been smoking grass since I was like 15, but I didn't touch a single [other] thing until I was actually homeless … The things I see in hostels, Jesus Christ ... People were using, selling, everything … I've no impulse control … This past three-and-a-half years has just been like a blur, just drugs and fucking hostels and shite. (Woman with lived experience, Belfast)*

> *I think - especially in a place like this [hostel] - you're bored, you don't have anything to do, and you do fall back on to alcohol and drugs. (Woman with lived experience, Belfast)*

Stakeholder interviewees also noted that other forms of temporary accommodation, particularly bed and breakfast (B&B) hotels, were often extremely unsafe for women with experience of SMD due to their susceptibility to sexual exploitation by male residents and/or unscrupulous landlords. One expressed concern about the potential scale of exploitation in B&Bs used (as last resort in the absence of alternative options) for women who are released from prison, for example.

> *A B&B [bed and breakfast] for us feels like the last resort rather than somebody go on the streets … Some of those B&Bs [in name of area] are used for temporary accommodation for offenders, and they're not … managed properly, they're not monitored … and the owners of some of these B&Bs are … exploiting women for sexual favours in return for toilet roll, things like that. That's the kind of worst scenario. That's what we know about. The worry is what don't we know about... (National stakeholder, criminal justice sector)*

Several participants with lived experience had stayed in refuges for survivors of domestic abuse. Many reported very positive experience of women's refuge provision and/or were extremely grateful for the (potentially lifesaving) respite it provided. A number had however been refused access due to their substance use or were asked to leave because they had contravened refuge rules.

> *It [the refuge] was good. I got myself kicked out, mind. [Laughs] I brought boys back, and no men are allowed, are they? (Woman with lived experience, Swansea)*

> *[My boyfriend] got violent … I got social service involved. I had to be very, very quiet on the phone to them because I was scared he was going to go off. I got them to come and take me out and that's how I ended up in a [name of refuge] … I got kicked out … for arguing with the staff. (Woman with lived experience, Belfast)*

> *[Name of refuge provider] … were a double-edged sword … The child workers were so patronising … [and] I had to rehome my dog because they're not allowed in the refuge, which was horrible. On the other hand, they did get me a home. I was lucky. I found them useful and interfering simultaneously. (Woman with lived experience, Swansea)*

On this subject, a number of stakeholder interviewees observed that the capacity of traditional congregate refuges to accommodate women affected by SMD is limited given the scale and nature of their support needs and risk this group presents given refuge providers' prerogative to protect other residents, particularly children (see also Chapter 6). Some stakeholders pointed to promising outcomes recorded by recent 'Respite Rooms' pilots which, whilst taking different forms, provide intensive trauma-informed support in single-sex safe housing for survivors of domestic abuse or VAWG and who are or are at risk of street homelessness (DLUHC, 2023).

Most refuges … wouldn't be able to accommodate a woman's needs, particularly if she was, so-called, more of a chaotic user around substances and stuff like that. (National stakeholder, domestic abuse / VAWG sector)

Women's Aid is quite specific in its client group that it takes in. It has to be domestic violence ... They won't take anybody who has any substance issues … is actively using … That really takes away most of our clients ... The reason for that is because Women's Aid take in families or take in females and their families so they don't want the kids being exposed to people who are drinking or taking drugs or whatever. (Frontline staff, Belfast)

Experience of repeat homelessness was extremely widespread. Key triggers for repeat episodes included rent arrears, domestic violence, and/or difficulty sustaining tenancies (and recovery from addiction) when rehoused in neighbourhoods with high levels of substance misuse and little or no support.

I done [name of rehab] for eight months, three years ago, and I got a house in [name of area], and most of the village were on crack, and alcoholics. It didn't take me long to get back into it. (Woman with lived experience, Glasgow)

I had had no [housing] offers for nearly two years. So, when I got that offer, I jumped at it, even though I was told it was in an antisocial area and this and this and that. I didn't care. I was just excited to have a flat away from hostels, but that was one of the biggest mistakes I ever made. (Woman with lived experience, Belfast)

Worker 1: Basically, once someone's in permanent housing, resettlement support is six, maybe eight weeks maximum … For some, housing them with only that would be detrimental to their recovery … and then she's going to say, 'Well, there's another thing that I've failed at.'
Worker 2: Aye. Then the answer to that is to not think about the failure and just go and get mad with it again … Then you're losing the flat because you're not engaging with your services and you're inviting other people in and out, and you've got dealers coming to your door. Before you know it, you're back on the streets again. So it's a vicious circle. (Frontline staff, Glasgow)

Some had been homeless 'off and on' for very long periods – upwards of 20 years in a few cases – and attributed the sustained nature of their experience at least in part, to professionals' expectations that they are 'housing ready' before being allocated a home. A few noted that in practice that meant that they would in all likelihood remain homeless until deemed 'clean' of illicit substances unless able to access a service such as Housing First where such eligibility requirements do not apply.

I'm now 54. I've only had one council house in my life and I don't understand why I cannae get one. All's they keep saying to me is, 'You're no ready. You're no ready.' I want to know who is ready? … They want me to come off all illicit substance … They want me to engage with other services … They want me off everything before they put us into a house. It's no right. (Woman with lived experience, Glasgow)

In Belfast, an additional cause of (repeat) homelessness was women being severely intimidated and/or physically 'put out' of tenancies by paramilitaries given their (or in one case their partner's) substance misuse or their involvement in sex work.

I … got put out [of my flat] by paramilitaries, because of my ex's actions, not mine. I was clean at that stage, so it wasn't anything to do with me … Literally dragged out of our house … So left everything behind, and just didn't go back. That was also a bit of trauma, you know … They don't take substance misuse kindly. (Woman with lived experience, Belfast)

One of the staff members explained that paramilitaries tend to have very low levels of tolerance for sex work. This makes it very risky for clients even after they've been housed. The locals don't want lots of unknown men turning up etc. And these women and their visitors are reportedly not always particularly discrete about their drug using/ dealing/ sharing activities which can put them at substantial risk of being put out. (Field notes, Belfast)

3.2 Substance use

When asked about the history of their substances, the vast majority of women with lived experience traced its origins back to their early teenage years. They typically identified age 13 or shortly thereafter as the point they began drinking and/or using 'recreational' drugs such as cannabis or ecstasy. Their use usually escalated after this point, in that they began to drink in more problematic ways and/or use 'harder' drugs such as amphetamines, crack cocaine, or heroin to name but a few examples.

I was 13 when I started drinking … Then came the experimental drug use. That was just like cannabis and stuff. (Woman with lived experience, Belfast)

I started drinking when I was 13 … Then I moved on to opiates, then just progressively got worse … I just kind of followed the crowd … I ended up really bad. (Woman with lived experience, Belfast)

I have an alcohol abuse problem ... I have been abusing alcohol since I was 13. (Woman with lived experience, Glasgow)

I think I took my first eccie [ecstasy pill] when I was 15, so I was taking eccies and I can remember that. I was taking eccies when I was 15, but wasn't taking any other drugs until I was - maybe a sniff of cocaine but not too much. I didn't really like it - until I was 21 … when I tried [non-prescribed] Suboxone for the first time. (Woman with lived experience, Glasgow)

For some, the onset or exacerbation of substance use issues was catalysed by bereavement.

Well, my family are all big drinkers … and then my mum died suddenly when I was only 21. After that, that's when I became an alcoholic drinker … I didn't stop drinking. I drank round the clock … It was just a really difficult time … I've still not dealt with it … I keep relapsing. I can do well for so long and then it's just really hard. (Woman with lived experience, Glasgow)

I haven't been sober since my boyfriend died … last year … when I was pregnant. At the moment, taking pure [cocaine] is helping me deal with it. (Woman with lived experience, Belfast)

I started drinking alcohol at the age of 13. Then I'd usually get a drink with my pals at the weekend, and then I started picking up diazepam … It was just a weekend thing, and then before you knew it … Then my dad died when I was 13 … Then my big brother committed suicide as well, he hung himself … I was 16 … So then I started drinking more and more, and then I started using diazepam. (Woman with lived experience, Glasgow)

A few noted that their difficulties with substances had begun after initially becoming dependent on prescribed painkillers.

I ended up with … nerve damage … They had me on fucking co-codamol for about three years. It worked … but I ended up addicted to it really bad, to the point where if I didn't have it the withdrawals were horrible. (Woman with lived experience, Belfast)

Post-natal depression had triggered an increase in or return to drug use for some.

I worked as a lifeguard from 16 to 24 … [and] I started going out to town and discovered coke [cocaine] … It was recreational. I didn't do it badly, and then I had my wee girl … and got really bad post-natal depression … It was so bad coke was the only thing that got me... Well, I didn't believe in depression. I didn't understand it. I was in denial, so cocaine I just took every single day. (Woman with lived experience, Glasgow)

A small minority of women noted that their initial use of drugs (or in one case a relapse) had been underpinned by a desire to lose weight.

My friends said, 'I've got a quick fix for you to lose weight.' I had my first half a gram [of amphetamine], and … within three months I went from a 24 to a size ten … Then after a few months, it fries your brain. Then you can't keep still … It becomes you don't know what is real and what isn't … and before you know it, you've lost all respect and family, your friends. The only people you have around you are in the same mess as you (Woman with lived experience, Swansea)

They [psychiatrists] put me on medication that made me put on lots of weight, so I started taking whizz [speed] again to lose weight. It didn't work, but I got myself an injecting habit again. (Woman with lived experience, Swansea)

The escalation in use of 'harder' drug and/or transition to riskier means of administration such as injecting normally followed their introduction by peers or an intimate partner.

I started using cannabis at 17 … I wasn't really into drugs really at that point. I got into it through just hanging round the wrong crowd basically, and then being around them and going off with somebody. They're having it, and I wanted some then, and then that's how it started. It progressed and I got myself a habit … I went from cannabis to amphetamine, and I started allowing myself to be injected with amphetamine. Eventually got psychosis off that, so I've … been in hospital, sectioned and things. (Woman with lived experience, Stoke-on-Trent)

Many of the women sharing such experiences attributed this transition to their own 'curiosity', 'gullibility' and/or 'naivety', emphasising that it was not the result of force exerted by other people.

It was actually a relationship I was in … that's how I got introduced to that [heroin], but it was through my own choice. It wasn't forced upon me. It was more curiosity than anything. (Woman with lived experience, Belfast)

He [partner] was desperate for the money [for heroin]. He says, 'Can you give me £10?' I went well, 'Aye, here…' I went, '… but get me a wee bit to try.' Obviously, he was in an agreement so he could get the money. That was it. That was the beginning … Hooked. (Woman with lived experience, Glasgow)

I would just take anything. Somebody's like, 'Oh, try this,' and I'm like, 'Alright.' Especially if I've had a drink, I'm quite open to … trying things, taking anything. (Woman with lived experience, Glasgow)

In contrast, a number placed the locus of blame for the onset or escalation of their addiction at least partly or wholly on the shoulders of their partner at the time.

He [partner] would start giving me Valium, street Valium, saying, 'These will take your hangover away.' He got me hooked on them. I was oblivious to anything that was going on. He was abusing me mentally, he was taking my money, and he had me hooked on drugs. (Woman with lived experience, Glasgow)

I had a great partner, he was wonderful throughout my whole pregnancy … but it was kind of his fault that I ended up on the cocaine. If it wasn't for him, I would never have been near it. (Woman with lived experience, Belfast)

On this subject, a number of frontline support workers emphasised that men often exert control over women affected by SMD by being the one to inject them because women's veins are often harder to locate and inject.

One of the things that have been noticed over the years … is that female clients … will have a male partner … who can inject them. And that creates a power imbalance where the person is looking for their drugs, they can't administer them, so they have somebody who has a hold over them by being able to administer them … There is a form of coercive control that we've noticed for many of the clients, actually. (Frontline staff, Belfast)

In a similar way, some men were said to capitalise on women's reticence to be seen accessing substance misuse services (see Chapter 5) by taking responsibility for accessing clean works from needle exchanges, for example, and thereby exerting control over their ability to access safe injecting equipment.

Problematic drinking and the use of illicit drugs or non-prescription medication was almost always described as a form of 'self-medication', that is, consumed as a means of attempting to cope with recent or historic trauma (see also Chapter 4).

My CPN [community psychiatric nurse] … is convinced cannabis is the cause of all my problems, and I'm looking at her going, 'No, cannabis solves my problems.' I was like, 'I had all these problems before I started smoking cannabis. I smoke cannabis to help me cope.' (Woman with lived experience, Belfast)

I was abused from age 9 up until 13, and that's how I started at 13, it was right onto the cider … I just try and blank it out. Obviously I say about it and talk, it's like I've no

emotions to it anymore unless I'm drinking, if you know what I mean, and the anger and all that comes through … I blocked it out when I had a drink. (Woman with lived experience, Glasgow)

I wasn't really giving a shit … about staying safe [when sex working]. I just wanted the money to go to oblivion. I was taking uppers, downers, I just wanted to be anywhere but in my own head due to the shame developing the most over my daughter being removed …. I actually signed to say I'd let her go … so she's got a better life … and it kills me. (Woman with lived experience, Glasgow)

A lot of the clients, they're using their substance of choice to either dull their trauma or live with the traumas that they've had. (Frontline staff, Belfast)

The costs of their addiction (and/or in some cases their partner's drug use) had led a number of women with lived experience to become involved in acquisitive crime (discussed in more detail in the section below), begging, or sex work. Whilst participation in sex work had for most usually been street-based, the onset of the coronavirus pandemic had prompted some to start selling sex by 'camming'. A number began camming during the height of the pandemic and continued to do so after lockdowns given the perceived lower levels of risk to personal safety.

I'd say about five or six of mine … sell sex on-line. They go through phones like no one's business. It's got to be a smartphone because they need it because they've got to check their UC [Universal Credit]. Then, in the next breath, 'Right, I've got work to do,' and then they're online, doing whatever they're doing, trying to make money that way. (Frontline staff, Stoke-on-Trent)

A key finding with regard to substance use was the severity of impact on women's overall wellbeing and scale of challenge they faced in recovering from their addiction. A number emphasised the depth of despair and lack of self-worth they were currently feeling or had felt when at a particularly low point in their recovery journey.

Aye [I use] heroin … Since I've started to come in here [hostel] I've took rock [and] … I'm an alcoholic. I don't care if I die. I don't care. I've got grandkids now … but I really don't care. I've got nobody in my life now apart from my grandkids … I've tried to come off, I'm in a mess. It's too hard. I can't do it. (Woman with lived experience, Glasgow)

I was sleeping in the town … I was lying about covered in pee, sick, whatever, and stinking … I used to just get so drunk that I'd fall asleep not knowing where I was ... I didn't really care if I woke up or not, to be honest! [Laughs] … I hadn't eaten because I'd spent all my money on drink and drugs. (Woman with lived experience, Glasgow)

In this vein, one woman with lived experience acknowledged how distorted her perspective had become given how close to death she had recently been following a period of hospitalisation and how many of her friends and peers had lost their lives in recent years due to drug use.

I couldn't even tell you how many of my mates I've buried. See, the first thing that you're going to ask, 'Where do they get their stuff from?' You know it's strong because it killed them! It's so fucked up. That is weird; you're burying your friends but you want to know where they get their stuff from. (Woman with lived experience, Belfast)

Women with lived experience often emphasised the profoundly detrimental impact that their substance use (and similarly their involvement in criminal activity if/where relevant, see below), had on their social networks and general self-worth. Some noted that they continued to benefit from the support of a partner or family members, but the greater majority described being (or feeling) ostracised by their loved ones and/or society more generally.

> *[My two children's fathers] … just want me to get better, and that's what they both say. They're like, 'You wouldn't meet a better mammy in the world.' It's just when I drink everything else goes out the window, to the point where I would step on my weans [children] to go and get a drink … I didn't wake up one day and decide to be an alcoholic … I don't feel proud to say that my kids have to be at their dads while I'm in a bloody rehab and that I've tried to take my own life. (Woman with lived experience, Glasgow)*

> *What my mum wants is me getting off the crap [drugs], that's what she wants. None of the boys [sons] speak to me. The boys are being an arsehole with me now. (Woman with lived experience, Stoke-on-Trent)*

The sense of isolation experienced by some was exacerbated by the need to 'cut themselves off' from social networks in order that friends or family members still actively involved in substance use would not jeopardise their recovery.

> *I've cut everybody out as well … The people who use drugs by me. I know they knock the door sometimes for a rollie and stuff like that. It is in your face. When you're getting texts - because I still get the bloody texts to this day - about deals and stuff like that, but it's just not bothering me now … since I got on this Buvidal script ... It's been fucking hard though … having to cut everybody out. (Woman with lived experience, Swansea)*

> *After I OD'd [overdosed] … I de-socialised myself from everybody I hang out with. That was one of the hardest things for me … I knew, in order for me to sort myself out, I had to keep a distance from everyone, delete phone numbers, the whole lot. That, I found very hard. It was worth it. (Woman with lived experience, Swansea)*

Stoke-on-Trent has encountered specific challenges associated with the use of 'monkey dust' (sometimes also referred to as 'zombie dust' amongst other terms). The preponderance of this synthetic psychoactive drug was described as a 'scourge' on the local homeless population, and women affected by SMD in particular, given that a bag providing up to 30 hits could be purchased for as little as £2 and its effects highly unpredictable. It was reported to contribute to violence and paranoia and exacerbate female users' vulnerability to sexual exploitation. Further to this, some of its effects could include heightened sexualised behaviour, which made it very difficult to prove when women were victims of such offences.

> *I used to be a pothead, now a [monkey] dust head … It's cheaper and a lot stronger … But it's very weird because at least you know what's in weed. We don't know what's in dust. It's like all different chemicals, people dying of it … This monkey dust, it affects your brain even more … I talk to myself all the time. I'm like looking at them, 'What the fuck is she talking about there?' … It's just horrible … When I'm on the dust I get paranoid. (Woman with lived experience, Stoke-on-Trent)*

> *I've just recently got myself clean off monkey dust … I just became addicted to it, would not engage, nobody could talk to me. I had violent episodes where I'd lash out at people. I*

ended up pulling a knife on a juvenile in the street, so yes, that was the last straw, so I ended up in jail. (Woman with lived experience, Stoke-on-Trent)

3.3 Criminal offending

The women with lived experience emphasised that, with very few exceptions, their involvement in criminal offending had from the outset been directly related to their substance use, be that because they were under the influence at the time or were dealing or stealing goods to fund an addiction.

> *I've caused a lot of mayhem, done a lot of stupid crimes. I've got charged with assault, vandalisms, breaches, sectarianism … dangerous driving … It's all been under the influence. I've never done anything sober … Especially when I take Valium and drink. (Woman with lived experience, Glasgow)*

> *I've done really some fucked up things on … street Valium. I'm lucky I've not got a sentence with the police … I would shoplift stupid things … You'd walk into a shop and walk out with a can of drink and think nobody'd seen you do it. It's mental. (Woman with lived experience, Glasgow)*

Several emphasised that their involvement in criminal activity, and similarly any participation in begging, was driven by desperation given the imperative to avoid the pain of withdrawal.

> *I have [been convicted for] petty theft … When you're an addict you would basically do everything and anything to try and survive, you know … You would go out, and you would tap [beg] on the streets … or you would rob, or steal, or stuff like that. Not proud of it, but I did it myself, again to feed my own habit, because I was that deep, and in that much distress. The withdrawal is just awful, so you would do anything to get rid of that withdrawal. (Woman with lived experience, Belfast)*

Some had no recollection of their actions given their level of intoxication at the time, but were nevertheless very ashamed regarding their actions.

> *The police come and charged me, and I'm like, 'I can't say it was me, I can't say it wasn't me because I don't remember'. I don't just say that to get out of it. I physically don't remember … because I was so intoxicated, so away with the fairies. (Woman with lived experience, Glasgow)*

While some women who had served one or more custodial sentences described prison as a frightening or intimidating place, others reported that prison felt 'safer' than living on the streets and/or that they valued the respite offered from the harmful effects of homelessness and substance use.

> *I've been in and out of jail since I was about 32. I'm 51 now … Always get big sentences because of my previous [offences] … I was better off in the jail than out here … I like it when they do just send me there, I feel safer. (Woman with lived experience, Glasgow)*

> *[Prison] saved my life … really saved my life. It was the only way. It was the only way that I was going to be alive and - yes. I'm glad I went to prison. (Woman with lived experience, Stoke-on-Trent)*

The significance of prison sentences in interrupting and/or providing respite from harmful activities, and in some instances exploitation from abusive partners, was also commented on by frontline support workers and local/national stakeholders.

> *You don't really want anybody to go into custody, but in some instances, if they don't go into custody, you're frightened they're going to end up dead. (Frontline staff, Swansea)*

> *Sometimes we've recalled women to custody for their own safety, which should never be the case. We shouldn't be putting them back into prison but if they're on the streets, they're using heavily … Sometimes I feel our rationale for recall isn't always based on managing the risk to others. It's managing the risk to her sometimes as well … Sometimes a woman will say to us … 'I just need to go back in', because their use has become out of control, she's so unstable, she's so unmanageable. (National stakeholder, criminal justice sector)*

Further to this, a number of support workers highlighted the fact that being in prison presented opportunities for engagement that can otherwise be extremely difficult to access.

> *When they're not in prison, they're very chaotic, you can't get hold of them, you can't get no engagement. When they're in prison … it is just so much easier to try and start building relationships, and start doing meaningful engagement … They don't have to meet with you, but it does make contacting them and arranging things a lot easier, as opposed to when they're in the community, especially if they're homeless, or sofa surfing, they don't have mobile phones, they don't have no email addresses, that sort of thing. So contacting them can be very, very difficult. (Frontline staff, Swansea)*

A number of women with lived experience recalled benefiting from support and educational opportunities that they had not been offered or had difficulty accessing before being incarcerated (see also Chapter 5).

> *In prison, I seen more [services] … I had the [name of service] … it's for abuse. Done that. CBT [cognitive behavioural therapy], I did a bit of that … I have a personality disorder. Severe depression … I've seen a psychiatrist. That was in prison. (Woman with lived experience, Belfast)*

> *I was 16 … I met a lot of nice girls and … we did a lot of different programmes that I think I've benefited from … I ended up coming out with a Higher maths and stuff like that … I got my painting and decorating qualification from there, so I got all that stuff that I've really benefited from. (Woman with lived experience, Glasgow)*

Frontline staff reported that whilst they were aware of some examples of effective coordination of care in the lead-up to and following liberation from prison, the tendency for women affected by SMD to be released into (or back into) homelessness was a perennial frustration. This problem was especially common for women serving short sentences.

> *The problem being when they go … in [to prison] they're never in for long. They … dry out from drugs and alcohol, and then you're back out to exact same scenario, and you've got that merry-go-round then. (National stakeholder, criminal justice sector)*

A number of women described personal experience of this and/or noted that even where they were provided with temporary accommodation no other housing support was offered. This, they noted, left them at risk of repeat homelessness.

> *My sentence was 18 months, but I done half of that. Nine and a half month … When I came out I was homeless again. (Woman with lived experience, Glasgow)*

> *I was the only female in the house [allocated on release] … so I just stayed to myself. I just basically spent my whole time in the room … I never ate or whatever. I never went out because there was, apart from my social worker, there was no help for mental health. There was no help … Whenever you actually come out of those gates, you're left on your own accord. (Woman with lived experience, Belfast)*

A number of interviewees observed that in some localities the quickest (or in some cases only) way to access support tailored for multiply disadvantaged people which offers sufficiently intensive and trauma-informed support is via a referral from criminal justice services.

> *Sometimes your fastest route of access into treatment services is through criminal justice, so you find that people will commit crimes to be able to access treatment because they wouldn't be able to necessarily get the appropriate support from treatment services. (Local stakeholder, Swansea)*

> *I think it's a shame that girls have to offend and be on orders before they get any help. It's really a shame. There's nothing really out there … You need to be in trouble … before you get any help. It's just such a shame that's the way it has to go. (Woman with lived experience, Glasgow)*

3.4 Conclusion

Whilst some of the experiences relayed by women with lived experience echo those widely reported by men who are affected by SMD (Bramley et al., 2019), many aspects of their routes into and experiences of each domain were highly gendered. Regarding homelessness, women often moved in and out of situations of homelessness and/or different manifestations of it at frequent intervals and (sometimes) over a very long period. Experience of hidden homelessness, and sofa-surfing in particular, was almost universal. Such arrangements sometimes involved an exchange of sex for somewhere to stay. Street homelessness was much less common, and when experienced typically involved sleeping rough accompanied by a male partner or, if alone, hidden from public view (e.g. in derelict buildings or walking through the night rather than bedding down). These experiences further highlight the limitations of mainstream definitions of rough sleeping which focus exclusively on the most visible manifestations of rooflessness.

For most interviewees with lived experience of SMD, substance use dated back to their early teens, beginning with drinking and/or recreational drug use, and subsequently escalated to involve more harmful substances and/or riskier means of consumption. The women were usually introduced to 'harder' drugs by partners or peers, but the extent to which they blamed other people (particularly their partner at the time) was highly variable; some considered their partner to be at least partly culpable, others blamed themselves entirely. Many were consuming drugs in extremely risky ways. Problematic drinking and the use of drugs (illicit drugs or non-prescribed medication) was always employed as a form of self-medication, that is, to cope with historic or current trauma. Substance use had extremely detrimental effects on women's health and relationships.

Women with lived experience reported that their involvement in criminal offending was almost always caused by their substance use, with interactions with the justice system was typically initiated by the possession of illicit substances, acquisition of money to fund an addiction (e.g. shoplifting, drug dealing), or disruptive or violent behaviour exhibited when under the influence of drugs or alcohol (e.g. breach of peace, assault). Prison was often described as a space of respite from extremely harmful (and in some cases life threatening) lifestyles and/or persistent domestic abuse. That said, most of those who had experienced incarceration had served (in some cases multiple) short sentences and tended to be released back into the same circumstances with insufficient support. This served to perpetuate a cycle of repeat homelessness, substance use, and deterioration in physical and/or mental health.

Exploitation by men was a key theme present in women's accounts of homelessness, substance use and offending. Experience of manipulation in mixed-sex temporary accommodation (e.g. hostels and B&Bs) was reported by many women; so too some regarding sofa surfing. Gendered power inequalities associated with the exchange of sex for drugs or somewhere to stay, men's influence over the administration of drugs (particularly some women's reliance on their partner to inject them), and the fact that some women fund their partner's drug use (via sex work in some cases), were all noted to be cause for concern for service providers. Further to this, the elevation of threat to street homeless women presented by the risk of sexual assault was noted to be a key reason that women actively avoid rough sleeping insofar as they can. Those who do sleep rough often rely on the presence of men for protection or 'fortify' themselves with alcohol or drugs to cope.

The routes into SMD, and experiences of each domain, were often complexly intertwined with experience of abuse, violence, poor health, and/or the removal of children from their care. These experiences and inter-relationships are discussed in detail in the following chapter.

4. Experience of Violence, Abuse, and Poor Mental Health

This chapter discusses experiences of violence, abuse, and poor mental health which commonly preceded and/or coincided with women's experiences of the SMD domains focussed on in the previous chapter. It opens with an overview of their experience of trauma and its impacts on their mental health. This is followed by observations regarding the impact of shame and stigma on their experiences.

4.1 Experience of trauma

The universality of trauma in the lives of women affected by SMD was consistently highlighted by staff and stakeholder participants and starkly evident in the life histories shared by women with lived experience.

> *All of the women, and I mean 100 per cent of the women that we currently work with today have significant trauma. They've been in the care system. They're self-coping with alcohol and drugs … Physical, sexual abuse … It's without exception, there's some form of trauma, and when we explore how has that trauma been addressed … what support they have had … It isn't there, to be honest. (Frontline staff, Belfast)*

> *The vast majority of women … who have multiple disadvantages have often come from a space of trauma … and often multi-complex trauma. If you look at it from an early intervention perspective, you would be looking to get in early at that first experience, and to try and minimise the multiple experiences they have as a result. I think that there is not enough understanding or investment in that response. (National stakeholder, health sector)*

The following subsections discuss the incidence and nature of trauma experienced in childhood and adulthood respectively.

4.1.1 Abuse, neglect, and family dysfunction in childhood

The vast majority of women with lived experience recalled traumatic experiences dating back to childhood. Almost all had witnessed violence in the home when growing up. The accounts of most women were replete with personal experience of (in some cases extreme and/or persistent) sexual abuse, physical abuse, emotional abuse, and/or neglect.

> *My father and my mother split up when I was about six, so up until then I'd witnessed a lot of domestic violence … Seen my father raping my mother and things like that. It wasn't the best start. Then, oh God, where do I go from there? I don't know. Bad childhood, basically. Emotionally neglected, sexually abused... (Woman with lived experience, Swansea)*

> *I came from an alcoholic family … That was the norm to us … Well, it seemed normal, do you know what I mean? My ma was a good ma, the best she could be. My da was a bastard … He used to batter my ma. (Woman with lived experience, Glasgow)*

> *I had a very abusive mother … My father had raped her and wouldn't let her get an abortion, and she held that over me … If I'd do something wrong in public, that would be the reply, 'You're nothing but a fucking rape child, see how you make my life bad' … The*

trauma that instilled in me, and the detrimental behaviours and thoughts I have because of that… (Woman with lived experience, Swansea)

I was abused as a child right through over the years. Mentally tortured, physically abused, sexually abused … [by] my mother's partner. (Woman with lived experience, Belfast)

My stepbrother, from my father's first marriage … sexually abused me and my sister when we were five. That went on 'til we were about nine years old … He'd told us it was his secret, and we were his favourite girls but you mustn't tell anyone … I absolutely loathe him. (Woman with lived experience, Swansea)

Some argued that they had been 'born into' a life of SMD and/or social services or police intervention given the scale and/or nature of what the Adverse Childhood Experiences (ACE) literature typically labels as 'family's dysfunction' [refs], such as parental drug/alcohol use and/or incarceration. A few had been introduced to drugs and/or alcohol from a very young age by parents or 'born rattling' (i.e. experiencing the physical effects of withdrawal from drugs).

I was born into it … My dad was my mum's dealer, that's how they met. They used to give me Valium and stuff when I was a child. She jokes that codeine was my favourite. 'I don't want that medicine, I want the yellow medicine,' which is the codeine … My mum kicked me out when I was 16 … I ended up homeless. (Woman with lived experience, Swansea)

Well, [I was involved with] social from the day I was born … My mum decided she was going to take drugs throughout her pregnancy … I was born rattling. I was going in withdrawal … One of the earliest childhood memories I have of her is me coming down the stairs to ask for a sandwich because I was starving, and she was lying on the sofa absolutely out of it with a needle hanging out of her arm. (Woman with lived experience, Belfast)

My dad was a drug user, and my mum was an alcoholic … They were always fighting, and police got involved and stuff …. My dad was getting lifted. My mum was drunk … My dad had needles and things hanging out of his arms, and it was just horrible … I was dealing with that growing up, and that's how I've left the house so young [age 15] … because I just couldn't cope with it all anymore. (Woman with lived experience, Glasgow)

4.1.2 Violence, abuse, and exploitation in adulthood

Experience of gender-based violence and abuse in adulthood was universal, that is, was reported by every single one of the 60 women with lived experience of SMD interviewed. All had experienced domestic abuse perpetrated by an intimate partner, and often multiple consecutive partners over the course of their lifetime. For many, this abuse involved physical or sexual assault.

My ex raped me, and sexual assault with penetration … put his hands right up inside of me … All of that, you know what I mean? … He was beating me … punching me and kicking me … and he was telling me, 'Cry. Cry louder. I want to hear you cry louder. Are you crying? I want to hear you crying.' He kept banging my head off the ground. I'd try to run to the stairs to get out, he'd drag me back in. (Woman with lived experience, Belfast)

About two years ago … things got bad; they got really violent, where he would literally just smash my house to bits. He'd grab me by my hair; he'd punch me in the face. There was just no end of it … I was very scared … Next door would phone the police if she'd hear

us arguing, because I was too scared to phone the police, because … I'd have to deal with the consequences of him being arrested. (Woman with lived experience, Swansea)

I've had violent relationships where I've had to ring social services and flee with my child, and then he's found us in the refuges and things, so I couldn't cope. (Woman with lived experience, Stoke-on-Trent)

Many also recalled experiences of coercive control, that is, the deliberate and sustained pattern of behaviour wherein one person within the relationship (in this case the woman's partner) seeks to exert power and control over the other. This often involved controlling their social interactions, appearance, attendance at appointments, and/or threatening to catalyse the removal of their children.

[Name of ex-partner] never laid a hand on me … it was all coercive control, sleep deprivation, abuse … He wouldn't let me out on my own, and he would always be at the [medical] appointments. (Woman with lived experience, Swansea)

I couldn't go out with my friends. People weren't allowed to come to my house, because he'd have a headache … If I did go out, then he was like, 'You've got to be home by this time. You can't wear that; you've got to wear this.' (Woman with lived experience, Swansea)

I ended up with another abusive relationship … He was an actual psychopath [but] … I didn't spot it. He was mean to the kids as well, and when I tried to leave he threatened me with … having the kids taken away, or making sure the kids' dad got them, or whatever. I was terrified. (Woman with lived experience, Swansea)

This coercive control often involved financial exploitation, most commonly where partners demanded money to buy drugs.

He [husband] kept my bank card … He kept my phone. (Woman with lived experience, Belfast)

[Name of partner] used to take all of my money to buy heroin … so I was left basically to use credit cards to be able to afford food, things like that … Then obviously I didn't have any money in my bank account, so I couldn't pay my bills. So I've got loads of arrears. (Woman with lived experience, Swansea)

My next partner … was a really good role model to my son in the beginning, and then drugs got involved and he just went downhill … I would supply him … because I'd have to give him the money, and if I didn't, oh, there'd just be argument after argument after argument, until, in the end, I'd just give in, because it was easier. (Woman with lived experience, Swansea)

Box 3: Case example – Abigail

Abigail is in her late 20s. Her main recollection from childhood is of "desperately trying to please people" from around the age of five in an attempt to reduce the frequency and severity of her father's physically violent outbursts. She notes that "he didn't have the best upbringing" and was paranoid and possessive. Things would be a "a bit of a shit-show" at home when he had been drinking, she explains. Her father hit Abigail and her sister frequently and was emotionally abusive to her mother. Abigail left home when she was 16, in large part because she "could not stand to live" with her father any longer.

Abigail was diagnosed with diabetes and epilepsy as a child. She describes being very frustrated and angry about her conditions at times but was forbidden from articulating these feelings by her father. She has painful memories about being bullied (and in some instances quite seriously physically injured) by her sister and cousins. She reports intermittently cutting herself to numb emotional pain from the age of 11. Her mother and aunt initially punished (hit and grounded) her for self-harming, but eventually sought help from children's mental health services.

She discloses that she has an alcohol problem since she was 13. She has experienced periods when she has been able to drink in moderation, and sometimes not at all, but when drinking "destructively" she experiences "really bad breakdowns". Abigail concludes that "I can't be near alcohol, otherwise it's just … chaos!"

She has attempted suicide three times; the first when she was 19. She was referred to a mental health services at that point and diagnosed with bipolar disorder and ADHD. She has had support from a psychiatrist and CPN since then. She describes the former as "very helpful and very compassionate" but notes that antipsychotic medication prescribed made her very unwell given her diabetes. She has appreciated her CPN's support in relation to mindfulness and grounding but explains that it is unhelpful when she is experiencing a crisis, for example when having a flashback or feeling compelled to self-harm.

Abigail describes having been in a series of "bad relationships". In hindsight, she recognises that one partner had exercised coercive control by dictating what she ate, who she spent time with socially, and even what music she listened to. In retrospect, she recognises incidents of sexual assault during their two-year relationship which, she says, "In my head didn't count because he was on drugs … even though I'd said 'No, don't' and stuff". He threw her down the stairs on one occasion, shortly after she had terminated a pregnancy.

She recalls starting to take cocaine with a subsequent boyfriend, in part because it "made him nice and loving" toward her. He moved into her rented flat and never contributed to household expenses. She accrued substantial debt and became involved in 'camming' to fund both their coke addictions. Camming, she explains, enabled her to "make a lot of money really quickly" in a way that was much safer than street-based sex work which she was glad she had never felt compelled to do. She stopped using cocaine, and camming, when that relationship ended.

Abigail was living in a women's-only homeless hostel at the point of interview and was weighing up whether supported accommodation or an independent tenancy would be the most appropriate option going forward because of her mental health. She wants to ensure that someone will check up on her wellbeing regularly given the frequency which she experiences mental health crises. Abigail notes that she is adjusting to the recent "realisation" that she is gay. She describes the hostel staff as "absolutely brilliant", in large part because they are "really caring".

On this subject, a number of women with lived experience emphasised they had multiple repeated experiences of being in an abusive relationship. For many, all (or almost all) of their intimate relationships had been with men who were also experiencing SMD.

> *[I've been] involved with the police due to domestic violence a number of times. Always in one relationship, out, into another relationship, out. Three months to a year and a half was a longer relationship. They'd always turn abusive, whether that's from being drug fuelled or everybody's a bit messed up … One abusive partner, one after another. All kinds of abuse. Physical abuse, mental abuse, emotional abuse. All of it. (Woman with lived experience, Swansea)*

> *My current partner … is in another homeless place … He has had the jail … He's been in and out all his life … Just robberies and stuff … He uses [drugs] too … Most of the men in my life have been like that … You would think I would learn. (Woman with lived experience, Glasgow)*

A number of women also reported experience of sexual assault perpetrated by men who were unknown to them. In most cases, this had occurred when they were sleeping rough or involved in sex work. One participant recalled an attack perpetrated when she was sourcing drugs for her and her partner.

> *I sleep on the street … I've been raped a few times. (Woman with lived experience, Swansea)*

> *I was away scoring Valium and … [a] guy grabbed me and dragged me into his house … I got raped. (Woman with lived experience, Glasgow)*

> When we were discussing the risks that women are exposed to on the street, [support worker] explained that she had worked in a hostel for some time and that on more than one occasion a female resident "would come in, tell us [staff] she'd been raped, change her clothes, and go back out again as if nothing had happened". She remained horrified that so many seemed to view experience of rape as 'normal'. (Field notes, Belfast)

4.1.3 Loss of children

Beyond the forms of abuse described above, the loss of children was central to many women's experiences of trauma. The majority of mothers interviewed had had one or more children removed and taken into residential or kinship care, fostered, or adopted because of their own substance use and/or because they were in an abusive relationship.

> *The problem is, with the child at risk things, they look at four things, four factors for parenting, when they consider the parents may not be able to safeguard their children enough. It's mental health, substance misuse, domestic abuse, and disability. I ticked all four, you see? (Woman with lived experience, Swansea)*

> *I met [name of ex-partner] and then just then started being out of control, really, and … I'll always admit that I put [name of ex-partner] first before my son, which is wrong. I've learnt from that mistake, and I would never do that again, but social work don't see it like that. They just say, 'No. That's it, she's…' …. [and] 'Oh, she's that sort.' (Woman with lived experience, Glasgow)*

He was very abusive, the daddy I was going with, and he used to drink a lot … So it was just bad, that's why I got them [children] took off me, because of him drinking and he assaulted me and stuff … He got arrested and stuff. I went into a hostel … I went back to him after and that's why the kids went under care, so they did. (Woman with lived experience, Belfast)

The removal of children had often initiated a downward spiral characterised by worsening substance use, overdose, and/or suicide attempts.

I jumped out a [fourth floor] window … when my oldest boy got took off me by social services … It was a suicide attempt … I've had three more children and they've all been took from me from birth. They've never gave me a chance. (Woman with lived experience, Glasgow)

I'd just lost my kids, because my kids went up for adoption … When I lost my kids that's when I went on … monkey dust ... I miss my kids. (Woman with lived experience, Stoke-on-Trent)

Further to the above, a few of the women with lived experience interviewed reported trauma resulting from miscarriage or stillbirth.

[I have] depression and anxiety. I had a really bad time with… I've had 13 miscarriages since I was 17 … But only six are confirmed because I didn't go to the doctors about the other ones, because they were only early. I had no treatment or anything for them, basically. (Woman with lived experience, Swansea)

My baby died … after five and a half months inside. So I gave birth to her. There was other babies crying [in the hospital]. I was in the room, but I could see the babies crying and that. It was really traumatic … I've never really got over that. (Woman with lived experience, Glasgow)

The magnitude of loss was noted to be especially acute for those women whose children had been adopted, that is, where there is no prospect of them (re)gaining access beyond letterbox contact.

With these women, the children are not dead but it's still a loss. So they're grieving but no matter what they do in their life, if they turn it round, they're never going to get the children back … For them, no matter how clean they get … it's not going to happen … They've [the children have] been adopted, names changed, whatever. (Frontline staff, Stoke-on-Trent)

Where the prospect of gaining or regaining access to children did exist because children were in kinship, foster, or residential care, this was a substantial source of hope and motivation to recover.

I [entered rehab because I] wanted to stop taking heroin and methadone, basically … I've got my two wee girls to think about … I'm focussing on myself because I need to make sure that I'm 100 per cent before I see them again. (Woman with lived experience, Glasgow)

I'm going to try and get a new house closer to my mum [who currently has care of child], she's gone through a divorce, and my wee girl will be coming back [to Glasgow]… So I'm going to try and get sober. (Woman with lived experience, Glasgow)

I've got two adopted, two that live with their dad, and then [name] who's adopted as well … I have letterbox contact, so I get photographs and things … As long as I stay clean and sort myself out, it's looking into seeing them [children living with fathers] again. (Woman with lived experience, Stoke-on-Trent)

Echoing the findings of AVA's research on the removal of children from survivors of domestic abuse and/or multiple disadvantage (AVA, 2022a), staff and stakeholder interviewees emphasised that the depth of the trauma associated with the loss of children should not be underestimated.

The majority of the women that I've worked with over the last 15/16 years, they've already had their children removed, and I think their ongoing experiences and disadvantages are absolutely perpetuated by that loss. It is like a life-altering, life-changing damage, which propels drug use and offending and all of that stuff because I just think women just don't have anything left to lose when that's happened. (National stakeholder, homelessness sector)

4.2 Mental health

Almost all of the women with lived experience of SMD who participated in the study reported having current or recent experience of very poor mental health. Reports of anxiety and depression, including postnatal depression, were extremely widespread. Many had been given a formal diagnosis of one or more other conditions including, by way of example, Post-Traumatic Stress Disorder (PTSD), Bipolar Disorder, Schizoaffective Disorder, or Personality Disorder. A number were awaiting formal assessments for their mental health but had been told by a health or social care practitioner that they exhibited symptoms of a diagnosable mental health condition. The life histories of some women were punctuated by serious mental health crises requiring stays in specialist psychiatric wards, with some recalling periods when they had been involuntarily sectioned under the Mental Health Act.

Their experiences when attempting to access and/or using mental health services are a particular focus of the next chapter. The subsections below focus on issues that were especially prominent in the data, including: first, the prevalence of self-harm and suicidal ideation or attempt; and secondly, concerns regarding the preponderance of personality disorder diagnoses.

4.1.1 Self-harm and suicidal ideation/attempt

Experience of self-harm was a prevalent feature in many women's narratives. For most, this had begun in adolescence and was reported to be directly attributable to their traumatic upbringing. These episodes continued to be catalysed by stressors (most commonly but not only domestic abuse) in adulthood for many.

I've been hospitalised a few times with … the cutting. (Woman with lived experience, Belfast)

I was self-harming; I've got a big scar from there with that … It was more just like a kind of release from whatever was happening; it took it away … Last year I had slashed all my face open and stuff like that … Sometimes I can do it sober, sometimes I'll do it when I'm taking stuff. It just depends. (Woman with lived experience, Glasgow)

I have very bad mental health issues. See these here? [Shows scars on arm] I cut these because [name of ex-partner] beat me … Begging him to stop, cutting my arm, begging

him to stop, and I cut these here, I've got a couple there. [Shows more scars]. I got tattoos over it. I never self-harmed as long as I wasn't with him … Literally, he drove me stone blind mental. (Woman with lived experience, Belfast)

Experience of suicidal ideation and/or attempt was similarly common.

I hadn't gotten help because I can't– it's hard to speak about. I find it very hard. I'm suicidal as it is, and when I start speaking about them [multiple rapes] and [the removal of] my kids and all that, then I just end up going again. (Woman with lived experience, Swansea)

When I'm no good I do try and take my own life. I've done that I don't know how many numerous times. (Woman with lived experience, Glasgow)

4.1.2 Personality disorders

The preponderance of personality disorder diagnoses or labels used to describe or explain severely and multiply disadvantaged women's behaviours was frequently commented on by frontline staff and local/national stakeholders. On this issue, it was notable that no less than one in four of the women with lived experience who participated in the study (n=15) disclosed (unprompted) that they had been diagnosed with such a condition, most commonly either Borderline Personality Disorder (BPD) or Emotionally Unstable Personality Disorder (EUPD).

In all such cases, the interviewee recalled being confused about what a Personality Disorder diagnosis meant and/or unclear regarding how it might affect her navigation of day-to-day life. A few also questioned the accuracy of the diagnosis.

Literally ten minutes I've seen her [mental health professional] … she turns round, and goes, 'You have BPD … That's borderline personality disorder' … I was like, 'What the hell is BPD? How have I got it? How do I cope with it? What resources are out there to help me with it? What medication is best for it?' Like nothing. She just told me I had it. That was it. (Woman with lived experience, Belfast)

[The mental health practitioner] diagnosed myself and five other females in the same care home with emotionally unstable personality disorder … I put up a fight to this, I was like, 'This is wrong, this is not…,' because I looked it up to see exactly what it was and I was like, 'This does not match me whatsoever.' … Then I got … an amazing doctor … and he really fought for me. He realised that what was going on with me wasn't just a personality disorder or anything like that. (Woman with lived experience, Belfast)

Several local/national stakeholder interviewees described witnessing an increase in the volume of personality disorder diagnoses amongst women affected by SMD in recent years.

It's [personality disorder is] definitely something that's boomed out of nowhere, it seems, in terms of diagnoses for women … When I first started working in the sector, it was mentioned here and there, but it seems that the vast majority of women that I've supported or heard the cases of, they have a diagnosis of borderline personality disorder. So, I think it's a lot more common than it was maybe five, six, seven years ago. (National stakeholder, homelessness sector)

Box 4: Case example – Rhiannon

Rhiannon is in her mid 40s. She explains that her mental health has been an issue for her for as long she can remember. Quite a few phases of her life "are a bit of a blur" but she pinpoints her first pregnancy at age 25 as when "things started going wrong". Her partner used her mental health "as a weapon", saying things like "'When the baby comes if you can't look after it I'll make sure it's taken away', kind of thing". She did not recognise this as abuse at the time.

She experienced post-natal depression after the birth of both their children; this was so severe after the arrival of her second daughter that she was admitted to a psychiatric ward, where she was diagnosed as having bipolar disorder. Rhiannon and her partner went to couples counselling but did not find this helpful. She left him shortly afterwards. The Children and Family Court Advisory and Support Service (CAFCASS) became involved with her family during custody proceedings.

She ended up in another abusive relationship, recalling that her new partner did not fit what she describes as the modus operandi of previous abusive partners, such that she "just didn't spot it". He was a functioning alcoholic, physically abusive, and (like her previous partner) repeatedly threatened to have the children taken away. She has since done a course to help her recognise signs of abuse.

Rhiannon and her girls lived in a refuge for a while. This provided safe accommodation at a critical time but she felt judged by the staff, noting by way of example: "they bloody reported me to social services because my kids had dirty feet because I let them play in the garden barefoot!" Rhiannon was then allocated a council house. She recalls struggling to cope with her two young children.

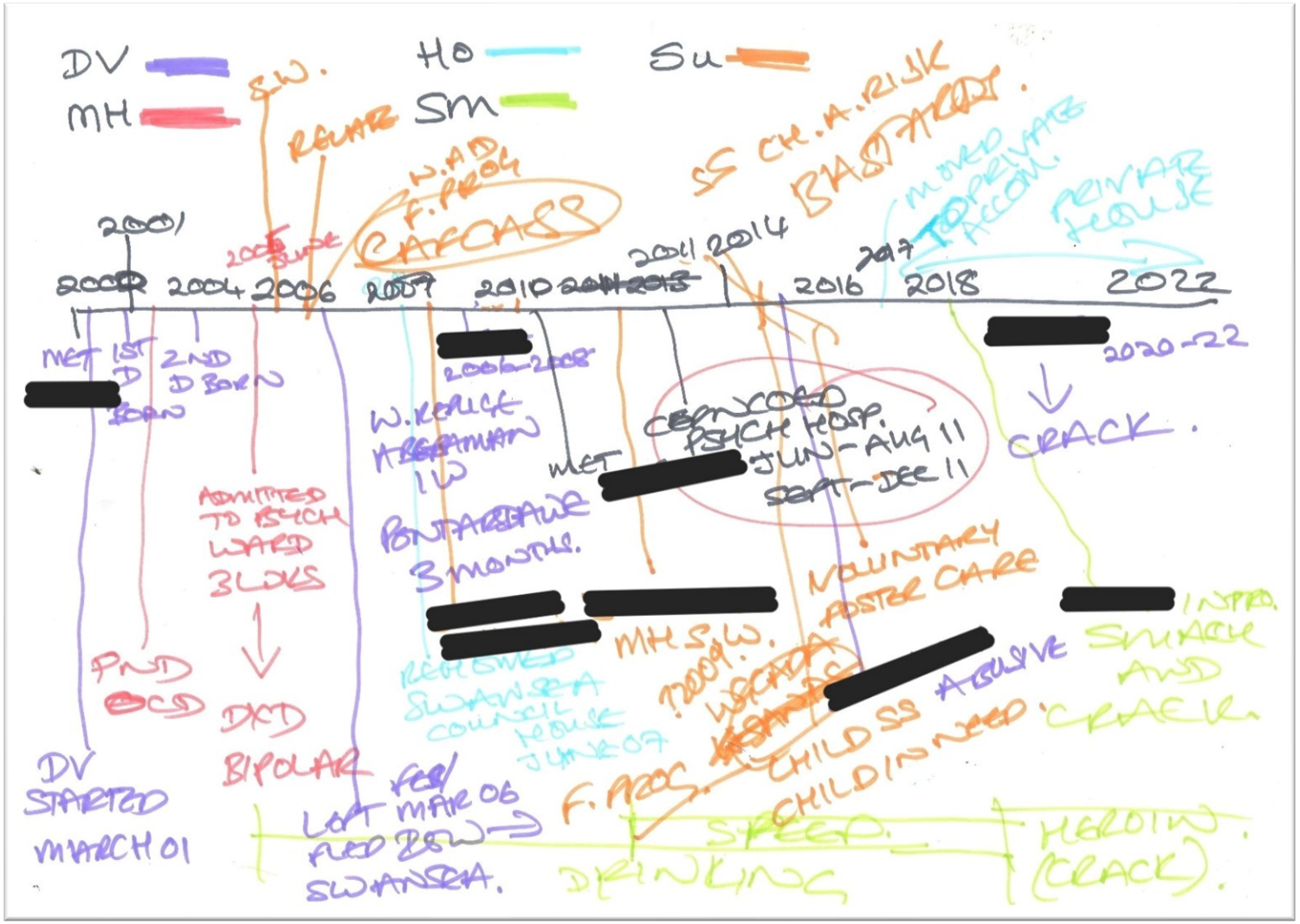
Her mental health deteriorated badly at one point when her medication was altered. She was then admitted to a psychiatric hospital. Her girls were put into voluntary foster care for a period of three months and Rhiannon visited them under supervision in a contact centre. She had gone to such effort to hide her mental health issues from her girls that they did not understand why she had been hospitalised. She has, she thinks, overdosed on her prescription medication three times over the course of her lifetime, reflecting that "I didn't want to die, I just wanted everything to stop".

Rhiannon describes engaging with a string of "six or seven" social workers after her children returned home. She struggles to comprehend exactly why her girls were put on the child protection register but thinks there had been some miscommunication or misunderstanding regarding the level of risk that her new partner posed. She had found social services to be relatively supportive when her daughters were classified as 'children in need' but says the social workers who became involved when they were (in her view incorrectly) assessed as 'children at risk' were "absolute bastards".

Rhiannon began drinking "too much" on a regular basis in her late 20s and continued to do so. She recalls using speed for "literal medicinal" purposes when her children were growing up as it helped her focus and gave her the "physical strength to get stuff done" given her ADHD and fibromyalgia. She was introduced to heroin and crack a few years ago by her most recent partner after telling him that he could only get his intended "two dark and lights" (two shots of heroin and one smoke of crack) "if I can try it". She laments that "I was in my 40s, you would think I'd know better!"

At the point of interview Rhiannon was living in private rented housing but was at risk of homelessness due to rent arrears resulting from Universal Credit administration problems. She has only very recently sought help for substance misuse; she had waited until her youngest child was 18 before contacting relevant services given concerns that intervention from social workers might be triggered otherwise. She is on a wait list for a specific treatment for heroin addiction and describes the support provided by her current mental health worker as "absolutely brilliant".

Figure 2: Rhiannon's timeline



NB: Colour coding differentiates between: DV (domestic violence, purple); MH (mental health, red); HO (homelessness, blue); SM (substance misuse, green); SU (service use, orange); names of individuals ((ex)-partners and professionals) redacted

Local/national stakeholder interviewees expressed concern about this apparent escalation in personality disorder diagnosis on three main grounds. First amongst these was scepticism regarding the veracity of such diagnoses.

> *Is it personality disorder, or is it a presentation of challenges, experiences, trauma? … Lots of people have been diagnosed with psychosis and all kinds of things when actually … they have dissociative disorders, and I think it's the same kind of thing. We're looking at it with a specific lens, and actually, we should see that's a normal response. To dissociate when the trauma is that bad and when it's that repeated and when it's that damaging is a very, actually, normal... Not healthy, but … it's a response that's protective of the person. (National stakeholder, domestic abuse / VAWG sector)*

> *My personal opinion on it is that the manifestations of borderline personality look very much like complex trauma … I don't know how you would sort out which one was which, or whether it even matters really, but what does matter is … if they are going to be given a diagnosis attached to a treatment pathway attached with an offer of support … That was never the case. (National stakeholder, homelessness sector)*

> *There's an interesting question as to … how women presented in terms of their behaviours, then became pigeonholed in terms of a personality disorder … It kind of makes me think of historical conceptions of hysteria and how that was applied to women, when in actual fact, it was simply because a lot of women's health and the particular circumstances that women were experiencing, and how that then manifested in their behaviours, was really misunderstood and under-researched. (National stakeholder, health sector)*

The second main objection was founded on the fact that a diagnosis of personality disorder restricts access to support services within and beyond mental health.

> *They're sticking the label on them and then saying, 'We can't help you with that. It's a really difficult thing for us to deal with,' and then the door's shut again. I feel it's almost a way of pushing women to the side. (National stakeholder, homelessness sector)*

> *I've yet to see, in my 20-plus years as a clinician, where someone being diagnosed with a personality disorder has … opened roads to treatment or has even helped in their understanding of who they are and how they're trying to navigate a world that requires you to be able to trust, for example. (National stakeholder, health sector)*

On this, some expressed concern that the increased volume in diagnoses may be indicative of a pressure on health services and active attempts to reduce the pool of people entitled to treatment.

> *Mental health services, I don't dispute are under pressure, both inpatient and certainly community mental health services, but I think there's been too many really negative labelling on women where they've been described as having a personality disorder. (Local stakeholder, Glasgow)*

Third, staff and stakeholders objected to the fact that a personality diagnosis places the locus of blame on recipients which, they argue, diverts attention from the trauma and structural disadvantage underpinning their behaviours. One went as far as to suggest that the utilisation of such diagnoses for women affected by SMD was tantamount to “gaslighting on an industrial scale”.

Instead of acknowledging the trauma that women have been through, they're [mental health practitioners are] just sticking the borderline personality disorder label on them to be like, 'That's what's wrong with you' … It also puts blame, I think, on the women in saying that this is what you have, rather than acknowledging that the systemic issue is the domestic abuse they've experienced, the multiple disadvantage they've been experiencing, which is all systemic. (National stakeholder, domestic abuse / VAWG sector)

It's [personality disorder diagnosis is] a horrendous shortcut that … implicitly blames, and I think shames the person as being responsible, as in 'It's you, it's your personality that is disordered' … I think it's absolutely unforgivable, and an example of institutional assault really … [For] women who may have been subject to male violence … to then come into the health service and be told, often by a male in a position of authority, that they are the problem, I think is a sort of gaslighting on an industrial scale. (National stakeholder, health sector)

A few stakeholders noted that specialist services for personality disorder do exist in some areas, but emphasised that wait lists for these tend to be long and such services are not generally equipped to cater for the complexity of severely and multiple disadvantaged women's lives.

In [name of area], for example, loads of the women … had this diagnosis of personality disorder … but it didn't result in any treatment pathway or care. There was a personality disorder service, which the waiting list was about two years long. Once we did actually manage to get someone assigned … all they'd [social worker would] ever do was visit them [service user] every six weeks … They weren't set up to deal with borderline personality disorder diagnosis plus the fact someone is street homeless and using alcohol really heavily, for example. (National stakeholder, homelessness sector)

4.3 Elevation of shame, stigma, and perceptions of 'acting up'

A number of frontline workers emphasised that many women affected by SMD appear and actively want to be perceived as 'hard as nails' in an attempt to disguise their vulnerability and reduce the likelihood of being exploited and/or harmed by other members of homeless, substance using and/or offending populations. It was frequently noted that these women's dismissive, ambivalent and in some cases aggressive behaviours tend not to elicit sympathy on the part of service providers and/or policy makers.

Often women might present in ways that do not evoke sympathy. That sounds trivial, but I think when you play it out over day, by day, by day, it means that the resource, and the care, goes towards people who evoke care rather than people who don't … People present in ways that were done to them, and so the care, and resource tends to drift, unconsciously maybe, but definitely towards those who evoke concern. (National stakeholder, health sector)

Many staff and stakeholder participants acknowledged that shame and stigma also affect men with experience of SMD, their perception was that for women such issues tended to be elevated and/or take a particularly gendered form. These differences were typically attributed to the degree of severely and multiply disadvantaged women's deviations from social norms regarding femininity and/or motherhood. On this, many staff and stakeholder interviewees argued that women have a greater tendency for self-blame and/or that these gendered aspects of stigma are projected onto them by society more generally.

Women are hardwired to put an awful lot more pressure on themselves to be the ideal mother, wife, sister, daughter, because of all of those cultural and societal expectations … I don't think you can deny the stigma for males either. I think as we're saying, it's just that women either put it more on themselves or people put it more on women … because of motherhood, you always put your kids first above you and everything else, you're meant to have all these other pre-set notions or ways of being. (Local stakeholder, Belfast)

One of the women … was told that it was her choice of partners was one of the reasons why her children were being removed. Again, that places the onus completely on her. Yes, you can then understand why that reinforces that internalised shame and stigma … I guess it is internalised shame, but it's also reinforced and it's also rooted in something, which, I suppose, it's misogyny that is embedded across the system. (National stakeholder, domestic abuse / VAWG sector)

Concern that women affected by SMD were especially susceptible to accusations of being deliberately difficult or 'acting up' – when their responses to extreme distress are in fact entirely understandable – was frequently expressed by staff and stakeholder interviewees.

Frontline practitioners … said, 'We think that our colleagues think about women acting up' … They were describing different behaviours of men and women, and women being noisier … women being more aggressive … To me what they're describing is a very noisy, vocal, physical presentation of distress, annoyance, anger, which ... If we listed what had happened to that particular woman, it's likely that we would all feel all of those feelings. I might have the resilience, the emotional solid base of well-being that I might be able to express that, and manage that differently. For a woman who's feeling in absolute despair ... It's a very different thing, isn't it? I just think in those services women are punished for that. (National stakeholder, domestic abuse / VAWG sector)

Some women were identified as being especially susceptible to accusations of 'acting up' given a combination of poor mental health and/or neurodivergence (e.g. Autism Spectrum Disorder (ASD) or Attention Deficit Hyperactivity Disorder (ADHD)). A few interviewees with lived experience explained that the failure of caregivers and/or professionals to recognise their neurodivergence had served to further compromise their psychological wellbeing in childhood and/or adulthood.

I have a physical diagnosis [name of condition] … I'm [also] diagnosed with borderline personality disorder … The physical stuff, 100 per cent they [adoptive parents] understand. It was anything to do with my brain they didn't understand. Any symptoms of neurodivergence, the anxiety, anything like that, it didn't mean anything to my family … They don't understand how much they messed me up by trying to scream it out of me when I was younger. (Woman with lived experience, Belfast)

I was recently diagnosed with ADHD [Attention Deficit Hyperactivity Disorder], but the medication doesn't work for me … The psychiatrist said, 'You're definitely on the spectrum.' Yes, like the ADHD medication is great for focussing and doing one thing, but it makes stimuli a bit too much like, yes, noise is my big one. (Woman with lived experience, Glasgow)

On this subject, one stakeholder suggested that there is scope for services to consider gendered stigma as part of unconscious bias training, to equip staff to be more aware of factors underpinning their own reactions to difficult behaviour.

Some of the women that I worked with … just wore everything that they'd experienced really strongly and would also be really rude … How do we teach people to be resilient to some of that and be able to see beyond it, rather than go, 'Oh gosh, she just called me a cunt'? … That's a term … I will use when I'm really cross with somebody. I will say I'm not cross enough often enough to use it across the piece. Some of these women, of course they are! Let's understand their position … We do stuff about unconscious bias, but we don't do it about behaviours of a trauma response. We do it about tattoos, we do it about LGBTQ+, we do it about racism and things like that. Do we actually do it about this kind of stuff? I think there is a place for it. (National stakeholder, domestic abuse / VAWG sector)

4.4 Conclusion

Experience of a trauma, typically but not always dating back to childhood, was a common denominator in the life histories of women with lived experience of SMD. Some describe being 'born into' SMD given the extent of their parents' involvement in substance misuse and/or criminal offending in particular. Sexual violence and domestic abuse perpetrated by men – which was often extreme, repeated, and/or prolonged in nature – loomed large in women's narratives of their experiences in both childhood and adulthood.

The removal of children had been experienced by many of the women with lived experience of SMD. This was a major source of extreme and sustained trauma, but also (if/where children had not been adopted but were living in kinship, foster, or residential care arrangements) a source of hope and motivation to recover. Trauma of losses associated with miscarriage or stillbirth, and difficulties triggered by (sometimes severe) post-natal depression, were also prevalent features in a number of women's accounts of their experiences.

The prevalence and in many cases severity of mental health issues reported by women with lived experience – and what some stakeholders perceived to be unjustifiably disproportionate levels of personality disorder diagnoses in particular – was notable. For some women, these mental health issues were accompanied by neurodivergence which made them particularly susceptible to accusations of 'acting up' by service providers who often struggle to comprehend their dismissive or ambivalent response to offers of care.

The outcome of these issues, which are compounded in part by gendered stigma, is that women affected by SMD are frequently perceived by service providers as especially and 'deliberately' difficult. This phenomenon, and women's tendency to self-blame and behave in ways that do not elicit sympathy, have profoundly detrimental effects on their engagement with and experiences of services. The next chapter describes these effects in detail.

5. Routes Into, Around, and/or Avoidance of Services

This chapter turns to focus more explicitly on women's experiences of services. It begins by exploring their routes into support services, with a particular emphasis on factors shaping when and from which sector(s) they initially received support. It then turns to women's experience of service networks, especially the tendency for them to feel 'shunted' between and/or inadequately supported by the services offered. The final section provides an overview of the reasons underpinning many women's reticence to seek or accept offers of support.

5.1 Routes into services

A core finding in the analysis of women's pathways into services was that there was a notable disparity between the experiences of those whose families had been subject to social service intervention when they were children and those who had not. Many care-experienced interviewees, for example, recalled 'going homeless' (that is, making a statutory homeless application) immediately upon leaving care (see also Chapter 7). Others approached the council to make a homelessness application later on, often after a relationship breakdown with a cohabiting partner. For most, these experiences occurred in their late teens or early 20s. The common denominator differentiating their experiences from those of other women affected by SMD was familiarity with statutory 'systems' and awareness of support to access housing in particular. In a similar vein, women who had experience of refuge as a child were aware of support availability for those affected by domestic abuse.

Women who had not experienced very minimal or no social services intervention during childhood often only sought help after they had exhausted every other perceived support option available to them, by for example sofa surfing, exchanging sex for somewhere to stay, or remaining in abusive relationships because they would otherwise be homeless (see Chapters 3 and 4). The age at which they first did so varied significantly: for some it was in late teens/early 20s, but for others into their 30s or even 40s. Staff and stakeholder interviewees emphasised that the decision regarding whether to access support was sometimes taken out of these women's hands because they had for example experienced crises such as being hospitalised after a physical assault, sectioned, arrested, or their children were at risk of being taken into care.

> *By the time they are accessing a service, it's at real crisis point, and quite often it's not because they want to, it's because they have to. It's because they've been attacked on the streets, and it's because they're sectioned under the Mental Health Act. (National stakeholder, domestic abuse / VAWG sector)*

Regardless of which of these trajectories women had experienced, pregnancy represented a critical juncture which triggered the intervention of at least some support services. For some women, social service intervention was described as 'automatic' given their prior experience of being in care as a child. For others, social service intervention was initiated because they were homeless, using substances, or their partner was deemed a threat to their child(ren) (see Chapter 4).

Whatever the circumstances, participants consistently emphasised that the support provided by social services tended to focus almost exclusively on the welfare of the child(ren) rather than any support needs of the mother. It was frequently noted there was very little if any support provision for mothers in the lead up to, during, and following the child removal process in particular (see Chapters 4 and 7 for more detailed discussions on this subject).

The amount of people I know that have got their kids taken off them, we're like, 'Where's the support for us?' There's nothing … They won't give you social work to support you, there is nothing out there at all … I've researched and looked and looked, and … there's nobody to even phone or nothing … Who do you talk to? It's quite a hard subject to speak to other people about it as well because … you might not want to let other people know about that. (Woman with lived experience, Glasgow)

Something that comes across consistently is that the support just falls away. They might have had ... contact with a solicitor constantly, or support constantly that was orientated to her needs maybe before. Then the child gets taken away, and then there's, like … no one contacting her anymore, and obviously, the most normal thing to do in the world is to use more substances, or to do whatever you need to do to deal with the traumatic effects … It's really troubling. (National stakeholder, homelessness sector)

Another key finding is that the timing and/or location of a woman's entry into support services were usually determined by factors outside her control. They had no influence over whether their family experienced homelessness or social services intervention during their childhood, for example, yet these experiences had a substantial effect on their awareness of (and, in the case of care leavers, entitlement to) support when encountering crises as adults. Furthermore, the receptiveness of agencies they sought help from or were referred into, (regardless of which sector this was), depended to a large extent upon the capacity, expertise and/or attitude of the staff she initially interacted with (see also below).

On this account, several local and national stakeholder interviewees noted that a 'postcode lottery' of provision strongly influences the likelihood of women receiving a positive response at the first point of service engagement (and indeed thereafter – see below). In a similar vein, one stakeholder interviewee argued that the question of which care pathway a woman ends up on is often *'circumstantial'* (National stakeholder, criminal justice sector).

It's a bit of a lottery now. If you get a really good worker, happy days, you'll have a good non-judgemental approach. When you get someone then who's kind of … very risk averse and talk about then almost the punitive approach, especially when you're talking about mental health, drugs and alcohol with women … that's a different story. (Local stakeholder, Swansea)

The community mental health teams … struggle, even internally, to signpost and refer cases to different localities because the consultants have a different approach to who they accept and who they don't accept … So you're left in a position with it seems to be a bit of a postcode lottery. It also seems to be who you know and what managers are in the community mental health teams as well. (Local stakeholder, Glasgow)

The next section further elucidates this issue by discussing women's experiences of support service networks.

Box 5: Case example – Jane

Now in her mid 30s, Jane recalls "knowing the script" on homelessness, after having experienced it as a child when her mother fled domestic violence. She then experienced homelessness from age 16, staying in hostels for young people until the age of 18 and sofa surfing for a while after that.

She became pregnant with her first child at the age of 21 and got a social rented tenancy with her partner at that point. Jane remained in a relationship with him for 15 years, having another two children with him. She went back to college, got a job in administration, and had what she describes as "a perfect life" during this period.

Then, Jane explains, "life went shitshow" over the period of a few months. Her partner "battered the fuck out of" her and left her for another woman (who was known to her). She "took a breakdown" and was prescribed Valium by her doctor who told her the pills would "take that feeling away". She soon began using street Valium and drinking heavily, noting: "I couldn't get out of my bed unless I had 50 Valium and a bottle of vodka, and that was me just being normal". She latterly began using, and then dealing, crack and smack (heroin).

The children's father intervened, and the children were placed in the care of wider family members. A children and families social worker became involved. Jane recalls getting very angry during a meeting involving her mother, sisters, social worker, drug worker, and the children's teachers. Her drug and alcohol use continued to worsen throughout this period.

At one point when Jane's "head was fried with drink and drugs" she accidentally overdosed. She signed herself out of hospital "and went and got Valium and vodka" straight away which, she claims, demonstrates just how much she "didn't give a shit" about her wellbeing.

Jane reports "getting done with all sorts of police charges", including physically assaulting her new partner, assaulting a police officer and paramedic, and breach of bail conditions. She cannot remember any of these incidents as she was under the influence of alcohol and drugs at the time but feels very remorseful and embarrassed about them.

She only managed a couple of weeks in residential rehabilitation the first time she tried it, signing herself out when hearing that her partner had had an accident and then falling back into using street Valium almost immediately.

Jane was back in rehab at the point of interview after being referred by a drug worker and had successfully made it to the end of the initial detox period. She describes that as "fucking horrible … I rattled and I gret and gret and gret [cried and cried and cried]" but says she is now beginning to understand the roots of her substance use given all the support she has as part of the programme.

Getting and remaining "clean" so that she can be reunited with her children is a key priority for Jane. She notes that she has a strong family support system via her mother and a sister with whom she has recently reconciled.

Jane still has her own tenancy to return to after rehab, which her partner is currently staying in. She is grateful that he has apparently cleaned it up while she has been in rehabilitation because she had "left it in a riot" after smashing up the interior when under the influence.

5.2 Routes around services

A key theme in the narratives of women with lived experience of SMD is that they typically feel 'shunted' from one service to another, in large part because, with some notable exceptions, the majority of services available focus on one of the domains of SMD (i.e. homelessness, substance use, or offending) rather than a combination of them.

> *Women are constantly … being shunted from bits of parts of the system to other parts of the system. It feels like people don't know what to do with women who present in a way that … they find difficult … The social care system and the criminal justice system … don't know what to do with them. The refuge sector doesn't know what to do with them. So they shunt them to the homelessness sector. The homelessness sector doesn't know how to support with domestic abuse … So yes, they just get shunted around. (National stakeholder, homelessness sector)*

> *Most of the clients that we work with, one of their biggest complaints is that they're shunted from one service to another and they have to constantly repeat their story over and over and over again to different services … So if it was family and childcare … all their interventions would be based on that. If it was mental health … that deals on the remit just of mental health. It's back to the fragmentation of services or the siloing of services. (Frontline staff, Belfast)*

This phenomenon was clearly evident in the experiences narrated by women affected by SMD. Some reported feeling 'fobbed off' and were highly critical of services that merely signposted them elsewhere without providing any tangible assistance to access alternative services.

> *I don't think a lot of women … get a lot of support. You tell your GP and all that and it's like that, the antidepressants. You tell somebody else and it's, 'Oh, you need to see this person or you need to see that person.' I don't know who the fuck they persons are or where they're frae [from], do you know what I mean? (Woman with lived experience, Glasgow)*

> *I'd asked for an adult social worker; she came out … and she's just given me leaflets! … She did give me a bit of paper [about] … a respite place … But there was no support to get there, nothing … You're like, I could kill myself before I can get there! (Woman with lived experience, Glasgow)*

> *It really goes in a circle. It goes ring [name of crisis helpline], [crisis helpline] contacts the police, the police bring you to hospital. The hospital gives you a safety plan to call [crisis helpline]. [Crisis helpline], police, hospital, safety plan, [crisis helpline], police, hospital, safety plan … It's just a big loop. (Woman with lived experience, Belfast)*

A number recalled being excluded from services on grounds that they were said to be 'too chaotic'. All such women were confused as to the reasons why and/or unclear what if any other support might be available to them at the time. Stakeholder interviewees confirmed that this was a widespread issue, especially for those who had not received a sufficiently rigorous mental health assessment.

> *My family nurse took me … to the mental health place … They said my life was too destructive, there were too many things happening … My lifestyle is too chaotic for them to take me on … and I said, 'Is this not what you're here for; to kind of help these things*

that are happening in my life? I really need to speak to somebody!' No, so they knocked me back so I wasn't getting anywhere at all. (Woman with lived experience, Glasgow)

There is still this difficulty in terms of cases being either accepted, never mind managed, and any default on appointment and or treatment more often than not means that … the woman is discharged from the service … So many people have not really had a formal diagnosis. Most of its either been ill-informed labelling, out-of-date labelling or … they've just not been accepted full stop, simply from the point of view they're described as too chaotic. (Local stakeholder, Glasgow)

On this issue, staff and stakeholder interviewees consistently draw attention to what they perceived to be a stark disjuncture between what existing evidence indicates 'works' for and is therefore endorsed as good practice in work with people affected by SMD (see for example NICE, 2022; Scottish Government, 2021b) and what typically happens in practice. Without exception they deemed the rigid eligibility requirements widely employed by statutory services to be unreasonable and indefensible for this population.

We're finding that they're coming back to say, 'Look, I missed an appointment, they've struck me off' … They're set, I think, sometimes, almost set up to fail … 'You will attend in the morning. You won't swear at anybody. You won't get annoyed,' … and that's a no-go straight away … I'm like, 'Do you know that person?' They get annoyed with us and they like us! [humorous tone] (Frontline staff, Belfast)

In a nutshell … we are working round systems that are very rigid, and they're certainly not bending to even simple needs, let alone complexities of needs … Statutory services … deliver a fantastic service, but people aren't attending medical appointments. Appointments … are sent in the post where some of our clients can't read … They give them PIP [Personal Independence Payment] because they can't communicate, and yet they don't recognise it in a service! So it's just really bizarre. (Frontline staff, Belfast)

Virtually all women affected by SMD are by definition experiencing (or have recently experienced) the coincidence of mental health and substance use issues. Commonly referred to as dual diagnosis, this represented a major barrier to mental health treatment in many contexts, with the majority of participants with lived experience reporting that they had been denied support for mental health issues because they were actively using substances.

I've really had bad experiences of hospitals and doctors. It's the chicken or the egg. I go in there saying I need antidepressants to help me cope, and they go, 'Well it's the drugs,' and I'll go, 'Well, no, I'm taking the drugs to try and cope.' (Woman with lived experience, Swansea)

Mental health services, they won't work with you if you smoke weed, or have an alcohol problem. You need to stop it yourself … You feel like you have to say you're not using … Then if you're like, 'No, I don't smoke,' but you do smoke … you cannot be honest, and just get the actual support and help you need, I think. (Woman with lived experience, Belfast)

Women with lived experience were particularly exasperated by the fact that they were being denied such services even when being very open with health practitioners about the fact that they were using substances to cope with underlying mental health issues (see Chapter 4).

I'd asked them, 'Look, what am I going to do about mental health? Can I have treatment for that?' and they were like, 'Unfortunately because you haven't engaged with addiction services' … I explained to them, I am happy to come off the drink and drugs, but I need to be kept on the green [marijuana] because if I come off of that, I will end up doing something to harm myself … and they were like, 'No, sorry, you need to come off every single drug before we can offer you help.' (Woman with lived experience, Belfast)

I feel like if you're a drug user, they [mental health services] don't really want to help you … But I've had issues before I even took drugs … I know the drugs probably don't help it at all, I know that for a fact. Probably the drugs do make it a lot worse but at the same point … I take them for a reason! (Woman with lived experience, Glasgow)

The lack of provision of women affected by dual diagnosis was also a longstanding source of exasperation for frontline staff, not least because of their cognisance of prevalence and severity of trauma in female clients' histories, but also the fact that they end up dealing with the consequence of women's repeated exclusion and/or disengagement from services.

You have that table tennis. Is it drugs? Is it mental health? Back and forth, back and forth. I personally don't give a hoot what it is, it's just somebody take responsibility for the person there … The services are like 'She needs to deal with her mental health before we can deal with her addiction.' 'Oh no, she needs to deal with her addiction before she can deal with her mental health.' You're like, 'Aargh'!! (Frontline staff, Glasgow)

When discussing dual diagnosis with a staff member, they asserted that "Dual diagnosis workers are like unicorns!", explaining that that while government believes in them, and lots of agencies claim to have them, "no-one has ever actually seen one", that is, no referral pathway ever seems to lead to one. They laughed when telling me this but were deadly serious in emphasising that the way dual diagnosis obstructs access to mental health support is a source of immense frustration for them and their colleagues. (Field notes, Belfast)

[With] dual diagnosis … If we took them to mental health services, they would just say, 'There's nothing we can do because there's drugs involved. There's alcohol involved. They have to be sober before we can even help them.' It's just that same cycle over and over again. There's very little services that would actually work with them if they're still under the influence, even if they come to their appointment sober. If they know there's drugs and alcohol involved day-to-day, then they usually just say no. (Frontline staff, Swansea)

Local and national stakeholder interviewees asserted that whilst they were sympathetic to the financial and other pressures the NHS faces, they were extremely impatient (and in some cases irate) regarding political inaction in redressing this extremely long-standing issue in the face of growing evidence that inflexible interventions are ineffective for this population (see Chapter 1).

As I understand it, there cannot be a diagnosis given when people are still actively using. Now, that's just stupid. I can't think of a better way to describe it. Often what people are using, or the motivation for using substances, is to dampen the trauma. (National stakeholder, substance use sector)

Dual diagnosis, it's been talked about and talked about. You'll hear it mentioned all the time. But the decision-makers aren't making the changes that we want to see … I think the argument has been made and won that we need to move on dual diagnosis. It just

seems obvious … It's one of the blockages that we need to remove so that we can take action in other spaces. (National stakeholder, homelessness sector)

We have to stop this nonsense of, 'Oh, well, you need to deal with her substance misuse issues before she can come into services because we can't deal with it'. Well, you can deal with certain things. There are frontline workers who are dealing with the emotional and mental health of people coming through to these services. They'll be doing that all the time. (National stakeholder, criminal justice sector)

Levels of exasperation were particularly heightened in contexts where extensive effort had been invested in improving access to healthcare for people affected by SMD but where 'blockages' or 'sticking points' regards mental health provision remained.

We're a year into a new complex needs service and still we haven't bottomed out and signed off our mental health pathway into community mental health services because their view is still that default position, 'Stabilise somebody's drug and alcohol use and then we can see whether or not we can work with them.' Whereas I think we're more than able to understand that there are underlying issues that clearly need addressed … We have to work with the person in the round rather than wait till they try and manage their substance issues, and understand why women are involved in substance use as they are. (Local stakeholder, Glasgow)

There was a widespread consensus amongst staff and stakeholder participants that until such time as the 'dual diagnosis debacle' (see Chapter 7) is redressed, there is a risk that that provision from other sectors functions as little more than a 'sticking plaster' and that women affected by SMD will remain susceptible to a revolving door of homelessness, substance use, and involvement in criminal offending – and thereby exposed to the heightened risk that the accumulation of these experiences entails as regards their vulnerability to exploitation.

What I do see a lot of is clients keep coming around, so you'd give them the support, you'd get them on their feet … [but] you're just sticking a plaster on it … The trauma is still there, you sort out their housing needs, and then we have to move on then and take on another client, so the actual issues that they started with are still there, they've not been dealt with. (Frontline staff, Swansea)

5.3 Reasons for avoiding services

Women's reluctance to seek help is widely reported in existing literature (see Chapter 1) and was also a key theme of the accounts of women with lived experience. It was possible to identify nine main reasons underpinning their reluctance to disclose problems regarding and/or seek help for homelessness, substance misuse, poor mental health, and/or experience of domestic abuse.

Key amongst these were concerns about the *implications for access to their children*. In short, many worry that if social services learn they are struggling, their children may be taken off them, or (more commonly) where their children are already in care, that their current or future contact rights may be jeopardised.

I had to do a parent capacity assessment … passed that and I was doing a second one and I failed because they'd asked me about my mental health and [told me] to go to the doctors to get a diagnosis. But she said to me, 'If you do that, the care plan will change' - which … it might've changed for the better. But in my head alarm bells were ringing and

I'm like, 'I'm not going to the doctors. No chance in hell! My kids will get taken, I'll never be able to see them!' (Woman with lived experience, Glasgow)

I'd left [name of ex-partner] and I'd moved house, but [name of ex-partner] seemed have wormed his way back in, so within about six months … he was back. [Name of ex-partner] knew how to manipulate me and how to make me get back into a relationship with him, so then I was back to square one. Then … there was no one to talk to, because if I phoned the police it would be social services again, and there'd be that risk of, 'Oh my God, am I going to lose my kids this time'. (Woman with lived experience, Swansea)

We do work with women who don't report the domestic abuse because they are frightened to death of having their children taken away … they are absolutely petrified. We can say, 'Oh yes, this might not happen', but the reality is it might, they might have their children removed because of the domestic abuse because they're not deemed as keeping their children safe. (Local stakeholder, Swansea)

Women's reticence was often borne out of prior negative experiences of social service intervention or a sense that social services' inaction had failed them and/or their siblings during childhood.

I've had social services involvement since I was a nipper … because my dad was an abusive alcoholic … [The social workers asked me] Was I happy at home? What was it like at home? … I just couldn't speak on [that] because … I was too frightened of my dad … The two youngest brothers they were put in foster care, but me and the other brother weren't … They didn't do anything for us … They were fucking useless. (Woman with lived experience, Belfast)

I hate social services … They are a fucking joke because … they had plenty of opportunities to remove my wee brother from that woman's [mother's] care, and they didn't … She used to sell my wee brother's ADHD medication … Social services finally caught up with her and the child was removed when he was eight years old, but it shouldn't have took eight years. (Woman with lived experience, Belfast)

Some reported seeking help from social services but later regretting it because they felt this info had been used 'against' them.

I've been on their [social services] system five times, but each time it's been me that's phoned them to ask for support … and they've [said] 'We can't help you. There's nothing we can do'. But then, as soon as my daughter says, 'Oh, my mum's boyfriend has been sexually assaulting me', 'Oh, [own name] has been on our system five times for this, this, this and this. Wow, she's a bad mum'. 'Fuck you. I did that call to you'. 'It doesn't matter who made the call, you're still on our system'. (Woman with lived experience, Swansea)

I did beg them to put me in a mum and baby unit because I was going through quite a domestic violent relationship and I thought they would actually help me. But when I did ask for that help … they turned against me, social work ... [and] took my kids. (Woman with lived experience, Glasgow)

Box 6: Case example – Fiona

Now in her late 20s, Fiona asserts that her extensive experience of drug use, and much of what has followed from that, stems from her traumatic childhood. Her mother abused her physically, and father sexually, but social services did not "get wind of" the family's issues and intervene until she was six years old. She was taken into care for six months but then placed back with her family. She thinks she would have "lived a completely different life" if social services had "done a better job of protecting" her. She began drinking when she was 13, and then used cannabis and other recreational drugs experimentally in her mid-teens.

A sequence of abusive relationships further contributed to what Fiona describes as her "demise". She reports that: "My therapist thinks that I need a man in my life to try and substitute for a caregiver, because I always felt like I needed to look after somebody, which I didn't have". Fiona has had five children, all of whom have been removed from her care by social services.

She had her first baby when she was 17. He was taken into kinship care as an infant because her partner at the time (who was not the child's father) was abusive to both her and her son. "That's when I hit the heavy, heavy drugs", Fiona recalls. She started using heroin and "it just escalated very, very quickly". Her second child was born experiencing withdrawal and removed from her care at birth. Her partner "kicked her out" and she moved into a homeless hostel around this time.

She sought treatment, "got clean and did really well" for about five years, but subsequently relapsed because she missed four days of her methadone prescription which was then suspended. She re-engaged with treatment services later but relapsed again after having her fifth child, at which point she started using cocaine after being introduced to it by her partner.

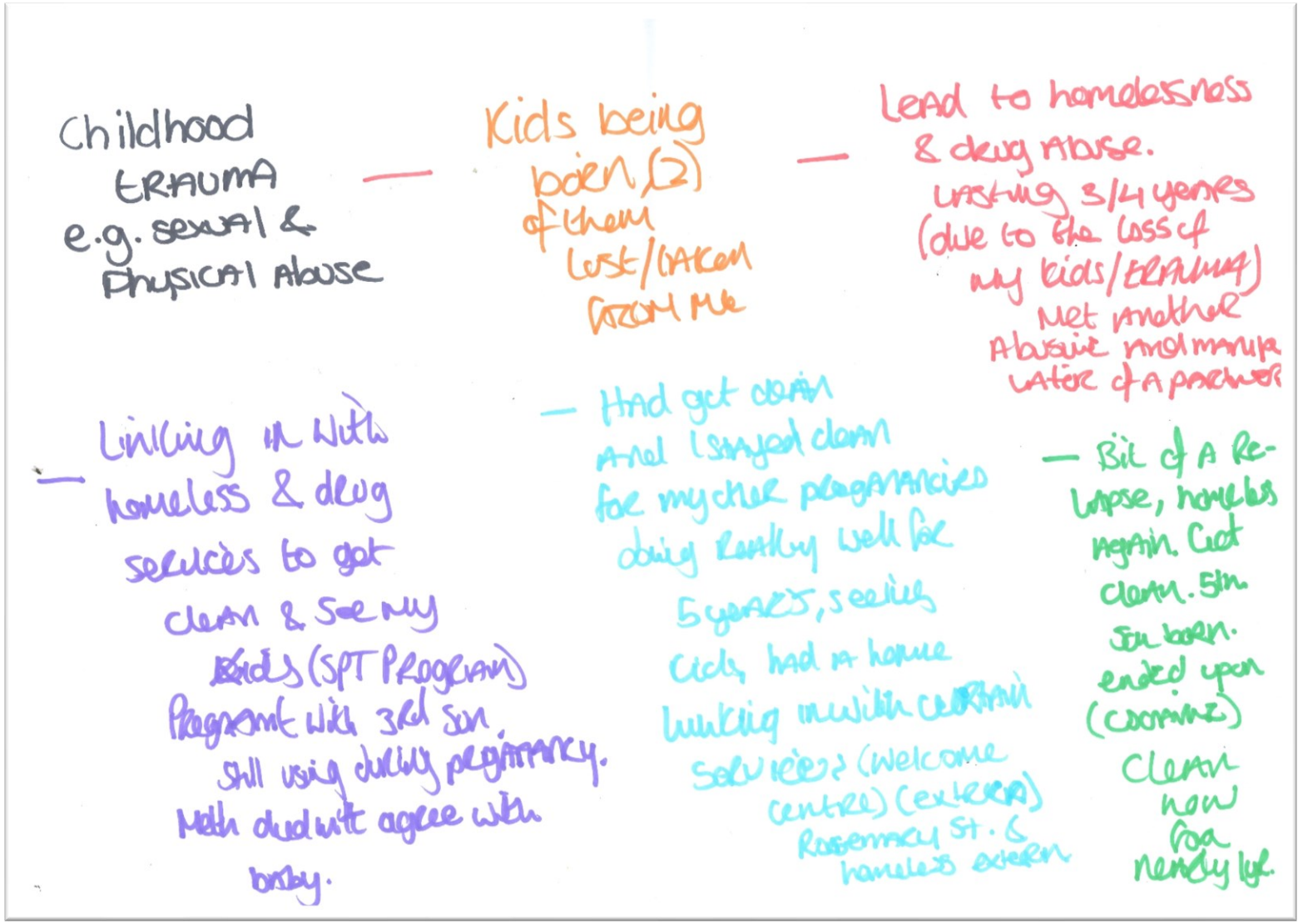
Fiona reports that she is "not proud of" the fact that she funded her addictions by begging ('tapping') on the streets and "stealing and stuff like that". She emphasises that "The withdrawal is just awful … so you would do anything to avoid it". She has a few charges on her file for petty theft and served a suspended sentence but has never been in prison.

She recalls being homeless "on and off for about 11 years", with a lot of this time being spent in hostels, albeit she had a flat for two periods within that timeframe. One flat was destroyed by fire. She and her partner were "put out" of the other property by paramilitaries because of his drug use "which they're very staunch on, it's everything against drugs". She was "clean" at the time. Fiona and her partner were both dragged out of the house; he was beaten badly and a gun was held to her head. They fled to another city and she did not return for a long time.

At the point of interview Fiona was living in self-contained transitional accommodation, had not used illicit drugs for several months, and hoped to move into her own social tenancy as soon as one become available. She was determined to avoid going into another hostel because "it's not a safe environment for people who don't want to go back on drugs". She was hoping to hang onto the understanding that "I don't need to be with somebody to feel loved". This, she hoped, might reduce the likelihood of finding herself in yet another abusive relationship.

Fiona was seeing her fifth child – who was in the care of their father (who has been clean for some time now) – a few times a week at that point in time. She was trying to get back into contact with her other children. She was in fairly regular contact with social services "as they make decisions about my kids" but was not optimistic that they would be much if any help in facilitating access to her other children. She was also volunteering in a homelessness service to "give something back" and to give her something constructive to do to help sustain her recovery.

Figure 3: Fiona's timeline



Frontline support workers commonly emphasised that many women affected by SMD perceive social services to be 'the enemy' as a result of their prior experience.

> *Worker 1: What I've seen in practice is once they've [social services have] removed the child, they [mothers] don't want anything to do with social services because they've taken their child off them.*
> *Worker 2: They see them as the devil. (Frontline staff, Swansea)*

> *There's no doubt that social work are seen as the enemy a lot of the time, for women, and that's largely down to their own experiences as a child. Often when social services have been involved, if you've got family that parents and grandparents have been involved in the criminal justice system, social work are seen as when they're around they're no good, all they do is intervene when they shouldn't, or they take children away, there's that negativity around them. (National stakeholder, criminal justice sector)*

A second key reason for avoiding services was the *presence of men in mixed-gender services*. Some women reported being comfortable using mixed-sex services (and in one case to actually prefer them). The greater majority, however, noted that they self-exclude from mixed-gender services and/or prefer women-only provision given their prior experience of gender-based violence.

> *I wasn't told that it [hostel] was mixed … There was no female staff on the day I moved in, so I was very on edge and it was just a room and I had to share the bathroom and the kitchen with a male. It was terrible, horrible … Not all men are bad, but it's just a trigger … You see one and you're like 'Oh God' … I'm just scared of men … I kind of isolated myself from everyone and locked myself in the room. (Woman with lived experience, Belfast)*

> *I pick up my script from [name of service] … They get me a taxi there and back … It's okay but if there's guys there, I'll stand over at reception. Even if there's a seat there, I won't sit in it because of the guys there. It's just a fear I've got. (Woman with lived experience, Glasgow)*

Frontline staff and key informant interview confirmed that the majority of their female clientele tended to express a preference for women-only services. The lack of refuge accommodation available to women affected by SMD and postcode lottery of women-only homeless hostels (see Chapter 7) was deemed especially problematic for this reason.

> *The feedback [from women] was there's nothing for them … They felt there was much more services that they couldn't attend simply because men were there. They've been abused or their histories would mean that they would not attend if it was just a mixed gender. They simply don't attend. (Frontline staff, Belfast)*

> *Some of the hostels … I don't think do good to anyone, man or women, but particularly very vulnerable women who have drug issues, and we know that they feel very vulnerable, that they will sometimes stay on the street rather than take a placement because they feel safer on the streets. (National stakeholder, homelessness sector)*

A third reason was fear regarding congregate temporary accommodation, which, again, was almost always borne out of prior negative experiences of living in hostels and exposure to 'chaotic' substance use and/or criminal activity of other residents, regardless of its gender composition (see also Chapter 4).

I think it's also important to say many women don't want to live in communal spaces. A woman's hostel is not necessarily a safe space for other women. Women who've had really bad experiences of being in prison, being bullied, or they just don't want to be in that … No one really wants to live in hostels, let's be honest, very few people. (National stakeholder, homelessness sector)

When you come in here [hostel] - for me - I felt this place has impacted me. I'm scarred for life already. I've seen too much in too short a space of time … It's just drama, and with drugs and alcohol and everything else involved, it's wild. (Woman with lived experience, Belfast)

A fourth reason underpinning women's reluctance to seek help was that *some do not want to be exposed as a 'homeless woman' and potentially become a target for exploitative men*.

Women will try and stay out of the way of city centres or where other homeless men may be, which is what the women say. 'We don't want homeless men to know we are homeless women.' So that's a real barrier to accessing services. We have a great service in [name of city] … and they do have scheduled women's times there, which is wonderful. However, there's still a lot of homeless men around the centre so the women still don't always feel safe even accessing it on women's day, because they're still going to be identified as homeless women. (National stakeholder, domestic abuse / VAWG sector)

A fifth reason was a *sense of shame or embarrassment* which appeared to be especially acute for women involved in injecting drug use and/or sex work.

I was embarrassed … That's why it took me so long to get help, get sober … I would just really say to people, just be truthful with your drug worker or whoever. It's all right. They want you to be all right. (Woman with lived experience, Glasgow)

This is the first time I've actually been in treatment, because I wouldn't come in …Now, it's the best thing I've ever done. I think I was the biggest obstacle, because as I said, I didn't want to associate myself with the drug places … I didn't want my work finding out through the grapevine that [own name] is on drugs, do you know what I mean? (Woman with lived experience, Swansea)

This meant that some actively hid their substance use (or the more stigmatised elements of it, such as injecting, at least) from their family and/or colleagues until they got to a point that their physical and/or mental health was so bad that it was no longer possible to conceal.

When I was younger I was led to believe heroin's this dirty drug that kills you. Only scruffy people [use it] … I think a lot of people think that it's [heroin is] only injected, and obviously people leaving all their supplies around everywhere. The caps off, cookers everywhere … My mother and father … don't really know the extent of what my drug use was … I just didn't want to tell them about the heroin because [of] the stigma that comes with it. (Woman with lived experience, Swansea)

A sixth reason inhibiting willingness to seek help was *coercive control exercised by an intimate partner and/or their associates*. With this, some recalled how a male partner actively deterred or forcibly prevented them from accessing support.

I've got schizoaffective disorder. I've stayed away from mental health [services] over the years, but definitely, sort of, involved now … My ex was scared of them … and he didn't want me to use them. (Woman with lived experience, Swansea)

It's incredibly difficult to work with women when they are trapped and stuck in that cycle with an abusive partner … It's a way of keeping that control. They [abusive partner] won't let them have access to services. (National stakeholder, domestic abuse / VAWG sector)

In other cases, however, women's resistance to seek help for issue such as domestic abuse or sexual assault in particular was underpinned by concerns that doing so would elicit (potentially violent) repercussions from the perpetrator or, in Northern Ireland, being branded a tout and risk being targeted by paramilitaries.

He [ex-partner] got remanded for an assault years ago on me, but … I made my statement a lie, basically … because I knew if I didn't get him out he was going to kill me. He would have killed me … When I was told he got sentenced … I think it was like 14 weeks and he'll do four - I thought once he gets out in them four weeks he's going to come looking for me. I knew I was in for it. (Woman with lived experience, Swansea)

It was actually the social workers that picked up on the fact … that my partner was abusing me. They could see that. Even when I was trying to hide it … I was also worried that he would find out I was speaking to authorities and stuff, because he went to prison so he didn't like authorities. (Woman with lived experience, Glasgow)

It's hard at times to get people to go to report it [sexual exploitation] to the police … The fear is that they report it to the police, they're given the name as a tout and it may come back on them on the street … There's a lot of fear around it. (Frontline staff, Belfast)

A seventh, and commonly articulated, reason for not seeking help might be described as *scepticism regarding the likelihood of such an approach leading to tangible assistance*. Sometimes this is underpinned by prior experience of not being believed or feeling judged when engaging with housing and/or healthcare services.

Oh, don't ask me about them [the council] … Because they do nothing for me. I don't like them … They wouldn't believe me about this stuff, this woman gave me murder and that. She did. Oh, she gave me hell. So I can't be dealing with her now, and I can't. (Woman with lived experience, Swansea)

The NHS treat you like scumbags because you're an addict to them … They don't really look at you the same way … You feel it. The minute you mention that you're an addict to any nurse or doctor, it's like they just don't want to know. (Woman with lived experience, Belfast)

I did have a counsellor before and … he was a twat, I've got to be honest. What an idiot. He does have no respect. He just looked down his nose at you. I went twice and then he put me off for ages. (Woman with lived experience, Swansea)

The same was often true regarding women's reluctance to report domestic abuse or sexual violence perpetrated by people unknown to them to the police.

I got raped … My man says … 'You need to phone the police', and I didn't want tae, because I was like, 'Who's going to believe an addict?' Do you know what I mean? Who's going to believe a junkie? … Nae police, naebody. (Woman with lived experience, Glasgow)

One of the women I was introduced to in the reception area told me she had a lot to say about services – especially the police who were apt to not believe what she said. She said that she had gone in a room with two men and then was sexually assaulted and the police said, 'Are you sure you are not complaining because one of them didn't pay?' (Field notes, Glasgow)

At other times such scepticism or despondency was founded on prior experience of disclosures not leading to concrete assistance.

There's been lots of times I've needed help, but I haven't really known where to go … or when I did ask for help shouldn't have bothered … [Like] when I went to the doctor's and I told them I was having severe bad thoughts, low thoughts … [and] she asked me, 'What do you want?' You know, what do I want, as if I knew any of the things that were available. And then she didn't help. (Woman with lived experience, Swansea)

The criteria to actually get support is so high that people know they can go to a mental health assessment and because they've been there before and nobody does anything, they don't even want to do it. They're so despondent because of the lack of support that's there. (Frontline staff, Swansea)

An eighth reason for not seeking help was *a perception that abuse is 'normal' or 'does not count' if the perpetrator is under the influence* of alcohol or drugs at the time.

From any time that I was getting into a relationship, and it could have been mentally abusive, verbally abusive, physically abusive, and I went, 'Oh, this is like home. This is what I'm used to'. (Woman with lived experience, Belfast)

I didn't realise it [my relationship] was abusive. I didn't like, he sexually assaulted me at one point, and in my head, it didn't count. Like, I didn't see it as sexual assault. Even though I'd said, 'No. Don't,' and stuff. I just didn't see it. Like it didn't count because he was on drugs. (Woman with lived experience, Glasgow)

Finally, some women do not seek help because they are *overwhelmed by the scale of challenge, and potential social isolation, associated with the recovery process*. On this issue, support workers cautioned against under-estimating the magnitude of the 'ask' and challenge involved in moving away from harmful lifestyles, especially given that for many women this involves cutting themselves off from peer networks (and in some cases family members who also use substances as well).

I know a lot of people who have had drug addictions and whatnot … [who] would say they have to change their whole lifestyle after that. Change their friends, places they used to go, all that kind of thing … They change all that, because they know they need to … It's like, 'I'm not going to be round that anymore, I'm just going to change my lifestyle, move away'. (Frontline staff, Glasgow)

I think we really underestimate what it is that we're inviting people to do, and what it takes to support through not just getting to the, 'Oh, look, you've got a tenancy,' and,

'You're in college.' Okay, that's where the work begins. That's where it starts getting really scary. (National stakeholder, health sector)

On a related point, some stakeholders argued or insinuated that what is commonly referred to as recovery is arguably better understood as discovery for many women, particularly where they do not have existing positive, and particularly familial, social support networks to 'return' to.

We talk about recovery a lot, which again implies that there's something to get back, something that you once had. I think for a lot of these women … there is no relational capital to recover. So what you're talking about in treatment would be discovery. To discover for the first time at the age of 25, for example, that … some people … won't harm you, let you down, abuse you, abandon you, mistreat you. (National stakeholder, health sector)

It's hard to break away from that stigma. It's hard to get away from something that you've always known … Even though we see it as an unhealthy relationship, it's all they have ever known. (Frontline staff, Belfast)

5.4 Conclusion

Women with lived experience of SMD typically experienced one of two main trajectories as regards their initial route into support services. The first was characterised by familiarity with statutory support systems, regarding housing/homelessness in particular, borne out of their family's engagement with social services (and in some cases being put into state care) or having lived in a refuge during childhood. These women typically sought assistance from their council housing department at a relatively young age, usually in their late teens or early 20s. The second trajectory was commonly experienced by women who were less familiar with and/or fearful of service intervention and therefore sought assistance only after they had exhausted every other option perceived to be available to them, often prolonging their exposure to risk in so doing. The age at which this second group first sought assistance varied dramatically, ranging from their late teens/early 20s to their 30s or 40s. In some cases, the decision about whether or not to seek help was taken out of their hands because they had for example been hospitalised, sectioned, arrested, or their children deemed at serious risk of harm and involuntary intervention thereby triggered.

Another core theme in women's narratives was experience of being shunted between and/or excluded from services, often for reasons that they did not understand and sometimes with little or no signposting or support regarding alternatives. The barrier presented by dual diagnosis was noted to be extremely problematic, and an issue that frontline staff and local/national stakeholders are increasingly exasperated by, especially in contexts where intensive efforts to overcome them have not delivered the degree of systems change hoped for. The ire of many stakeholders is catalysed, in large part, by continued use of rigid and highly conditional eligibility requirements for mental health care in particular. Such conditions are widely deemed indefensible in the face of increasing evidence regarding the comparative effectiveness of flexible trauma-informed approaches for this population.

Further to this, women with lived experience recounted multiple reasons underpinning what was widely shared reluctance to seek help. Key amongst these was fear of jeopardising their current or future access to their children. The presence of men within, and/or general 'chaos' of congregate temporary accommodation such as hostels (regardless of gender composition), were other key barriers identified. Some women reported that shame and embarrassment regarding their circumstances deterred them from seeking help, while a number cited concerns that exposing their homeless status might elevate their risk of being targeted by predatory men. A number were

prevented or deterred from seeking help by a male partner, and/or concerns that disclosing domestic abuse might provoke repercussions from his associates. Some women did not seek help because past negative experiences of services made them sceptical that doing so would lead to meaningful assistance. The magnitude of challenge associated with recovery – which for some necessitates cutting themselves off from existing peer (and in so some cases also family) networks, was another major deterrent to seeking or accepting help.

The next chapter turns attention to participants' observations regarding what helps in overcoming the reticence of women affected by SMD to seek or utilise support services, what is effective in ameliorating or resolving SMD, and what is needed to prevent it.

6. Service Attributes that 'Work'

Whilst the previous chapter focussed on women's (often negative) experiences of being shunted between and/or fear of using support services, this chapter highlights the attributes of services which they felt had worked well and that staff and stakeholders deemed effective in responding to the needs of women affected by SMD. It touches on issues of choice, eligibility thresholds, the 'stickiness' of support, use of outreach, utilisation of navigators, relational approaches, rapidity of response, and longevity of support.

6.1 Choice

Many staff and stakeholders emphasised the value of offering choice. In particular, the option of utilising women-only provision was deemed critical given many women's reticence to use mixed-sex services (see Chapter 5) and the risk that those living in areas without any women-only services will be left entirely without support (see also Chapter 7 for a more detailed discussion on single-sex vis-à-vis mixed-sex provision).

> *For me, it's more about enabling choice … You need to go to a woman and be, like, 'It's your choice … Would you prefer to be in mixed gender, would you prefer to be in single gender, what would you like?' But there's not an option. There's not that option for most people. (National stakeholder, homelessness sector)*

Moreover, participants highlighted the need for choice with regard to accommodation type, particularly whether they are offered temporary accommodation (only) or settled accommodation with appropriate level of support.

> *There's got to be different options …. There needs to be stuff that's temporary and that women can just have safety and respite, and be able to process some of the trauma, and then be able to decide what they want. But for those women who do want to get into settled accommodation really quickly, and have those complex co-occurring traumas, etc., Housing First is the perfect option … You're not in congregate accommodation, you've got your own property, and the multiagency support that's wrapped around.. (National stakeholder, homelessness sector)*

> *[My addiction support worker] realised that it was only because I was in that place [hostel], that environment that I saw people taking drugs, I saw people drinking … It got to me in that I got that way because I was copying what they were doing and that was their way of coping mechanism. So I found that as a coping mechanism. So once I was out of there and I had my own place I felt more relief not to be around people influencing me with alcohol or drugs like that. (Woman with lived experience, Belfast)*

As noted in one of the quotations above, Housing First was often heralded as a particularly effective settled housing option for women affected by SMD, albeit that it may not be the preferred or a suitable option for everyone (see Johnsen et al., 2023), including for example those survivors of domestic abuse who find the presence of staff in supported accommodation schemes reassuring.

> *The Housing First model tends to work really good, even with the most chaotic clients, because when you've got them somewhere safe, and you've got a support network built up around them, then you can work around the substance use, and the sex work, and any other issues that are there. (Frontline staff, Swansea)*

I want to be in supported accommodation. I don't want a house … I don't feel safe anywhere. I need … supported accommodation where I get watched … I just don't want them [perpetrator of violence and threats] to find I'm in a house, and then they come into my house and do things. I'm scared. (Woman with lived experience, Glasgow)

A similar argument was made as regards choice in support and therapy options addressing substance use. On this, some women really valued (women-only) recovery groups, but other noted that group-based recovery services were ineffective for them regardless of gender composition.

I like the fact that they've got a women's only group. Because of everything I've been through, I'm not really wanting to be around any men, and I don't trust my own judgement. I feel safe in the [name of group] … There's a few girls who come every week, and that's solidarity in that ... I get a lot of strength out of … that solidarity thing of the girls, we're in it together. (Woman with lived experience, Swansea)

Group therapy, my God! … Just every time I hate it - and I'm bad enough on a one-to-one basis, never mind group therapy and us all sitting and kumbaya together. I was shitting it! No. Hell. There's a room full of people you don't know. (Woman with lived experience, Belfast)

6.2 Low threshold

The imperative to provide low-threshold services which do not exclude people for substance use and/or have no (or only very limited) requirements regarding 'engagement' with support (e.g. attendance at pre-scheduled appointments) for example, was a key theme. Low threshold services, interviewees noted, not only facilitate initial access but foster honesty in women's engagement with support workers.

This one here has been the most helpful place … At other hostels you would get put out for using drugs or drinking and stuff like that, so you would hide it. … If you're using Valium every day and even if they say you can't take it, you're going to take it. They'll support you no matter what you're doing … It's helped me a lot. (Woman with lived experience, Glasgow)

Interviewees emphasised that, where employed, high-threshold eligibility requirements – such as restricting access to specialist counselling to women who had agreed to press charges against the perpetrator of sexual assault just by way of example – act as a significant barrier to support.

We've got specialist services … that can help, through name of [sexual assault referral clinic] and counselling and stuff like that … [But] you only are offered immediate counselling through [that] if you press charges. That's the only time you get immediate access to counselling services … They deal with past abuse and stuff as well, but they'll only, if there's an active court case and you are going to take it to court is when you're offered immediate support in those circumstances. (Frontline staff, Swansea)

On a related point, a number of stakeholder interviewees emphasised that 'no wrong door' approaches which direct women to appropriate services regardless of where they first seek or are offered support are widely considered to be good practice.

We absolutely advocate a no-wrong-door approach, and agencies, whatever they are, being proactive at trying to identify those issues that might be occurring. Whether that be about violence against women, domestic abuse, or whether that be about the risk of homelessness, public services being proactive, seeking to identify any issues, and having the skills and the knowledge to understand what to do if they are alerted to an issue, and where to refer. (National stakeholder, homelessness sector)

6.3 Sticky support

Women with lived experience emphasised the value of services which 'stuck with' them given the (sometimes extreme) lengths of time it took them to develop trust in individual support workers.

It took me a long time to trust. So it was nearly two years before I actually trusted anybody, or would speak to anybody … They [support workers] didn't push me. They didn't walk away from me, or whatever. They just built up the trust gradually, and then slowly I managed to be able to trust. But anybody else that comes into my life, or I kind of meet or whatever, like trust is a massive thing because I got let down a lot in my life growing up. (Woman with lived experience, Belfast)

I was quite against having workers. I rebelled a lot, and I didn't want to speak to anyone because I thought they were all the police, thought they were all social work. And in actual fact they've done me a really good favour by working with me … I just thought everybody was out to get me! [Laughs] … You need to trust them, and now I literally trust my worker … with everything. (Woman with lived experience, Glasgow)

On this issue, they emphasise the value of their support workers' perseverance, which was often quite assertive, especially following periods of disengagement.

[Name of substance use worker] is Wonder Woman in my eyes … When I'm no good she stays in regular contact … She sticks with me … I am big and I am loud and I can be quite aggressive, do you know what I mean so, aye … I wouldn't work with anyone else. (Woman with lived experience, Glasgow)

My addiction worker, she had to fight to get through to me quite a bit, to make me realise that she was helping me. I used to just ignore her. I'd block her number and all that, and she'd show up at my door, at the services I was in, trying to talk to me and I'd be like, 'I'm not talking to you.' She really, really, really persevered with me, and I ended up being … like, close to her. (Woman with lived experience, Glasgow)

On this subject, frontline staff echoed the narratives of women with lived experience regarding the time taken to build trust given the nature and depth of the trauma they have experienced.

People like Jess [vignette case] have been let down by services most of their life. So they don't trust them … A lot of the work that I find I end up doing with this type of client is building trust, relationships, because if they can't trust you, they're not going to talk to you. So it's really about trying to find something … that you can click on, build that relationship, and then they're more likely to tell you what they do need, and you can then offer the support. (Frontline staff, Swansea)

They also emphasised the necessity of flexible arrangements wherein women can retain entitlement to support even after a period of disengagement. This, they argued, should negate any need for women to heave to re-navigate complex referral pathways.

> *[What happens is] if … you go into distress again, any housing distress, mental health distress, addictions distress, you present again, you are back at square one in the referral process … You're now on the waiting list. You will get seen again for an assessment … To me, professionally … they should not be at square one. (Frontline staff, Belfast)*

6.4 Outreach

There was a strong call amongst participants for increased provision of outreach-based services which 'take services to' women affected by SMD. A key benefit of outreach, they argued, is that it circumnavigates the barrier presented by women not wanting to access services due to fear of the threat presented by other people (particularly men) using them and/or stigma associated with using substance misuse services in particular (see Chapter 5).

> *I just miss appointments if I have to go to them … Social workers, doctors, mental health appointments … My anxiety goes through the roof. (Woman with lived experience, Belfast)*

> *So with my mental health … they'll make me go into see them in the office which also doesn't help me. [Name of another service] would come out to my house … It helped a lot more with my mental health for me to be able to sit in the comfort of my own home where I felt safe basically, rather than going into an office building. (Woman with lived experience, Belfast)*

Outreach was also reported to mitigate the risk of women being distracted or diverted (by drug using peers, for example) when travelling to building-based provision.

> *Outreach … works better for people who are quite chaotic. If you're basically giving them an appointment to come into an office, anything could happen on the way to the office … especially if she's in addiction as well. Has she got a bus pass? Is she going to spend that money? … She's not going to come to you. Sometimes, the expectation is that she comes not being under the influence. So that's really, really hard. So that's why it's better, outreach services, you go to them. (Frontline staff, Glasgow)*

On this subject, a core theme in local stakeholder consultation discussions was the added value of multi-agency and multidisciplinary approaches in outreach services targeting this population (see also Chapter 7).

> *It's that need to be peripatetic, but in teams, so not just us, groups of people working for different organisations that are providing the support, whether it's healthcare etcetera, and being able to deliver it … to them where they're at … We need to go out there and send the services to the people. (Local stakeholder, Swansea)*

> *I think the overwhelming evidence that we've got from [name of local initiative] is that the approach has to be explicitly outreach. It has to be explicitly assertive. And it has to be multi-agency or multidisciplinary … We found that to be hugely valuable in terms of engagement and retention of women in the service. (Local stakeholder, Glasgow)*

Both stakeholders and service users emphasised that the call for a greater shift toward outreach services applies to specialist mental health provision as well as other services which have a longer track record of being delivered peripatetically (e.g. street-based outreach for people sleeping rough).

> *If a woman says, 'I like this place, I'm safe in this place,' then we go to that place. We don't say, 'Oh, but these really important, well-paid people, they're over there.' Well, those important, really well-paid people should want to have success in their services, and they should move so that there is success in their service. We need to work with people's motivations … If you want to say you're achieving your targets, well, that's the best way. (National stakeholder, domestic abuse / VAWG sector)*

6.5 Navigators

The value of a trusted worker who has capacity to help women navigate access to the services that they need was frequently highlighted by women with lived experience of SMD.

> *The nurse that came in here [hostel], she … got me back on to the doctor's [register], thank God. The lady that comes in, [name], she's from an agency that go around all the hostels to do with health and things like that. She's getting me back on antidepressants again, and to see the psychologist person to get all the crap out of my head. (Woman with lived experience, Belfast)*

> *The best service is [name of service] … They phone the social for you, they phone the council for you, and if you get any problems they send you up to the law centre … There's a nurse that comes in for anybody that's no got a GP. She'll prescribe them what they need. They give you stuff to eat if you've no money … They give you clothes if you've no clothes. So they're really, really, really, really good. (Woman with lived experience, Glasgow)*

This was especially true for women who struggled to articulate themselves clearly and/or would get frustrated when communicating with professionals who they perceived to be unhelpful or judgemental.

> *Sometimes I can't explain things over the phone. Then, if they say something and I lose my temper, I'll end up slobbering down the phone. I'm better off doing it in the office where if I do get overwhelmed and I'm starting to lose my temper, I can just hand the phone to them [staff]. Because sometimes housing officers can be very abrupt and I don't like it. (Woman with lived experience, Belfast)*

6.6 Relational approach

A common denominator in women's accounts of services that they had found helpful was the establishment of a trusting relationship with one or more support worker. Without exception, these staff members were described as caring and/or non-judgemental.

> *The [name of service] … was brilliant. That was amazing … I just like the staff. The way it was run. It was brilliant. Pretty much the same way I feel about this. The staff are amazing and everything … They're just more involved with you, more caring. They come and check you. (Woman with lived experience, Glasgow)*

These ones in here [hostel], they're good … They don't judge you … They really make sure that you know that they're there for you, and that they'll do a lot to help you. (Woman with lived experience, Belfast)

To be honest with you, my worker from [name of service], she was amazing … [because of] the way she would talk to you. She was more like a friend than a worker. You could tell her things that maybe I can't tell my worker now, do you know what I mean? (Woman with lived experience, Swansea)

On this issue, women with lived experience highlighted the imperative of facilitating the consistency of worker insofar as possible given how difficult they find it to develop trust and to avoid having to rehearse their traumatic experiences repeatedly (see Chapter 5).

See, [here] you're always working with the same person, where other services, it's a new face every time you're going in, somebody else. Then you have to start all over again and explain your situation to that person and you're just constantly going round in circles with most people. (Woman with lived experience, Belfast)

I was always getting different workers in the [name of service] teams, you know … You're telling your story constantly, and to me if there's something about you, and it's in your notes … but they just don't bloody read the notes. (Woman with lived experience, Glasgow)

A few frontline workers asserted that the time taken to develop rapport with women affected by SMD should not be misconstrued as an inappropriate form of dependency, but rather a necessity given the consequences of the trauma they have suffered.

We're talking with women that maybe it's a year before they will actually tell us anything about them. They need to know … Are you going to be there for me? Are you not judging me? … They are devastated when a worker … leaves. They just disengage … Our funders would argue that's because it's dependency. I say it is not. I say this is about the relationship that these women need in order to be able to trust somebody to that level to get the support they need. (Frontline staff, Belfast)

It was however noted that consistency of workers is difficult to preserve in a context where the turnover of staff in services supporting this client group is high. High staff turnover was highly disruptive for women with lived experience, in part because of the length of time it takes them to develop rapport, but also because having to repeatedly share their experiences can be re-traumatising.

I have been here [hostel] about ten months … She's my third key worker since I moved in here … See most of the staff that were here whenever I moved in are gone. There's maybe like two left … It's all new staff. (Woman with lived experience, Belfast)

The difficulty is inconsistencies in social services as well. Social workers that leave the organisation very quickly, people don't stay around, they don't retain staff … So again a woman is retelling her story and having to get used to somebody new. That in itself is traumatic. (National stakeholder, criminal justice sector)

High staff turnover was commonly attributed by stakeholder interviewees to the low salaries and/or challenges associated with frontline work in this field, including exposure to vicarious trauma.

You need to be able to get, pay staff a decent wage to be able to … get the qualified, trained staff that you want. I think a lot of times my frustration is that we talk about vicarious trauma. We talk about the need for flexibility, and we're constantly dancing round the issue of that we pay frontline staff terribly to do a really, really hard job. (National stakeholder, homelessness sector)

In the last year, I lost two very experienced workers, and they simply could not - their wages were not covering their bills … But that's a sad loss, because both of them said they would not leave the service at all otherwise. Three females disengaged from the service completely because one of them left. (Frontline staff, Belfast)

On this, there was a widespread call amongst staff and stakeholder interviewees for greater recognition of the fact that voluntary sector support workers are often more successful than their statutory sector counterparts at initiating and maintaining the engagement of women affected by SMD.

I think social workers in particular don't use us enough. They don't recognise that we're on the ground, we're seeing the person very frequently, we've got far more idea than a lot of services involved, and they're not interested in our opinions. So it can be really difficult to get them to acknowledge what we're saying. (Frontline staff, Swansea)

I've worked with organisations who, despite their absence of high-wizardry training, have actually managed to … get their head round ambivalence as a core construct in human psychology, which … the health service does not seem to be able to understand … I've worked with third-sector organisations who've … shown that you don't need to be a consultant clinical psychologist to repair trust. What you do need is time, and tolerance, and commitment, and compassion, and humanity. (National stakeholder, health sector)

6.7 Rapid response

Interviewees with lived experience identified a multitude of missed opportunities for intervention wherein they were highly motivated or felt 'ready' to access support but were thwarted in their attempts to do so by long referral times or waiting lists. Missed opportunities such as these were a source of immense frustration for frontline staff in all four case study locations. Delays were noted to be especially problematic for women needing specialist mental health support (see also Chapter 7).

Waiting times. Waiting lists … The referral process [for mental health support] takes weeks, sometimes months. By the time they're given the appointment, they're in a completely different headspace and a completely different space in their life. (Frontline staff, Belfast)

Well, the thing is, is for someone in the community, if they're ready and willing to engage in to be linked in to either a counsellor or trauma specialist or whatever, then that takes time …. I think the time's like 18 months. First port of call is your GP. They would then refer. It's usually about … a year and a half that you wait before you can get that help. (Frontline staff, Glasgow)

A strong desire to be able to respond more rapidly in order to capitalise on windows of opportunity was also widely articulated by local and national stakeholders.

I do think that if somebody comes to us and they're homeless, we should be seeing them within an hour, not within a day. If somebody is reporting that they've seen a drug dealer, that should be dealt with immediately. If a woman's come to us and needs rapid prescribing, that should happen instantly. If somebody needs counselling, that should happen instantly. The longer we leave it, we may have missed that opportunity, and we often do. (Local stakeholder, Swansea)

6.8 Long-term support

The brevity or absence of tenancy-related or other forms of support after being rehoused had been highly problematic for a number of women with lived experience, thus highlighting the need for long-term support to prevent repeat homelessness.

They [housing officers] were like, 'Well you don't really need our help, you can just live on your own' … I couldn't cope … Its ridiculous isn't it the way they throw you in the deep end, like 'Just get on with it'. (Woman with lived experience, Belfast)

The homeless [local authority housing department] put you into a scatter flat and leave you. There's nae workers that come out to see if you're okay. Even the housing officer or a worker … to go with you to get stuff and stuff like that. Nae support there, at all, whatsoever. (Woman with lived experience, Glasgow)

On this issue, frontline staff and stakeholders often emphasised that women with experience of SMD are commonly targeted by exploitative individuals, especially predatory men, even after being housed and/or making substantial progress in their recovery from addiction.

Some of those cases … they're targeted. This is a vulnerability … It's not the woman's issue, it's the fact that men will target them. They will move from one poor relationship into another domestic violence, and that's not a reflection on them, it's just that they are targeted. (Frontline staff, Belfast)

This woman, she's been in the cycle for over 20 years … She's the sweetest person you could ever meet, but because of her upbringing and the trauma she's gone through, she became very self-reliant on alcohol as a coping mechanism … She's easy pickings because of her alcohol. She gets undesirables knocking her door all the time, and when she's had a drink, then she doesn't recognise how dangerous the situation is. (Frontline staff, Swansea)

They noted that this fact, together with the potential for relapse which is a 'normal' part of the recovery process, showcases the need for provision to be made for long-term support for women affected by SMD.

6.9 Conclusion

This chapter has provided an overview of the aspects of support which participants considered to have been most helpful or effective in the amelioration and resolution of SMD affecting women. Key amongst these was allowing for choice in type of accommodation and support (e.g. women-only vs. mixed-sex, independent settled housing with support vs. supported accommodation with staff on site, group vs. individual therapy approaches etc.), utilisation of low access thresholds (i.e. no/minimal engagement requirements), and emphasis on 'sticky' support wherein women retain entitlement to support even after periods of disengagement.

A focus on outreach (i.e. taking support to women rather than requiring them to attend fixed appointments in service settings) and utilisation of navigators to lead on communication with and/or coordination of other services were also deemed to be good practice. Relational approaches which take account of the time often required for women to develop trust in support workers was reported to be critical, and rapid responses that are able to capitalise on windows of opportunity when women are motivated to engage invaluable. Finally, participants highlighted an imperative to provide long-term support which is cognisant of the ongoing potential for relapse and women's ongoing vulnerability to exploitative individuals (especially predatory men) even after being rehoused or undergoing treatment for substance use issues.

7. Implications for Service Provision

Building on the findings presented earlier, this chapter comments on key implications for service provision. It consist of four sections. The first focuses on trauma-informed approaches and consideration of gendered trauma in particular. This is followed by observations regarding the merits of gender-specific vis-à-vis mixed-gender services. The third section comments on progress made as regards joint working, while the final section discusses current thinking on prevention.

7.1 Gendered trauma and trauma-informed provision

This section discusses the extent to which understanding of trauma, and gendered aspects of trauma in particular, has permeated provision for this population.

7.1.1 Awareness and understanding of gendered trauma

National and local-level stakeholder interviewees referred extensively to the valuable work of agencies with specialist experience in responding to gendered trauma, but were unanimous in emphasising the need for frontline staff to be better equipped as regards this issue more generally across relevant sectors. Many called for central and/or devolved governments and commissioners to lead more proactively on the promotion of and accountability regarding gender-informed practice.

> *[Devolved government should] prioritise making sure all public services and services commissioned by public services … become more gender-informed, in conjunction with being trauma-informed. And understand the specific traumas and stuff around coercion, power, control, of those things that are quite specific to women, as well as some of the knock-on impacts that particularly affect women, such as the issues around children being taken away. (National stakeholder, homelessness sector)*

> *I think what we need to see now from central government is leading from the front and saying ... women's multiple disadvantage looks different to men's … They need to see women's provision and gender-informed provision as a must, as a priority, not as an add-on or a nice to have … It's an equalities issue … They need to be holding organisations to account to demonstrate how they can provide gender-informed support and asking for tangible examples of what that looks like. (National stakeholder, homelessness sector)*

Specifically, they highlighted both a need and appetite for investment in training to help frontline staff and service commissioners better understand the manifestations of domestic abuse, its effects on survivors, and survivors' susceptibility to repeat experience even after they have for example moved into an independent tenancy and/or exhibited significant progress on their recovery journey.

> *We need to be saying … at a national level … everybody has to …have an understanding of domestic abuse … Its thinking about the period after someone's been moved … It's understanding all the repercussions of where … putting someone into permanent housing … then leaves someone … and that somebody's really at their most vulnerable for a time. And that they're more likely to leave and return many more times than … many people realise. (National stakeholder, domestic abuse / VAWG sector)*

The psychological impacts of the loss of children was highlighted as another subject area that should ideally be covered in such training programmes.

> *In homelessness services especially … you don't get bespoke training about how to support women with that life-altering trauma [removal of children]. It's not spoken about. Sometimes you don't even know that women have children for months, or even years, because you're not asking the right questions … Support workers aren't trained about how to support women through the legal processes and around contact and things like that. It's not spoken about. (National stakeholder, homelessness sector)*

On a related note, there was a very strong call for the involvement of women with lived experience of SMD in the design of services and training aiming to help services become more trauma-informed.

> *We need services to be looked at specifically from women's perspectives and for that voice to be seriously listened to … Don't hear me wrong, I'm not saying that we've got this completely misogynist system in that nobody cares about women's voices at all. That's not true. But I think there needs to be more of an emphasis on listening to people with lived experiences. (National stakeholder, homelessness sector)*

> *The women who've had these experiences … should be involved a lot more in the process, advising, guiding, and they should be listened to. They are the experts at the end of the day … I know co-production, it's one of those buzzwords, it's out there, people say they're doing it, but it's done quite often on a service level … I think this could be a bigger thing, and I think it could be done more. (National stakeholder, domestic abuse / VAWG sector)*

A number of stakeholder interviewees also noted that the involvement of frontline staff in service design would add further value given their extensive knowledge of the day-to-day challenges that women with experience of SMD face when trying to access support.

> *Sometimes your staff are ahead of where you are on a policy issue. So, there's a real drive from the staff to be able to do things differently. I think the challenge for someone like me and our policy and commission teams is to get that lived experience, understand that better, and the staff better because they will tell you 'This is not working'. (National stakeholder, homelessness sector)*

A core goal of such endeavours should be to help frontline staff and service commissioners appreciate the nature and extent of what one national stakeholder interviewee referred to as 'relational injury' affecting women with experience of SMD. They emphasised that experience of pervasive neglect and/or abuse makes it extremely difficult for such women to make use of many services.

> *[We need] to recognise that a woman who finds herself rough sleeping … dependent upon heroin, in abusive relationships, and getting involved with the criminal justice service, did not choose it, and is not making choices in the way that we are implying that she is. That this is the manifestation of a severe life-limiting injury … [a] relational injury that manifests itself in the ways that are visible even though their core injury is not so visible … If the services were going to work for this group of women, they would have done so by now. So clearly they are structurally wrong … because implicitly … they demand that the person can relate, connect, attach, trust, make use of human relationships … (National stakeholder, health sector)*

They went on to argue that the operationalisation of such understandings would require a shift away from rigid approaches which take little or no account of the nature and scale of injury sustained. On this, they likened the use of inflexible appointment times and rigid requirements regarding

engagement to locating a wheelchair clinic somewhere which is physically impossible for severe spinal injury survivors to access.

> *To be really concrete about it, is a wheelchair clinic service doomed to fail if it keeps positioning itself at the top of three flights of stairs? Yes, it is. Does that require it to structurally change itself and maybe put in the odd lift? Yes, it does. How does it get to a point where it feels like it needs to put a lift in place? Well, it needs to have an understanding … that the person cannot climb stairs. They're not just being lazy, or doing it out of badness, or they can't be arsed climbing your stairs, or not interested in the clinic. It's that they cannot climb stairs by nature and consequence of the injury. (National stakeholder, health sector)*

This argument echoed a wider call for systems change which acknowledges the inappropriateness and potential futility of expecting women affected by SMD to engage with many mainstream services. On this point, interviewees were unanimous in highlighting a need for wider embedding of what is already considered to be good practice in the provision of trauma informed care (NICE, 2022; Scottish Government, 2021), as noted in the next section.

7.1.2 Wider embedding of trauma-informed approaches

The general escalation of emphasis on trauma-informed provision within the homelessness, substance use and criminal justice sectors in recent years was heralded as an extremely welcome development by staff and stakeholder interviewees alike. A few did however caveat their generally positive appraisal of progress made by noting that the rhetoric about trauma-informed care has not always translated into practice to the extent that policy discourse sometimes implies.

> *If you [are] … trying to sell whatever the policy mechanism is within DoJ [Department of Justice], they all go, 'But do you have health around the table?' … If you go to health, you can get the same thing, 'Do you have DoJ?' Even at that level, we're very siloed … All of these glossy documents come out talking about joint working and joint commissioning, working together, but it's clunky from the top which makes it clunky everywhere else. (Local stakeholder, Belfast)*

Whilst stakeholder interviewees were sympathetic as regards the immense pressure that statutory services are under in the current economic climate, social work and mental health services were targeted for severe criticism for failing to operate in a sufficiently trauma-informed manner with this population.

> *The model of support that we know works best for women experiencing multiple disadvantage, it's personalised, it's flexible, it's non-paperworky, it doesn't have technical jargon. This is the approach which women have told us for years they want and need … The thing is social workers can't kind of rebrand themselves because that's not the way that they are structured or commissioned to deliver services … There is a big gap between how social workers are able to practice … and what this group of women actually need. (National stakeholder, homelessness sector)*

> *They [women affected by SMD] do want the support, it's just it's not there in the capacity they need it to be. It's very rigid. It's a very rigid structure, the mental health services, I think … They don't serve women with multiple disadvantage. (National stakeholder, domestic abuse / VAWG sector)*

Stakeholder interviewees highlighted three key areas where they believed further consideration and skills development for social workers and/or mental health practitioners would be particularly beneficial. The first was improved recognition of many women's prior negative experience of social services' intervention and its effects on their willingness to engage with social workers (and in some cases other practitioners) later in life (see also Chapter 5).

> *I've worked with many women who had social work involvement themselves as a minor … and felt let down, and had a really negative experience. And I think the social workers who may be involved in their family with that person as a mum, needs to recognise as well how re-traumatising it is to have that service back in your life again, and how it may impact on her engagement, how there can be a mistrust. (National stakeholder, domestic abuse / VAWG sector)*

Second, a number suggested that there was scope for improvement in understandings around the effects of domestic abuse on mothers, including but not only when their children are at risk of being removed.

> *In a lot of cases, the social workers or the system is orientated so that it doesn't comprehend the dynamics of domestic abuse, and the structure of child removal means that the blame tends to be placed on the woman in that process. It's generally considered a woman's responsibility to look after the children, and therefore any failure to look after the children's needs is directed at the mother, and therefore the dynamics of domestic abuse that are at play tend to be overlooked. (National stakeholder, homelessness sector)*

A third area of potential development highlighted was training to improve social workers' and mental health practitioners' understanding of the dynamics of substance dependency, especially the likelihood of relapse in the cycle of recovery.

> *There needs to be … increased understanding and empathy around the reasons as to why women experiencing trauma are using substances. They're not doing it to be difficult … by not attending appointments and not reducing their substance use … They [mental health services] need to be a lot more flexible, a lot more open … and work alongside substance misuse services. (National stakeholder, homelessness sector)*

> *There needs to be like a big paradigm shift with how social services view these things … I think it's about … them understanding recovery as well, because part of the recovery model is relapsing … If someone's open about that … that should be seen as a positive. (National stakeholder, domestic abuse / VAWG sector)*

On a related note, stakeholder interviewees emphasised the importance of both supporting and paying frontline staff adequately given the genuine risk of them experiencing vicarious trauma and level of expertise required in working with this population.

> *Given the … traumatic things that frontline workers experience, the vicarious trauma that they get from doing their jobs every day, and the stories that they hear, and the things that they witness … For staff being able to get the support for those things is really, really important. (National stakeholder, homelessness sector)*

> *We need a different approach to commissioning that understands that front-end staff need to be paid decently … They have a really, really hard job. (National stakeholder, homelessness sector)*

As noted regarding gender-informed provision, stakeholder interviewees called for central and devolved governments to lead proactively in generating environments conducive to the development of trauma-informed services more widely. The Scottish Government's Trauma Informed Practice Toolkit (Scottish Government, 2021) was identified by a number as an example of good practice in this regard.

> *So I think that that would be really beneficial to have a blueprint of what being trauma-informed means that is gendered and also is culturally responsive. We need to see that guidance on what trauma-informed practice looks like … The Scottish Government have a toolkit available that they published … the Scottish Government seems really ahead in terms of that toolkit. (National stakeholder, domestic abuse / VAWG sector)*

7.2 Gender-specific and gender-informed provision

The relative benefits of women-only vis-à-vis mixed-gender provision, and means of operationalising gender-informed approaches in both, were key subjects of discussion with staff and stakeholders. This section explores key themes regarding each in turn.

7.2.1 Women-only provision

Staff and stakeholder interviewees expressed a very strong appetite for continued investment in – and many called for greater provision of – women-only services, given that women affected by SMD are vulnerable to exploitation in mixed settings and/or actively avoid using them because of the presence of men (see Chapter 5).

> *There's definitely a shortage of women-specific services … I'd be interested to meet the person who would argue otherwise, to be honest. (National stakeholder, homelessness sector)*

> *When women are presenting with multiple disadvantage, there is always a lot of trauma in there. And more often than not, maybe nearly always, some of that trauma is linked to a male somewhere. Whether it's from an experience in their childhood, whether it's relationships that they've had as they've got older, quite often both. (National stakeholder, domestic abuse / VAWG sector)*

> *I have to say, every incident in this organisation, and there's lots of them, there is something about women in those services … [being] exploited. Sexually exploited. Exploited in terms of finances. Sometimes, at that point of greatest vulnerability, they can make connections with men, that again, are not that helpful. (National stakeholder, substance use sector)*

The provision of single-sex services equipped to cater for women experiencing SMD[2] was nevertheless widely described as an extremely uneven 'postcode lottery', such that many women have no reasonable prospect of being able to access it.

> *So there needs to be an increase in women's services, but it needs to be consistent so there's not a postcode lottery of it like there is now … Where I'm based, there's loads of*

[2] See Chapter 3 regarding the limited ability of traditional women's refuge services to cater for this population (also Bramley et al., 2019).

women's services and there's some really great work, but you go to other boroughs and there's not as much. Then elsewhere across the country there can be nothing. (National stakeholder, homelessness sector)

Specialist services play a vital role in supporting women with multiple needs. It's just that they are so patchy and it is a postcode lottery. So I suppose they're chronically underfunded and under-resourced, but I do think there are really good examples of good practice that can be transformational for women with multiple unmet needs. (National stakeholder, domestic abuse / VAWG sector)

I think we need more of single gender accommodation, significantly more. I think one of the things we hear across the board … is there's a severe lack. (National stakeholder, homelessness sector)

Stakeholder and staff interviewees noted that the value of women-only services lies not just in the absence of men, but in the specialist expertise of staff, especially as regards the impacts of gendered trauma and gendered routes into each of the SMD domains (see Chapters 3 and 4).

We need more women-only services, absolutely, for the staff to have that specialist knowledge … You have an understanding of women's issues that I don't think services get when they are generic … Although the DSM [Diagnostic and Statistical Manual of Mental Disorders] definition of what depression, anxiety, post-traumatic stress may be is very generic and standardised, the experience for men and women in regards to those conditions is very, very different … Why women turn to substances, that's also very gendered … If someone's working generically, they're thinking generically. Whereas, if … a woman [is] working with women … that's what her focus is all the time. (National stakeholder, domestic abuse / VAWG sector)

It's very hard work to support women … when they're experiencing multiple disadvantage, and they might have an ex-partner that might pop up. They might have a current partner that's abusive. I think there would need to be really strong evidence in a mixed service that this is how we're supporting staff to have that knowledge and understanding of gender-specific issues. Yes, the danger is always that's gets diluted if you're running a service which is predominantly for men. (National stakeholder, homelessness sector)

A number of interviewees also called for greater provision of women-only spaces within mixed-gender services.

Accessing services that are mixed gender can be really traumatic for the women … It's impossible for the women to be open and vulnerable in those spaces ... So it's a real barrier to support … Women do need that space to be able to access services themselves, just women, in all of the services … because of where a lot of the trauma comes from. (National stakeholder, domestic abuse / VAWG sector)

In terms of women-only spaces in … mixed services … my sense is again that there's not enough. There's certainly not enough specialist services for women and there's not enough women's-only spaces … I can't see how that could be denied. (National stakeholder, homelessness sector)

Some did nevertheless caution that service providers need to think very carefully regarding the range of factors that might deter women from accessing women-only spaces in mixed-sex services, particularly given the risks of encountering men within or in the vicinity of the building.

> *I believe in women's-only spaces, but I think when we do it we have to think about the dynamics of abuse and how it plays out … We need to be thinking about that whole environment of safety … How is the woman travelling to there? What are we going to do about the men that might be hanging around? (National stakeholder, domestic abuse / VAWG sector)*

Stakeholder interviewees attributed the perceived shortfall of women-only services and spaces at least in part to a lack of robust data quantifying levels of need. On this, they emphasised challenges in evidencing demand because of the tendency for many women to disguise their homelessness, substance use, and/or poor mental health (see Chapters 3, 4 and 5) and tendency for investment to be targeted at the majority population.

> *I would say [there's] probably not enough [women-only temporary accommodation], but I would say that the data isn't there to understand what the unmet need might be … One of the things that I think is an enabler for the work that you're doing is having better data around what the need is and what the gaps are … It's a cliché, but in my experience it's true, what's counted is what counts. (National stakeholder, homelessness sector)*

> *There's not enough [women-only provision]. I mean, there is more than there used to be … I think part of the problem of that is … it's really difficult to evidence the need for more women's provision because we don't have accurate records about how many women are experiencing homelessness … Often, they're not found or identified. (National stakeholder, homelessness sector)*

Several thus called for a more strategic approach to the commissioning of services which is cognisant of the potentially lesser visibility of women affected by SMD and challenges that they face. This was allied with a call for the development of more accurate means of assessing the scale of demand for women-only services and spaces, and for stakeholders to advocate for the provision of gender-informed services more generally.

> *They are commissioning specific services … on the basis of the greatest number of people that will benefit … For example, approved premises for women who are in the criminal justice system; that has been a discussion that's been on the table for about ten years. At one time, it got as far I think as [name of body] looking at it, and they decided that there weren't sufficient numbers. (Local stakeholder, Belfast)*

> *Oftentimes, services … are under-resourced, and there's less of a space at times for them to have an approach to planning and delivery of services that is considered, and has the space to think about how they're delivering those services and taking a step back. So what I have found is that you often then end up delivering services at pace, that are dictated or skewed towards the majority of the population that you're serving, which generally tends to be men. (National stakeholder, health sector)*

7.2.2 Gender-informed provision

That said, interviewees emphasised that investment in women-only services and spaces should not occur at the expense of the promotion of gender-informed approaches more generally. They argued

that a shift toward gender-informed provision will benefit men as well as women; so too individuals who identify as non-binary or gender fluid for example.

> *Women-only services … play a role, and I think that they're really important … I also believe that that in itself is not job done. That you have to mainstream a gender-informed approach across all services. (National stakeholder, substance use sector)*

> *One of the things that I found frustrating … was a tendency towards designing separate services for women, as opposed to a drive towards trying to make services across the board more gender-informed. Now, that's not to say that I don't think that there is a need for there to be separate services for women. There absolutely is a space for that. But I don't think that should be to the detriment of services across the board being gender-informed. (National stakeholder, health sector)*

> *I think there's often a disparity between an understanding of gender exclusive and gender informed … There's a complete lack of understanding across the homelessness sector about the need for services designed for women, and then even those who do get it, often are like, 'Oh cool, we just need a women's-only service', and it's like, 'Well, no, not really'. Yes, I think the homelessness sector is pretty poor … [in offering] gender informed provision to be honest. (National stakeholder, homelessness sector)*

On this issue, there was a general consensus amongst staff and stakeholders that levels of understanding regarding what gender-informed means for service delivery is increasing, but that the extent to which this is translated into practice is highly uneven.

> *I'd say it's a really mixed bag … When we spoke to commissioners for housing there were some who were brilliant … really gender- and psychologically-informed. They'd thought of it all really well. But then when we spoke to the majority it was like, 'Well, we've got provision. It's the same as for everybody else, really.' (National stakeholder, domestic abuse / VAWG sector)*

> *We understand … what gender informed means more, I think, now … I think it's probably unequal in terms of service provision. I think that different people will view the importance of that differently … It's patchy. (National stakeholder, substance use sector)*

> *My view is there are organisations who are more in-tune with being gender-informed than others, and that in some places it may well be pretty poor, but in some there's people that understand it and are passionate about it and are making it happen. So my impression would be is that it's really patchy. (National stakeholder, homelessness sector)*

The distinction between statutory services and non-statutory services in the implementation of gender-informed approaches was reported to be especially stark; so too that there was variability in the degree of operationalisation amongst voluntary sector service providers.

> *I think we're very far from statutory services being able to say that they're gender-informed, and we often see that services are designed around the assumed male white service user … Government perhaps should be producing a clear definition of what this entails, and providing training for practitioners … Then you look at specialist provision. We do have amazing gender- and trauma-informed specialist services, especially by and for organisations … where … there's really amazing specialist support. (National stakeholder, domestic abuse / VAWG sector)*

On a related point, where attention is focussed on gender in service delivery, this is often attributed (especially in its earliest iterations) to the commitment of highly motivated individuals working at either strategic or frontline levels who are passionate about challenging gender-based inequalities.

> *Specialist women's services will be gender-informed, but the statutory, the generic homelessness services that are provided won't necessarily be, unless there is somebody within the structure somewhere who has a passion for it or acknowledges that it's something that's needed … Often, I think, with services it can be one person who has the idea or has the vision or the ambition, but then if they leave … that goes and has not stayed consistent. (National stakeholder, domestic abuse / VAWG sector)*

> *I still think it remains a pool of people within homelessness organisations that are keen, that are interested, that are motivated, and the rest of the workforce who maybe is less interested, or doesn't care … There is no push for people to learn about how to be gender informed. I think it's still very much people can take it or leave it kind of thing. So it would be great to see organisations make that kind of learning mandatory and put energy and focus into it. (National stakeholder, homelessness sector)*

Whilst levels of interest in gender-informed practice were reported to have been increasing overall, there was a strong consensus amongst local and national-level stakeholders that there remains 'a long way to go' before such practice could justifiably be considered mainstream in any sector.

> *Relative to past decades, we've probably progressed somewhat … Services are gender-informed probably more so than they were in the past, but they're not where they need to be. (National stakeholder, homelessness sector)*

> *There's improvement, but we've got a way to go ... before we could say mixed sex services are gender informed …. It's not just about … women that are accessing the system and our services … As a society we've got work to do, and I think that filters right down. (Local stakeholder, Glasgow)*

> *I think we're a lot further on than we were ten years ago and someway further on than we were five years ago. When I started, it [gender informed] wasn't even a term I don't think … I think the fact that we're talking about gender-informed service provision and what that should look like is positive. (National stakeholder, homelessness sector)*

The distance between where service providers want to be on this issue and where they currently are was generally attributed to be a consequence of limited capacity rather than indicative of an absence of will or intent.

> *Even stuff that people are so signed-up to, so being more gender-informed, being more anti-racist … you get a sense that in this post-pandemic, cost-of-living, load-of-people-in-temporary-accommodation kind of context, it's harder … I'd say people are on a journey, but I think there's still some distance to go. And I also think that pressure on services has a massive impact on the ability of services to be gender-informed, as well as everything-else-informed. (National stakeholder, homelessness sector)*

A number of stakeholders also emphasised that the promotion of gender-informed provision should not be limited to short-term provision of training, but include adequate support for frontline staff and ongoing effort to affect a broader culture change within commissioning bodies and provider agencies.

I think training is one part of it. I don't think it's as simple as just training. I think, depending on the service, it may need to be an entire cultural shift of the service. It needs to be embedded all throughout the organisation, so in their strategic priorities, in their operational management, all the way down to the support work. (National stakeholder, domestic abuse / VAWG sector)

I think the commissioning environment creates certain behaviours and enables services and systems to be set up in a certain way. If we're talking about services being trauma-informed and also gender-informed, that just doesn't mean … training new frontline staff to take a certain approach. For me, it means that you also have appropriate support for staff to work through this. (National stakeholder, homelessness sector)

When reflecting on such issues, a number of stakeholders commented on current anxieties regarding the subject of gender in contemporary policy and legislative debates. Such anxieties, they observed, have been fuelled at least in part by recent high profile debates regarding transgender rights[3]. These appeared especially acute in Scotland given developments and controversies associated with the Gender Recognition Reform (Scotland) Bill[4]. A few stakeholder interviewees argued whilst these debates had arguably elevated the status of gender within policy discussion, fears around causing offence had in fact hindered constructive dialogue regarding how to most effectively meet the needs of women affected by SMD.

Stakeholder 1: I think we had got to a position … where people were understanding … that we had to do things differently … for males, and females. So not one being better than the other, just different … This [transgender rights debate] is confusing for people, and … when people are confused or don't fully understand … that's when people switch off … As soon as you say something about gender or gender-specific, you get a lot of eye rolling. So I think, yes, it's hindered … constructive conversations.
Stakeholder 2: I would agree that it's hindered … There's an awful lot of fear … of being accused of being anti-trans or whatever. Therefore, it coats any conversation with that level of trepidation … You don't want to be seen as doing the wrong thing. So it's just become really charged with emotion that has clouded … the argument, if you like. Because it's like 'We'll just put our head down below the parapet because we don't want to talk about it'. (Local stakeholders, Glasgow)

7.2.3 Provision for couples

It was widely agreed that levels of provision for couples, especially as regards temporary accommodation, is inadequate overall. That said, stakeholder opinion on this subject was divided as regards cases where there were concerns about a female partner's safety. On one hand, some stakeholders argued that the absence of provision for couples was indefensible on grounds that failing to cater for them could leave some women unsupported and potentially exacerbate the level of risk that they are exposed to. They noted that this was especially true in cases where a woman will sleep rough with her partner rather than accept an offer of a single bedspace in a hostel or other form of supported accommodation.

[3] For an overview of debates on this issue see Murray and Hunter Blackburn (2019), Cowan et al. (2021), Murray et al. (2021).
[4] For an overview of the content and progress of the Gender Recognition Reform Bill see Torrance and Pyper (2023).

I think there's more risk to that woman in that relationship on the street … I think there's more that we can do, and the woman can be safeguarded more, if we know where she is, and she's accommodated. Hopefully then she'll engage with services, and we can try and manage it in a safer way. Hopefully, he will engage with services as well … I don't think a woman should be left without services … because she is still trauma bonded to an abusive partner. (National stakeholder, domestic abuse / VAWG sector)

There's a real challenge in women who are in abusive relationships … They're even more at risk because they're street homeless and they're experiencing violence and abuse … There needs to be something for women who are either forced to be in those relationships or, for their own reasons and their own other protective factors, choose to remain with people who are violent towards them. It doesn't mean that they should be kept homeless, but they often are. (National stakeholder, homelessness sector)

In contrast, other stakeholders argued that non-exploitative relationships are extremely rare for women affected by SMD, thus in their view the risks of accommodating couples outweighed the potential benefits. They thereby advocated for the provision of separate accommodation and support for each individual in the partnership.

My experience … has been that there's been very rarely where I've worked with couples, where it's been a genuinely positive relationship … It's been to the detriment of the women more often than not, because either she's been the one that's been at the forefront of feeding both habits, as much as it has been around about certainly being manipulated into trying to access accommodation as a couple. (Local stakeholder, Glasgow)

It's down to an individual's perspective as to what they want to do, but from an organisational point of view, the risks [of housing a woman with an abusive partner] outweigh the advantages and the potential for further power and control, abuse or coercion is just huge. (Local stakeholder, Glasgow)

7.3 Service coordination and joint working

This section focusses on recent successes and challenges in multi-agency working and the factors facilitating and inhibiting the contribution of key actors across relevant sectors.

7.3.1 Progress with joint working

Intensive efforts to improve the coordination of services for women (and men) affected by SMD in recent years were reported to have led to significant improvements in joint working and access to services in all case study areas. Numerous examples were given of positive engagements within and outcomes resulting from multi-agency forums such as Multi-Disciplinary Team (MDT) meetings and Multi-Agency Risk Assessment Conferences (MARACs), for example. In this vein, the Women's Justice Blueprint for Wales (Welsh Government, 2019) and Complex Lives initiative (Belfast City Council, 2022) were noted to have led to marked improvements in cross-sectoral joint working within Swansea and Belfast respectively.

We could put a MARAC in if we felt that she ['Jess', vignette case example] was really vulnerable and we needed to get more support involved, we can do that … The MARAC is chaired by a DI [Detective Inspector] in the police, all services are present. What we tend

to do is share information and a plan is normally put in place as to moving forward. (Frontline staff, Swansea)

I think we're lucky … there is wonderful partnership working in [name of area]. I wouldn't say it's 100 per cent across the board, but there are regular meetings with [housing], the police, with [name of substance misuse organisation rep's] teams, with [name of domestic violence sector rep's team]. We have … Street Vulnerability MARACS. We have all sorts of meetings where agencies are meeting, talking, sharing information. (Local stakeholder, Swansea)

National stakeholder interviewees noted that these reports of improvements were reflective of wider trends across the UK, such that there were many 'pockets' of good practice as regards joint working and widespread appetite to recognise and redress the barriers that women affected by SMD continue to face.

There are pockets of good practice … where the sectors are convening … Where you can bring together those different stakeholders, including the VAWG sector and including specialist organisations … to identify best practice and opportunities for systems change. (National stakeholder, domestic abuse / VAWG sector)

We've seen really big leaps and bounds in the areas where I work. We've done a lot of that work to improve things to try and get consistency to say … 'Let's come together and let's talk about system challenges which are affecting all of us rather than just pointing fingers at each other and saying 'Why aren't you doing this? Why aren't you doing that?'' I see progress, and I see, yes, a lot of challenges remaining really, but challenges which we're trying to constructively acknowledge and do something about. (National stakeholder, homelessness sector)

That said, virtually all staff and stakeholder interviewees expressed frustration regarding the apparent intransigence of many of the barriers encountered by women with experience of SMD, especially given the level of effort expended in attempt to overcome them catalysed by the Women's Justice Blueprint in Swansea and Complex Lives initiative in Belfast for example (see above); so too the development of a Complex Needs service in Glasgow (Glasgow HSCP, 2022).

In fact, the progress made in amending local processes was often said to have led to more effective means of 'bypassing' or 'circumnavigating' existing systems rather than tangible systems change *per se*.

I think everybody is very committed to the [Complex Lives] approach and the model. We always said at the very basics, if we can … get in a room once a week and talk about the most chaotic individuals and how we can respond to them, we'll be doing something right, and we are. However … the aim is not just to work around the system or within the system at an operational level. It's to change it so that we can work with more, and get better, and that's the bit we're not getting to yet. (Local stakeholder, Belfast)

The approach that we've taken a bit in some areas is … creating multidisciplinary teams in the homelessness sphere that have mental health experts and substance use experts that people who are experiencing homelessness can access, without trying to get into the NHS system. But that only gets you so far, unless people within that multidisciplinary team are able to act as enablers into the mainstream NHS system. But at the moment it feels like

that's the only thing that makes something happen. It's really hard. (National stakeholder, homelessness sector)

These ongoing challenges were widely viewed as a key contributor to the shunting between services described by many women with lived experience (see Chapter 5).

They [services] don't seem to fucking talk to each other! … I got offered out-of-[name of city] emergency accommodation I don't know how many times, and because it wasn't in [name of city], it wasn't suitable for me. It's like, 'Right, okay, I'll get there. Well, how in the hell am I getting back to get my methadone tomorrow?' … This is supervised swallow in the chemist … 'That's not our problem.' Well, whose problem is it then?! (Woman with lived experience, Belfast)

I was getting referred to counselling and no one knew what was going on. No one was reading my notes and kept asking me what's going on. What kind of history of mental health have you suffered? It was just crazy. It was like going to a person and starting all over again and then going somewhere else and starting all over again. Just repeating yourself constantly. (Woman with lived experience, Belfast)

It was also notable that successes in breaking down the barriers described above has reportedly often hinged on the goodwill of highly committed individuals who 'go the extra mile' and/or have a level of influence which has enabled them to circumvent bureaucratic procedures at the local level.

The system will say that if there's a procedure to check in and wait, you will check in and wait. Again, we're very fortunate, we have some GPs that are absolutely amazing, but it shouldn't be down to these individuals … They will set a separate time to meet that person who turns up with really challenging behaviour, very aggressive, swearing at people … So that's amazing, but that should be an approach that is open to everybody, not just accidental. (Frontline staff, Belfast)

I think that what it relies on is passionate individuals who make things happen, rather than systems that are set up to enable these things to happen in a systemic way … There are some gems there, where that's happened, but I think the enablers for those are passionate individuals who are able to make things happen, and funding being available … specifically for this cause. (National stakeholder, homelessness sector)

A number of interviewees cautioned that gains are fragile in such circumstances given the high level of staff turnover within both public and voluntary sector services. Equivalent levels of commitment to combatting barriers and promoting systems change on the part of incoming staff is not, of course, guaranteed.

I think it's having the right people … in post that you can have open and honest discussions and dialogue with … It's like with [name of external stakeholder] … we've just been able to have a dialogue … but also not get offended when we don't agree … I think sometimes … those personalities do get offended … and they also hold a grudge. That can have a huge impact if that is the person who's at the helm, or the gatekeeper within a certain organisation. (Local stakeholder, Swansea)

Furthermore, whilst the relaxation of many bureaucratic processes enabling more flexible and 'pragmatic' service delivery during the height of the pandemic had raised levels of optimism regarding

opportunities for systems change, some interviewees expressed frustration that these had since been discontinued despite demonstrating positive outcomes.

> *I feel like during COVID there was some really good stepping up, and people getting around the table, and at a local and regional level just almost getting rid of all the red tape that supposedly prevented them from being able to work in partnership pre-pandemic. It felt that that was really, really positive … It feels like post-pandemic some of those have been maintained, but it has fallen away … in many areas. And that's because of the pressure on the system. (National stakeholder, homelessness sector)*

7.3.2 Contribution of health and social care services

Whilst sympathetic to the resource challenges currently affecting the National Health Service (NHS), interviewees frequently highlighted difficulties in obtaining input from health (and especially mental health) services.

> *One thing we do struggle with is the mental health side of it. Yes, that's because services are thinned to the max, I know that, but it's been historically I would say … You know, I've worked for about 17 years in this field, and predominantly with people with complex needs, and mental health services have always been a little bit standalone. They don't seem to link in that well. (Frontline staff, Swansea)*

> *My psychiatrist is a bit useless, but the [hostel] staff are really helping me try and get her to do her job. One of the staff members done an email to her basically outlining all the things that we feel like she's not doing, and she needs to do, but you see trying to get hold of her is a fucking nightmare. (Woman with lived experience, Belfast)*

One national stakeholder emphasised that this issue was not limited to sectors supporting individuals affected by SMD, but that its impacts were arguably most acutely evident for this population.

> *In terms of bringing people round the table, health has always been a major challenge … But I would say now, being … inside the health system, that that's not an issue that is unique to this population. It's just probably most acutely felt here. (National stakeholder, health sector)*

Input from Adult Social Care in strategic discussions and/or individual case conferences was said to be particularly difficult to elicit. Their absence from relevant 'tables' was widely believed to be symptomatic of resource constraints rather than a lack of will on the part of social workers. The same was said to be true of mental health practitioners (see above).

> *I think mental health … and adult social care services … still remain firmly outside most conversations … And it's not because I don't think they care about this group of women or they don't want to be around the table. Again, they are structured and commissioned to work in a really, really different way, and in a less flexible way. Often, they simply don't have what's needed on offer. (National stakeholder, homelessness sector)*

> *Social services are very poor at attending the [Women's Justice Pathfinder case] conferences, but I think that is a standard at the moment, particularly in our area for MAPPA [Multi-Agency Public Protection Arrangements] meetings, for MARAC. So it's not just the Pathfinder, it's down to staffing and how busy they are. (National stakeholder, criminal justice sector)*

Extensive reference was made to power imbalances between statutory and voluntary sector services. In this vein, a number of interviewees argued that representatives of statutory health and social care services often fail to sufficiently recognise and/or value the relationships that voluntary sector support workers have built with clients (see Chapter 6). The same was said to be true of voluntary sector support workers' detailed knowledge of an individual's specific circumstances and preferences as regards modes of support delivery.

> *There's a power imbalance … in terms of how those services interact. Because often it is the case that people who are working directly with individuals with dual diagnosis … their opinion and how well they know the individuals, and what they know would work in terms of actually getting them support … is not often given the weight necessary by the professionals working within the statutory health and social care services. (National stakeholder, health sector)*

> *I wish statutory services would listen to us a little bit more … One of ours [client] is autistic … They like routine, they like consistency … They [services] keep changing their appointments. That sends them [client] into turmoil. We have to then pick up the pieces of that … I know there's pressures on services, but if we're saying to you somebody really doesn't cope very well with that approach, please listen to us, because we're not just saying it for the sake of it. (Frontline staff, Swansea)*

7.3.3 Information sharing and data protection

Data protection issues were said to severely impede joint working in some areas. Working though the implications of the General Data Protection Regulation (GDPR) for data sharing protocols had proven to be a substantial logistical challenge in some contexts.

> *You get the buy-in at chief exec level … Chief execs are saying, 'We'll make this happen, whatever you need.' Then you spend months in the middle trying to liaise with senior managers and data protection, and within your services too, [to] bottom it out … It's not that the will isn't there. (Local stakeholder, Belfast)*

A number of stakeholder interviewees argued that data protection legislation was frequently used by some (particularly but not only statutory sector) bodies as an 'excuse' to avoid data sharing.

> *I think the multiagency work within Swansea is tremendous, but from my experience … health, it always seems a bit of a tough nut to crack … Health hide behind data protection, hide behind confidentiality and perhaps don't understand what we're looking to achieve by sharing information. (Local stakeholder, Swansea)*

On this issue, it was noted that data sharing often tends to be unidirectional, that is, there is an expectation that voluntary sector representatives share information with statutory bodies, but that this is not always reciprocated. This situation, staff interviewees argued, can sometimes put frontline support workers at avoidable risk.

> *We can share all our information and yet they're [statutory services are] not prepared to share their information … We deal a lot with domestic violence, so we don't necessarily know when a perpetrator is out in the community. They might have moved back in with the client. Statutory services, the police even, we can ring them, and they'll say, 'We're*

not telling you.' We're going out to houses and we don't know that there is a huge risk involved. (Frontline staff, Swansea)

Furthermore, rigid data protection protocols and the legalistic terminology associated with the GDPR were noted to have a detrimental effect on frontline workers' attempts to make referrals and advocate on behalf of the women they support.

I think we just have to be mindful about that the service user's not getting the service they need because GDPR seems to be trumping it a little bit … The classic one is … 'Is your service user with you?' 'No, they're not. I'm their social worker.' 'Well, we're not speaking to you.' … We're supposed to sit down and take them through the privacy notice … even for someone with … high complex addiction, high trauma … [and] ask them … to word a letter to say that, "I give consent for you to talk with thing" … That is verging on the ridiculous. (Frontline staff, Belfast)

That said, staff and stakeholder interviewees emphasised the need to be cognisant of many women's anxieties regarding data sharing, especially where they are concerned that disclosures might impair efforts to gain or maintain access to their children (see Chapter 5). On this issue, stakeholder interviewees highlighted the importance of clearly communicating to service users what support providers are and are not legally required to pass on to public authorities.

Women are saying that on one hand they really wanted information to be shared between agencies. They didn't want to have repeat themselves in terms of telling their story lots of times … but at the same time, there still exists that fear about one agency passing on information to another, particularly where it's social services, and that fear around children and what might happen. (National stakeholder, homelessness sector)

So, I think what we can do better there, and in the third sector, as commissioned services, is to be clear with women around the parameters in which it's safe to talk to us about. Maybe that's just about being upfront about what that criteria is for reporting on to statutory services … I would say to staff … that, if somebody said, ' I want to tell you something, but please don't tell anyone.', that you have to put a caveat within that. (National stakeholder, substance use sector)

7.3.4 Competition and risk

Competition for funding between voluntary sector providers, and even departments within local authorities, was widely deemed to further inhibit collaborative working as various stakeholders seek to promote and preserve access to increasingly scarce funding.

A lot of the distrust across all the bits of the sectors … is because [of] chasing funding pots … There's the fear that somebody loses … their seat at the table … as a result of recommending somebody else … You've got people not saying the right things in meetings because they don't want to give away a bit of a good idea. That's where we've let things to get to, and nobody wants to say that out loud, but that's where things really are. (National stakeholder, domestic abuse / VAWG sector)

it comes back to that issue of funding and people fighting it out for funding … You get different departments within the same local authority fighting it out for different budgets, and that all depends so much on internal politics in each area. So you just need that top-

down approach where there is a recognition that this is all shared funding … otherwise you just get these little fiefdoms. (National stakeholder, homelessness sector)

Some interviewees noted that smaller providers, including some with specialist expertise in addressing violence against women and girls, are often at a disadvantage in competitive tendering processes.

Services are encouraged … to be competitive and they have to bid against one another … That is obviously a hindrance. I think to help we just need to have better partnership working on the whole. That needs to take into account the fact that the organisations with the greatest capacity to perhaps be involved in partnership working often have the greatest resources, which means they're not perhaps the specialist services or the by and for organisations [provided by people with lived experience of disadvantage or discrimination for individuals with similar experience(s)]. (National stakeholder, domestic abuse / VAWG sector)

My personal view is that, where there are contracts for services specifically for women facing multiple disadvantage, that generic providers and housing associations should consider whether they are the best organisation to be bidding for those services, or whether it is right that a specialist provider who has the trust of women in their community, and has built up specialist skills and expertise in this area … is the right organisation to bid for that contract. (National stakeholder, homelessness sector)

It was also emphasised that short-term and insecure funding limits the ability of service providers and other stakeholders to take to take a long-term view of the systemic changes needed to improve the circumstances of women affected by SMD.

The very real inhibitors are the … consistency of the funding and the longevity of the funding …. That really stops you looking down the line and really stops you being able to plan ahead and keep staff secure in their role … When it's all short-term funding, there's much more competition, people are much more siloed and mistrustful of each other, which is really unfortunate in this kind of work. (Local stakeholder, Belfast)

I think obviously everyone would say this, but an end to that really short-term funding [is what's needed] … If everything's on two-year funding cycles … by the end of the first year, they're only starting to build up their reputation, and then they are threatened with ending their contract, and … the staff leave. It's just this cycle that's just really damaging to building an alternative way of delivering services. (National stakeholder, homelessness sector)

A lack of sustained funding was noted to be especially pronounced in Belfast where the hiatus of the Northern Ireland Executive had led to the utilisation of extremely short rolling contracts.

We've literally been rolling on annual budgets since 2015 … There was a year … where it was quarter to quarter that we were operating in terms of budgets. When you talk about complex problems like homelessness, how on earth are you supposed to respond to that with no ability to plan beyond three months ahead…? (National stakeholder, homelessness sector)

There was a strong call from stakeholder interviewees for a greater sharing of risk in policy and service responses to SMD experienced by women. This, it was hoped, should mitigate against the tendency for 'buck passing' between and within sectors.

> *It's not always a resource issue in terms of trying to do things differently. It doesn't always necessarily mean that you need an additional person or an additional resource to do so. At times, it actually is more about shared risk, innovation, being brave and courageous to try things … more so than necessarily a resource implication. (National stakeholder, health sector)*

> *There's a real interesting thing around how when you make a referral to, say, a safeguarding team or a care team, that passed the issue away from me to them. I think the multi-disciplinary, the Complex Lives … staff are saying 'No, this is all our issue, shared risk' … Shared risk in the sense that we've all got to find the solution here. (National stakeholder, homelessness sector)*

On this issue, they emphasised the imperative for responses to be cross-sectoral, and for central and devolved governments to play a leading role in developing coordinated initiatives to resolve and prevent SMD.

> *I think some of these are asks that are applicable across the board … It shouldn't be as hard for there to be cross-departmental or joined-up working at a government level … Some of the issues we've talked about cross the remits of communities, housing, health and justice … So I think that's an ask, particularly in terms of having a more joined-up approach to how they respond. (National stakeholder, health sector)*

7.4 Prevention

A final key theme in conversations was the issue of prevention, and appetite for earlier intervention in particular.

7.4.1 Earlier intervention

Many stakeholder interviewees emphasised that the severity and complexity of disadvantage that women with lived experience of SMD recount result, in part, from the absence and/or inadequacy of support interventions when they first encountered difficulties. Several pointed to the role that effective and timely intervention can play in preventing or at least arresting a detrimental spiral of worsening circumstances.

> *[We need to] recognise that women who have grown up in poverty, who have experienced adverse childhood experiences, are more at risk of growing up to be a woman who does have multiple complex disadvantage and support needs, and … intervene early to try and make sure that they don't reach that point in their life as an adult. (National stakeholder, homelessness sector)*

> *Often their experiences stemmed from one particular incident ... and [they] didn't have the support to cope. That then led them down a path of not having secure housing; engaging in substance abuse, which led them into multiple risky behaviours ... That then exacerbated their traumatic experiences, which they then did not have any support with, and [they] also … became less and less able to access … support that was going to be meaningfully helpful. (National stakeholder, health sector)*

On this issue, staff, stakeholders, and women with lived experience alike expressed strong appetite for further investment in earlier intervention.

> *Where were social work when my mum was neglecting me and my sister, you know? They were fast enough to take my daughter away, but where were they when I needed them? They let me down. My whole life I needed help, and I didn't get it … No one was there. I didn't have a social worker. I never had any workers. Now I've got a surplus. (Woman with lived experience, Glasgow)*

> *They [commissioners] never look at things in the long term, they only ever look at things in the short term. So the short term is always an emergency response to whatever the situation is at that given time … It's a reactive response as opposed to looking at – if we don't do something to help this young woman … then this pattern is going to keep on repeating. (Frontline staff, Swansea)*

The call for a redirection of focus from reactive crisis interventions toward preventative initiatives was particularly notable.

> *We have a reactive rather than a preventative approach … The problem of course is that that's more expensive and more damaging. Rather than trying to think, well actually how would we, more upstream, prevent this from happening? … Trying to find those intervention points at an earlier stage rather than after the fact. (National stakeholder, homelessness sector)*

That said, the challenge in operationalising such intentions in the current fiscal context was widely acknowledged. A number of interviewees noted that funding for early intervention is likely to be at particular risk going forward, and/or that they had already witnessed funding cuts for prevention services in recent years. On this, several local and national stakeholder interviewees who had been working in their respective sector(s) for twenty years or longer noted that the financial pressure on local authorities and central/devolved governments was the most severe they had beheld.

> *We had some momentum around early intervention … and having discussions about redirecting funds from … some of the traditional purchasing to more of the early intervention. What I will say though is the financial position that we are in is I think … that the first things to go will be those early intervention services … It's depressing, but it's real. (Local stakeholder, Glasgow)*

> *Let's be honest, we could all do better with early intervention. I think it is a resources issue … [and] to do with the way we work … It's difficult because there is a lot of people in the system, and there are a lot of issues at the moment, and the cost-of-living and everything else has put pressure on people like nothing before I've ever known. (Local stakeholder, Swansea)*

On a related point, there was a clear call for further investment in prevention or early intervention to be cross-sectoral, so that the burden does not fall to the housing sector which has historically 'carried the can' in resourcing and delivering responses for people affected by SMD (Bramley et al., 2019).

> *What we frequently find is that when you go to the Department of Justice, Department of Health, Department of Education, what they'll say is, 'Homelessness is not our problem. It's the Department for Communities' problem.' The problem there is that actually no it*

isn't … If we're going to have early interventions, we need these departments thinking through practically. How can we collaborate? How can we share information? (National stakeholder, homelessness sector)

More generally, interviewees called for the widening of access to interventions for people who are at risk of SMD but not necessarily in crisis, as well as more proactive exploitation of windows of opportunity for intervention (see also Chapter 6).

We've just done a review of our MARAC [Multi-Agency Risk Assessment Conference] process … for domestic violence. It's interesting because we tend to focus on the high-risk ones … We're not looking at the greens and ambers, to use the RAG [red/amber/green risk assessment matrix] language … If you're only looking at the high-risk ones, you're missing the opportunity to do something … with the people that are on your radar but aren't high-risk yet. (National stakeholder, homelessness sector)

There's always a window of opportunity that presents itself … I think that the prohibitive nature of statutory services and long waiting lists, 'You must do this, and you must do that, you can't access this service until you … deal with that issue', you lose those opportunities all of the time … It's about taking the opportunity when the opportunity presents itself, because if you don't, then it's lost. (Local stakeholder, Belfast)

7.4.2 Critical junctures, red flags, and windows of opportunity

Interviewees drew attention to six critical junctures or 'red flags' which they deemed to represent opportunities for intervention that are frequently missed. The first of these is presence of *disruptive behaviour at school*, especially when this is severe enough to lead to girls' exclusion from school given evidence that it is often symptomatic of experience of abuse and/or poor mental health.

The official data shows that persistent disruptive behaviour is the most cited reason for school exclusions. For young women, we know that that is often rooted in experience of abuse and violence and also poor mental health. It's very different reasons … to why young boys might be excluded … We need to be providing greater support for young women and girls of school age. (National stakeholder, domestic abuse / VAWG sector)

Also with regard to school-age children, several stakeholder interviewees called for increased focus on homelessness and gender-based violence within schools, especially recognition of the range of ways these may be experienced and where help can be accessed.

It would also be really good if, in schools, kids were taught about multiple disadvantage, about homelessness, about domestic abuse, about gender-based violence, about what to do if you're experiencing unhealthy relationships, or things aren't good at home. Because kids don't have the language or the understanding to know that things are really badly wrong until it's too late often. (National stakeholder, homelessness sector)

If we can get education into schools about what hidden homelessness is. First of all, that it's called homelessness if you sofa surf, and that secondly, it's not the only solution. You know, that there are other people out there to help and … not to be frightened of the system. (Local stakeholder, Glasgow)

A second red flag which is potentially indicative of a need for intervention is *problematic drinking by girls during or prior to their early teens*, given that this was a common denominator in the experiences

of the vast majority of women with lived experience and preceded the use of other substances (see Chapter 3).

A third critical juncture highlighted was the *transition when young women leave care*. On this subject, many care-experienced interviewees reported feeling 'adrift' and/or insufficiently supported after leaving care. Many described being ill equipped for adult life and some recounted susceptibility to exploitation from (in some cases much older) men immediately after leaving residential or foster care.

> *When you're 18, yes you're an adult, but you're not an adult … and you don't know what you're doing. I had to learn how to cook myself. I had to learn how to clean myself. You're not taught that in a foster home. They don't teach you anything. They do everything for you. (Woman with lived experience, Belfast)*

> *I was in foster care from the age of … eight until 16 … When I turned 16, that place finished and they dumped me … in a supported carer's place, but she never cared … This is when I met [name], my son's dad. I was 16 and he was 38. I was going missing and sleeping rough with him. It was a weird relationship and we were drinking a lot … They should put you somewhere and then they should help you … do something with your life … I was let down. (Woman with lived experience, Glasgow)*

The lack of support in the lead up to and following the transition from care was also widely criticised by frontline support worker and stakeholder interviewees, especially as regards the disproportionate representation of care leavers presenting as homeless at their local council.

> *It's their 18th birthday and they [care leavers] get sent to us with a bin-bag. That still unfortunately happens. (National stakeholder, homelessness sector)*

> *The majority of the female client group that we work with have been in care at some stage … Every September we get about five or six new people on to the street aged between the ages of 19 and 21 who have been through the care system; and quite quickly start going down the route of alcohol and substance abuse. (Frontline staff, Belfast)*

> *Once they turn 18 … all these services that have been wrapped around them drop away … In some respects we're setting people up to fail ... I think there needs to be an inherent change in the way the social services system works … because it doesn't accommodate that transition. (Frontline staff, Swansea)*

A fourth critical juncture identified was the *transition between child/adolescent and adult mental healthcare*. For some interviewees with lived experience, this handover was described as inadequate, not least because the increased expectations regarding engagement was unexpected.

> *He [Child and Adolescent Mental Health Service psychiatrist] was the best mental health professional I'd worked with … Then when I was 18 I was moved … into Adult Mental Health Services … They don't take a lot of time to work with you. If you don't work with them, they just see you as difficult … When, in reality, you do want the help … It's like you're taking a walk and all of a sudden, the path ends on a cliff, and you have to take that dive off the cliff ... and it's terrifying. (Woman with lived experience, Belfast)*

> *[It's] such a big difference, and the transition from it [Child and Adolescent Mental Health Service] is hard … They just basically say, 'Oh, well, you're too old for CAMHS now, we're*

going to send you to adult mental health services' … So, that's all you get. (Woman with lived experience, Belfast)

Leaving prison was identified as a fifth critical juncture. Frontline support worker interviewees lamented numerous missed opportunities wherein women affected by SMD were released with inadequate and/or insufficiently coordinated support. This issue was noted to be especially acute for women serving short sentences and deemed highly problematic given the scale of challenge women face if/when trying to move away from old social networks (see Section 5.3).

The amount of people released … and the prison are releasing them, knowing they're going to be NFA [no fixed abode] on release - is unbelievable … It's all the time … I think maybe more work needs to be done on the transition of coming out, not just coming back out to the same situation that you went in from ... It's easier for them to go back to the life they know than try and start afresh and move on. (Frontline staff, Stoke-on-Trent)

They seem to go into custody for short spells, and …it can take ages just to even get a visit in, and then before you know it, they're back out again and you haven't really set anything up … Prison is one of those windows of opportunity, because they're not on substances, they're not as chaotic, they've got structure, they've got routine, and that's, sounds awful saying it doesn't it, but that is an ideal situation to be able to … build those relationships, so there's a more positive outcome for when they come out. (Frontline staff, Swansea)

The *removal of children*, was identified as a sixth crucial juncture. On this issue, staff and stakeholder interviewees emphasised that the focus of support tended to be the child(ren) and that there was generally very little if any support for the mother in the lead-up to, during and after removal. The absence of post-removal support was said to be highly problematic given the nature and severity of trauma associated with the loss of children (see Chapter 4).

Once the child's been removed, that's where it [support] ends … There isn't really that back-up support, because … for social services, the child is paramount. It's about the child, it's not about the mother. (Frontline staff, Swansea)

I would say every single female on our books that have had children have got trauma because their children are not living with them … There is nothing … Once your kids have been removed - so the kids are safe - there's no aftercare. (Frontline staff, Stoke-on-Trent)

Social care is there to focus on the child … Then, if they haven't got any workers working with them … whether it's a domestic abuse worker, a substance misuse worker, whoever's working with them … then they are left completely alone. (National stakeholder, domestic abuse / VAWG sector)

Further to this, a number of stakeholder interviewees argued that additional support in the lead-up to and during child protection proceedings would reduce the risk of women affected by SMD losing their children and/or (if removal occurs) mitigate the associated trauma. One national stakeholder interviewee pointed to emergent evidence that peer support for women affected by SMD who have been through child removal can be beneficial in this regard (see also Agenda and AVA, 2018).

In the run-up to the risk of women losing their children, there's very little support for the woman available. It's very prescriptive … The expectation is, 'Well, we're telling you what to do to not lose your children, so you need to go away and do it.' There's very little

support to assist the mothers to do this. So I think there needs to be something in place there as a prevention, a service that supports mums who are in that position. (National stakeholder, domestic abuse / VAWG sector)

[We need] a framework for mother-centred trauma-informed support through child protection services with personal navigators for each woman to … sort out their housing, link them in with the mental health, get them the drug support, but also be their advocate, and be there … handholding throughout this really awful, debilitating process. (National stakeholder, homelessness sector)

7.5 Conclusion

A recent increase in provision of trauma-informed services for people affected by SMD has been welcomed, but stakeholders report that there remains scope for trauma-informed approaches to be embedded more consistently in many contexts. Furthermore, there is strong consensus that, localised pockets of good practice notwithstanding, awareness of gendered aspects of trauma remains limited. Stakeholders emphasised an imperative to upskill the workforce regarding the dynamics and impacts of domestic abuse, gender-based violence, and child removal in particular. This is paralleled by a call for commissioners to be more cognisant of the impacts of gendered trauma and severity of 'injury' that women with experience of SMD have sustained.

The availability of women-only services and spaces is at present highly uneven. There is a strong call for more provision of women-only services which are sufficiently equipped to cater for this population and well placed to provide specialist gender- and trauma-informed support. This is important given that some of women affected by SMD will not use mixed-sex services given fears borne of personal experience of gender-based violence; others will but nevertheless often find the presence of men in these settings anxiety provoking or re-traumatising. Stakeholders also called for provision of more women-only spaces within mixed-sex services, and careful consideration regarding means to ensure the (physical and psychological) safety of women inside and around buildings containing dedicated space.

All that said, interviewees emphasised that sight should not be lost of the broader imperative for all services to operate in a gender-informed way more generally, regardless of the gender composition of their target groups. Awareness regarding the influence of gender on individual needs is said to be growing, and desire to improve practice in this sphere appears relatively widespread, but levels of expertise and interest in gender-informed service delivery remain extremely uneven. Localised pockets of good practice do exist, but the scope for improvement on this issue is vast.

Substantial progress has been made in recent years as regards joint working in all case study areas, and these were believed to reflect wider trends elsewhere in the UK. Local multi-agency initiatives aiming to improve provision for women (and men) affected by SMD have made significant headway in breaking down barriers to service access. A number of particularly intractable barriers persist, however, and stakeholders often lament that achievements to date are frustratingly more symptomatic of the development of more effective 'workarounds' than tangible evidence of systems change. Furthermore, positive developments have often hinged on the intense commitment, goodwill and/or influence of individual stakeholders. Gains are thus precarious given high levels of staff turnover in relevant sectors.

Concerns regarding the implications of new data protection legislation (GDPR) for information sharing, allegations of professional 'snobbery' on the part of some stakeholders in health and social care sectors, and competition for funding were all deemed factors which impede effective joint

working. It is widely agreed that greater involvement of the health and social care sectors (particularly mental health and Adult Social Care) in strategic conversations is required if the tendency for women affected by SMD to be regarded as 'someone else's problem' is to be more effectively mitigated going forward.

Appetite for greater policy focus on prevention is substantial. The threat that current resource constraints pose for investment in prevention is widely recognised, but interviewees nevertheless drew attention to a number of 'red flags' and critical junctures which they regard to be indicative of important, but frequently missed, windows of opportunity for earlier intervention. These include: disruptive behaviour at school (especially when severe enough to lead to exclusion); problematic drinking during or prior to early teenage years; the point of leaving care; the transition from CAMHS to adult mental healthcare; liberation from prison; and the threat or actual removal of children.

8. Conclusion

This qualitative study has examined women's routes into and experiences of SMD with a view to informing the development of interventions to prevent, ameliorate and/or resolve SMD affecting women. This concluding chapter draws together the findings from the in-depth local case studies in Belfast, Glasgow, Stoke-on-Trent, and Swansea, together with national stakeholder interviews. It begins by reviewing key themes as regards women's routes into and experiences of SMD, before reflecting on implications for the commissioning, design, and delivery of support services.

8.1 Women's routes into and experience of SMD

8.1.1 Influence of compound disadvantage on experiences and service response

The study provides compelling evidence that many aspects of women's routes into and experiences of each of the primary SMD domains (homelessness, substance use and offending) are highly gendered. Furthermore, the co-occurrence of these issues, which are typically accompanied by experience of poor mental health and/or domestic abuse, severely compounds the challenges individual women face. For some, their disadvantage is further exacerbated by the intersectionality of other social categorisations or identities, such as being from a minoritised ethnic group, having a longstanding illness or physical disability, and/or experiencing neurodivergence, just by way of example. These domains of disadvantage and individualised attributes coalesce in myriad different ways, but almost always with the same outcome of heightening barriers to mainstream support services.

Recent years have witnessed increased recognition of the inter-relatedness of these disadvantages in policy debate. This has catalysed the investment of intensive effort, requiring deliberative multi-agency working, in attempts to overcome the barriers women affected by SMD face in many areas. That said, many of the successes in this regard are symptomatic of the goodwill of highly committed individuals rather than evidence of tangible systems change. Some mainstream services continue to operate as if oblivious to the existence and/or effects of such inter-relationships. The failure of mental health services to adequately support women experiencing dual diagnosis was singled out for particularly severe criticism in this regard. Local and national-level stakeholders are increasingly impatient (and in some cases irate) regarding the lack of political action on dual diagnosis given the length of time it has been publicly known to perpetuate the exclusion of vulnerable individuals.

A perceived increase in the number and proportion of women affected by SMD who are receiving Personality Disorder diagnoses was highlighted as an issue of significant concern. Anxieties regarding the volume of such diagnoses within this population are founded on scepticism regarding the veracity of many (but not all) such diagnoses, implication that blame for a recipient's extremely difficult circumstances lies in personal deficit or dysfunction (thereby detracting attention from structural causes), and the associated restrictions to support. Even where specialist personality disorder support pathways are available at the local level, these tend to be unsuitable for women experiencing homelessness or living what mental health (and other) practitioners often describe as 'chaotic lifestyles'.

8.1.2 Missed opportunities and critical junctures for intervention

The overlaps in disadvantage reported by women with lived experience were typically exacerbated by the absence or inadequacy of support when they first experienced difficulties. For the vast majority, experience of disadvantage and trauma could be traced back to childhood, with accounts of sexual abuse, physical abuse, emotional abuse, neglect, and/or family dysfunction looming large in almost all

women's narratives. Experience of sexual violence or domestic abuse in adulthood was universal amongst interviewees with lived experience of SMD; some of this was extreme and/or endured over prolonged periods. The loss of children was another source of sustained trauma for many women and the lack of support in the lead-up to, during, and after child removal a key feature in their narratives.

A number of women recalled being familiar with and sometimes (but not always – see below) willing to seek help from services for people facing homelessness or domestic abuse (i.e. council housing departments and/or women's refuges) given their family's experience of these issues during childhood. These women therefore tended to acquire (at least some) assistance comparatively sooner in their life trajectory than others. Others, however, were less familiar with or were fearful of engaging with services and tended to seek assistance only when they had exhausted every other option perceived to be available to them (by sofa surfing or exchanging sex for somewhere to stay for example) or the decision about whether to access help was taken out of their hands (e.g. they were sectioned, arrested, or child protection processes triggered).

The study has drawn attention to numerous missed opportunities for intervention during the lives of women affected by SMD. Most participants with lived experience asserted that more (or different types of) support at critical junctures in their lives would have prevented the accumulation of further disadvantages and/or reduced the severity of their effects. Key amongst these critical junctures and 'red flags' highlighted were: problematic drinking and disruptive behaviour during school-age years; leaving care; transitioning from child/adolescent to adult mental healthcare; and the removal of children (or threat thereof) during adulthood.

8.1.3 (In)visibility of circumstances and inhibition regarding support

This study lends further weight to existing evidence suggesting that the support needs of women affected by SMD are rarely obviously and/or immediately visible to service providers at the first point intervention would potentially have been beneficial. Rather, the difficulties these women are dealing with often only come to providers' attention when they are in a crisis situation, and in more extreme cases not until involuntary intervention is triggered (see above). Some women will go to extreme lengths to conceal or downplay the severity of their circumstances. A number of their actions, such as remaining in abusive relationships or exchanging sex to retain access to shelter and/or drugs to name but a few examples, can expose them to additional risk and perpetuate their experience of SMD.

Fears regarding support services are extremely widespread, and some women actively avoid seeking or accepting offers of help for long periods of time. The tactics of invisibility employed and inhibition experienced as regards engagement with support are often founded on concerns regarding the potential ramifications of disclosing vulnerabilities for current or future access to children. In short, women affected by SMD do not want social services to know if/when they are struggling with issues such as addiction relapse, suicidal thoughts, or domestic abuse for example. Some are forcibly prevented or more subtly deterred from accessing support by a (male) partner. Further to this, attempts to disguise homelessness are often motivated by a wish to reduce the risk of being targeted by predatory men, especially by those women experiencing its most extreme manifestations (i.e. rough sleeping).

Prior negative experiences in support services such as homeless hostels resulting from the intimidating and/or antisocial behaviour of other residents (particularly but not only men) present additional barriers for many women. Some are sceptical regarding the likely effectiveness of services given that previous interventions had made little or no positive difference to their circumstances. Shame and stigma further compound many women's reticence to disclose their circumstances or seek

help from wider social networks (e.g. family) and/or public authorities. Most are acutely aware of the extent to which their lives deviate from societal norms and assume that they will be judged by professionals and members of the public (including their own family in many cases) in stigmatised ways. On a related point, stakeholder interviewees asserted that women affected by SMD are disproportionately susceptible to accusations of being deliberately difficult ('acting up') despite the fact that their responses to extreme distress are entirely understandable.

8.1.4 Perception and experience of services available

The accounts of women with lived experience, together with staff and local/national stakeholders, indicate that there are pockets of localised good practice across the UK wherein women affected by SMD are provided with effective trauma-informed support. A number of services were also noted to offer explicitly gender-informed support, albeit this was considered less well established and/or widespread. The availability of such support was likened to a postcode lottery, however, and the sustainability of such services reported to be under constant threat given the preponderance of short-term funding cycles. The limited availability of these services, and tendency for many statutory services to cater for one SMD domain only (e.g. homelessness, or substance use, or mental health), mean that experience of feeling 'shunted' between services was extremely widespread. This issue was especially acute for women affected by co-occurring substance use and mental health issues.

Participants' detailed accounts of their routes into and through service networks indicate that many women have little if any control over the timing, point of entry, and appropriateness of responses. Critically, the likelihood of receiving a genuinely helpful intervention tends to depend on the capacity, expertise, and/or attitude of service gatekeepers and case managers, as well as the local availability (or absence) of services offering support appropriate to an individual's needs. All of these factors have a strong influence on, for example, the appropriateness of referrals, a woman's willingness to disclose current or past trauma, and whether accommodation provided serves to actually protect her from or (further) expose her to risk of harm. The nature and levels of such risk vary substantially depending on, for example, whether she is allocated to a refuge vis-à-vis mixed or gender-specific hostel, or settled housing provided with or without sufficiently trauma-informed long-term support.

All that said, participants highlighted a number of ingredients that they deemed to be effective in promoting service engagement and increasing the likelihood of positive outcomes for women affected by SMD. These broadly echo those endorsed in prior research on and good practice guidance for extremely excluded populations (e.g. Johnsen et al., 2023; Luchenski et al., 2018; NICE, 2022). They included: the maximisation of choice as regards accommodation and treatment type; use of minimal access and eligibility thresholds; allowance for 'sticky' support with few if any requirements regarding 'engagement'; emphasis on outreach; utilisation of navigators; operationalisation of relational approaches; flexibility enabling rapid response; and provision of long-term support which extends well beyond periods of crisis.

8.2 Implications for the commissioning, design, and delivery of support services

The primary policy implication is an urgent imperative for stakeholders across relevant sectors to share both: a) responsibility for responding to the needs of women at risk of or affected by SMD, and b) any (financial and/or other) risks associated with doing so. Critically, the primary locus of responsibility for action needs to be shifted from the individual women affected – who have been heinously harmed and let down repeatedly throughout their lives – to the policy makers and practitioners charged with redressing inequality and injustice. This will require clear leadership from central and devolved governments, and commitment from all sectors, including health and social care whose input has (with the exception of some localised initiatives) been woefully insufficient to date.

Other stakeholders are mindful of the immense pressures these sectors are under, but the cold hard fact is that until such time as responsibility and risk is more equitably shared, women affected by SMD will remain caught in a pernicious cycle of exclusion and exploitation.

In operationalising such a shift, it will be incumbent on commissioners at national and regional/local levels to create an enabling environment which both requires and sufficiently resources providers to design and deliver services that are appropriately trauma- and gender-informed. Pockets of good practice which is sensitive and responsive to gendered trauma do exist and should be emulated much more widely. Moreover, there is a strong call for more provision of women-only services targeting this population, as well as the further embedding of gender-informed practice across relevant sectors (in both women-only and mixed-gender services) more generally. On this issue, there is a particularly acute need to more effectively equip frontline staff to understand and respond to domestic abuse and gender-based violence, as well as the psychological effects of child removal. Greater use of existing toolkits might usefully support this endeavour (see for example AVA, 2022c; Homeless Link, 2018; St Mungos, 2020; Scottish Government, 2021b)[5].

Greater recognition of the severity of trauma and (relational) injury that women with experience of SMD have sustained and impact on their ability to make use of support services is also required. So too is greater appreciation of the magnitude of the 'ask' being made of such women, given that what is typically framed as recovery is, for many, tantamount to discovery (of self-worth, identity, purpose, trust, and so on). It is thus incumbent on commissioners and service providers to challenge systemic tendencies which 'punish' women affected by SMD, if for example they self-medicate with illicit substances when denied treatment for mental health problems, succumb to relapse (when doing so is a recognised stage in the recovery process), and/or (re)enter abusive relationships when they often remain a target for predatory men even after their homelessness is resolved and/or they are making progress on their recovery journey. Related to this is a prerogative to ensure that the needs of these women are not deprioritised because their behaviour does not evoke sympathy to the same extent as survivors of other forms of trauma (e.g. neglected children or people sustaining a life-changing spinal injury).

There is clear appetite amongst women with lived experience and professional stakeholders for a shift of emphasis from crisis intervention toward prevention, albeit few are optimistic about the likelihood of this eventuating in the current context of severe funding constraints. The issue of resource limitations aside, study findings indicate that investment might most valuably be targeted at key critical junctures and/or indicators of disadvantage (listed above) which commonly present windows of opportunity for earlier intervention. A widespread wish for social services to play a greater role in such interventions is notable, especially when young women leave care and mothers are at risk of having their children removed. That said, sight should not be lost from initiatives targeting perpetrators of domestic abuse and violence against women and girls more generally given their pivotal role in the causation and perpetuation of SMD experienced by women.

This is accompanied by a call for greater recognition and utilisation of the expertise of voluntary sector agencies, and frontline support workers in particular, in responding to the needs of women affected by SMD. Of note here is their reputation for comparatively greater awareness of individual clients' circumstances and success in engaging and remaining in relationships with those who are

[5] Examples of existing resources include AVA's guidance in relation to the removal of children from mothers facing domestic and sexual violence and abuse (AVA, 2022c); St Mungos' toolkit regarding the provision of support for homeless couples (St Mungos, 2020); and Scottish Government toolkit regarding the provision of trauma-informed support (Scottish Government, 2021b). At the time of writing, Homeless Link was developing a toolkit drawing together recent learning regarding the provision of gender-informed services for people experiencing homelessness.

often deemed to be especially 'hard to help' vis-à-vis other (particularly statutory sector) professionals. This expertise, it was widely noted by interviewees, is often undervalued in multiagency forums. Moreover, study findings echo wider calls regarding the importance of adequate support and remuneration for frontline practitioners who work with women affected by SMD given the specialist skills required, intense day-to-day demands of the job, and risk of exposure to vicarious trauma.

Looking forward, consideration of such issues in policy and practice discourse will place policymakers, commissioners, and support providers on a much better footing to be able to prevent, ameliorate, and resolve SMD affecting women.

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Appendix A: Staff Focus Group Vignettes

1. Jess is now 23 and spent a short period in care in her early teens. Jess has stayed in homeless hostels 'off and on' over the past few years but is currently sofa surfing. She is an active heroin user and involved in street-based sex work. Her engagement with services has been described as 'chaotic' and she is very hard to pin down to support her to move on with her housing or ongoing health issues. Jess has spent short periods in prison for minor offences but has never had a lengthy sentence. She often struggles to satisfy the requirements of her probation and services are worried she may be being exploited.

2. Gwennie drinks to problematic levels daily and has a substantial criminal background connected to her alcohol use. Formally homeless, Gwennie now has her own social tenancy. She is 32 and has three children all under 10 years who live with her mother but has little contact with them and is unable to let the children stay over as she hasn't the space. Gwennie's partner stays sometimes but this often results in the police being called due to fights. Gwennie has been hospitalised because of these.

3. Cara is 45. She has slept rough on occasion in the past but is currently staying in supported accommodation. She has four children, all of whom are in the care of the state and she has no contact with them. Cara intermittently uses substances but manages her property and appointments fairly well. She has had no contact with her mother, father and sister since she left home and has hinted to services that this is related to past abuse.

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