MAPPING THE MAZE

Services for women experiencing multiple disadvantage in England and Wales

Contents

Acknowledgements

Women's views on the services they have used and the type of support they would like are at the heart of AVA and Agenda's understanding of how to develop and deliver services that women find positive and effective. Our organisations frequently seek women's views, and in this instance, we are grateful to the women in London, Nottingham and Cardiff who took the time and energy to attend the consultation events arranged by our partners and share their experiences of receiving support at some very challenging times in their lives. The insight offered will add to the growing voice calling for increased provision specifically for women affected by drug and alcohol problems, mental ill-health, homelessness, their involvement in offending and their experiences of violence against women and girls.

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Introduction

Women's and men's experiences of multiple disadvantage are significantly different. Women facing homelessness, substance misuse and contact with the criminal justice system are more likely to have experiences of abuse, violence and trauma and particularly poor mental health[1]. Whilst research directly with women experiencing various difficulties in their lives is somewhat thin on the ground, the messages that expound are consistent: women who have used both generic and specialist women's services routinely express a preference for women-only spaces[2]. Equally, specialist women's services have been found to engage more easily with women that are excluded from other services and to achieve more positive outcomes than generic service providers[3]. However, there is currently no clear national picture of what provision is available for women or how this varies in different localities.

The aim of Mapping the Maze was firstly to map what and where specialist support is available for women affected by substance use, mental ill-health, homelessness and offending and to identify gaps in provision. In addition to providing an analysis of the findings, the services identified have been entered onto an interactive map on the Mapping the Maze website (www.mappingthemaze.org.uk). This resource will be of use to voluntary organisations, commissioners, professionals and other individuals (including service users) to understand what provision is available in their area and to make the case for increased and better quality services.

Additionally, the project aimed to identify a model of good practice for working with women affected by substance use, mental ill-health, homelessness and offending. This was achieved through a literature review, consultation with women who have accessed services for the aforementioned difficulties and professionals who deliver, or campaign for, specialist interventions for women.

This report is split into two distinct sections reflecting the two main research strands: the mapping project and the development of a model of good practice for supporting women affected by multiple disadvantage.

PART 1. Mapping the Maze: a picture of service provision for women experiencing multiple disadvantage includes a detailed description of the data collection and analysis methodology followed by the findings, broken down by support domains: substance use, mental health, homelessness, offending and 'other complex needs'.

PART 2. Developing a model of good practice for supporting women experiencing multiple disadvantage comprises an outline of the methodology, a summary of the literature review findings (the full version has already been published as a separate publication), the findings from consultation with women and key stakeholders, and finally the framework for positively supporting women experiencing multiple disadvantage.

Recommendations from the project are set out in the final section.

[1]McNeish, D. and Scott, S. (2014).Women and girls at risk: Evidence across the life course. London: Lankelly Chase and partners. Available at: https://lankellychase.org.uk/multiple-disadvantage/publications/women-and-girls-at-risk-evidence-across-the-life-course-2/ [accessed 30/04/17]; McNeish, D. and Scott, S. (2016). Joining the Dots: The combined burden of violence, abuse and poverty in the lives of women. London: Agenda. Available at: http://weareagenda.org/wp-content/uploads/2015/11/Joining-The-Dots-Report_Final_b_Exec-Summary.pdf [accessed 20/06/17].
[2]Anderson, S. (2011). A way through the woods: opening pathways to mental health care for women with multiple needs. Advances in Dual Diagnosis, 4(2), pp 63-74; Codd, H., (2016). An evaluation of the 'Vision', 'Avert' and 'Achieve' Interventions, Lancashire: Lancashire Women's Centres (unpublished); Cambridge Policy Consultants, (2016). Women's Experiences of Recovery from Substance Misuse, a review of women's only group therapy. London: EACH. Available at: http://www.drugsandalcohol.ie/25106/1/EACH%20womens%20recovery%20report.pdf [accessed 21/06/17]; Drugscope and AVA, (2013). The Challenge of Change: Improving services for women involved in prostitution and substance use. London: Drugscope/AVA. Available at: https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Challenge-of-change_policy-briefing.pdf [accessed 21/06/17]; Jones, C. (no date). Women Centred Working, Defining an approach. Available at: http://www.centreforwelfarereform.org/uploads/attachment/273/women-at-the-centre-summary.pdf [accessed 21/06/17]; Radcliffe, P., Hunter, G. & Vass, R., (2013). The development and impact of community Services for women offenders: an evaluation. London: The Institute for Criminal Policy Research, School of Law, Birkbeck College. Available at: http://www.icpr.org.uk/media/34025/ReportNuffieldfinal.pdf [accessed 20/06/17].
[3]See footnote 2.

PART 1. Mapping the Maze: a picture of service provision for women experiencing multiple disadvantage

The starting point for this project was the acknowledgement that support services for women experiencing multiple disadvantage are generally scarce, and where they do exist they can be difficult for women to access.

In beginning to collate information about the services specifically designed to support women who experience multiple disadvantage in England and Wales, it quickly became apparent that the task was highly complex. Many of the barriers that women face in identifying services that may be able to assist them were replicated in this academic endeavour.

If you don't know what types of services exist, for example, you may not ask the right questions to get the information you need. You are reliant on the knowledge of the person you ask, and they may not hold the information about a service relevant to you. Even if you are told about a service, you might have to make more enquiries to check if it still exists. You might also not be able to easily confirm if you meet the referral criteria. Moreover, there's a good chance that you won't know if the service is any good. And all this at a time when you might be in crisis, a point at which it is particularly difficult to make decisions or take any kind of action.

The picture of services across England and Wales for women experiencing multiple disadvantage that is painted in the following pages reflects these challenges. There may be services missing as the information wasn't made available. There may be services included that have now been decommissioned, which indeed may happen at an increasing rate across all public sector services as the full impact of austerity is felt. Furthermore, the way in which the data has been analysed and presented in this report mirrors how services for women experiencing multiple disadvantage are structured and funded, namely that:

• services remain very siloed, with most provision falling clearly into addressing substance use, mental health, homelessness or involvement in offending. The majority of more holistic support options reported were located in the voluntary sector.

• the effect of multiple funding sources – local authorities and health commissioners, national funding streams and voluntary sector grants – results in a complex and inconsistent network of provision between, as well as within, geographical areas. This in turn hampers the development of joined-up support for women, particularly those who may frequently move areas.

Overall, the snapshot of services currently available to women highlights how the system further disadvantages them by trapping them within a maze – a confusing jumble of paths that often lead nowhere or that give multiple and competing solutions to different points – rather than supporting them to move along and out of the labyrinth of difficulties that characterize their lives.

Women's experiences of multiple disadvantage vary greatly – whilst some women are able to somehow manage multiple, intersecting difficulties, other women struggle greatly. Different support options are therefore needed and this mapping exercise aimed to identify the full range of specialist services that women may need to access.

It is striking to note that just over one quarter (25.7%) of all the support services identified were specifically for pregnant women or those with a young baby. It is vital that pregnant women, babies and young children are supported and safeguarded, given that pregnancy and the immediate postnatal period is a time of increased risk relating to mental ill-health and domestic violence. However, that such a large proportion of the support available is limited to women at a specific point in their life is concerning. It acts to normalise societal expectations that equate womanhood with motherhood, in turn excluding those without that experience and shaming those women who have had children removed. Moreover, women's experiences of multiple disadvantage are compounded by the fact they experience them as women and we must pay full attention to women's needs and experiences beyond their capacity to reproduce.

The methodology for collating and analysing information about services for women experiencing multiple difficulties is set out overleaf, followed by the key findings of the mapping exercise.

Methodology

Data collection

The primary method of data collection chosen for this study was Freedom of Information (FoI) requests[4]. An advantage of using the Freedom of Information Act 2000 to extract data from public bodies is that they are legally required to reply, which can result in high response rates. A drawback, however, is that the quality and accuracy of the data provided relies on information made available to the person in the public body responsible for responding to the request. It was therefore considered prudent to seek the same information from multiple sources, namely from people who commission services as well as those who deliver services. To further triangulate the data, internet searches were conducted.

Mapping the Maze therefore comprised three strands of data collection:

1. FoI requests to:

    a. various local public bodies across England and Wales that may commission services;
    b. central Government departments that provide funding for services;
    c. health trusts/boards, as the deliverer of health services;

2. a survey circulated to voluntary sector organisations that may deliver services to women experiencing multiple disadvantage; and

3. searches of apposite online service databases of relevant services, plus additional searches using 'Google' where required to fill any identified gaps in the dataset.

Further detail about each strand is set out below.

Freedom of Information request

Between October 2016 and January 2017, FoI requests were submitted to 811 public bodies that potentially fund or deliver services to women affected by substance use, mental health problems, homelessness or involvement in offending (see Box 1).

Of the total 811 requests made, 593 requests were sent to bodies that may have a responsibility to commission or otherwise provide funding for services that support women affected by multiple disadvantage:

• 151 upper-tier and 201 lower-tier local authorities in England
• 22 single-tier unitary authorities in Wales
• 210 clinical commissioning groups in England
• eight central Government departments in England
• a single request to the Welsh Government

In addition, 211 mental health, acute and community health trusts in England and seven health boards in Wales were contacted as public bodies that may deliver services to women experiencing multiple disadvantage. Requests were also sent to all 22 Community Rehabilitation Companies (CRC) in England and Wales, but as private companies they are not subject to the Freedom of Information Act (2000). As a result, only one CRC (Wales) chose to provide information about how they support women.

Box 1: Who funds what?

Funding of public services, particularly in England where there is a mix of unitary and two-tier local authorities, is complex. In broad terms:

Substance misuse services are commissioned by Public Health in unitary or upper-tier local authorities.

Mental health services in England are commissioned by Clinical Commissioning Groups, with additional funding from NHS England for forensic and perinatal services. In Wales the planning and delivery of health services is the responsibility of the Health Boards.

Housing and homelessness services are funded through commissioning and grants in unitary authorities and across upper- and lower-tier local authorities.

Support for people involved with the criminal justice system in England and Wales is funded by various local authority departments as well as through centrally funded National Probation Service and Community Rehabilitation Companies. NHS England is responsible for offender health.

[4]There is increasing recognition of the value of using Freedom of Information requests to increase "scholarly understandings of governmental agencies" (p. 34) in both qualitative and quantitative studies (Walby, K & Larsen, M. (2012). Access to Information and Freedom of Information Requests: Neglected Means of Data Production in the Social Sciences. Qualitative Inquiry. 18(1), pp.31-42).

The FoI request asked for the contact information of any services the authority currently commissioned (or, in the case of health trusts/boards, are commissioned to deliver) specifically for women affected by substance use, mental health problems, homelessness, and/or involvement in offending. For all services identified, further details about capacity and how long the service is funded for were sought.

The response rate for the FoI request was high. Of the 813 public bodies contacted, 667 (82%) responded to the FoI request. Health trusts in England had the highest response rate, with 90% replying. A further 87% (n=133) of unitary and upper tier authorities across England and Wales also replied to the request. The lowest rate of response was from Welsh health boards, of which only four (57%) replied. Figure 1 details the response rate from all types of public bodies that were sent an FOI request.

Figure 1: FOI request response rate (%)
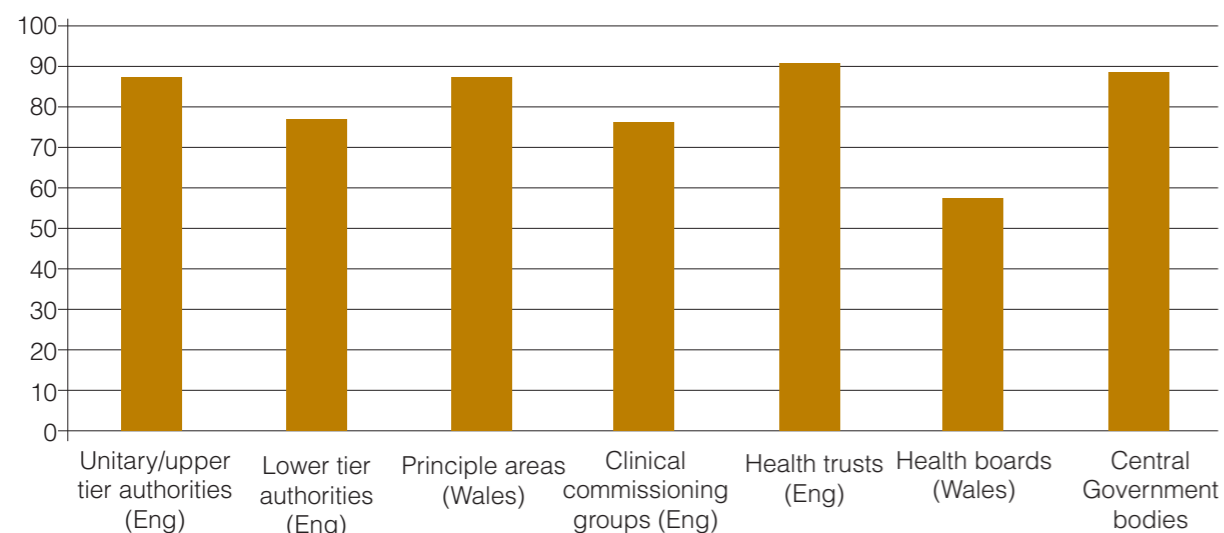
Voluntary sector survey

The voluntary sector survey comprised an online questionnaire created using Survey Monkey software (www.surveymonkey.co.uk). It was made available between January and March 2017 and was circulated through Agenda's and AVA's networks and contacts in the voluntary sector.

The questionnaire followed a similar format to the FoI request, including using the same main questions relating to organisations' delivery of services specifically for women affected by substance use, mental ill-health, homelessness. Additional questions about sources of funding for the services delivered were included.

102 completed survey responses were received.

Internet searches

Internet searches were used to triangulate the data collected through the FoI requests and voluntary sector survey. As an example, three sources provided conflicting information about mother and baby units. A search for the term 'mother and baby unit' using the Google search engine was used to confirm which areas are home to mother and baby units in England. Similar searches were used to confirm the existence and location of approved premises for women, women-only detox and rehab services and women's centres.

Additionally, several databases were reviewed to identify any further services that had not been captured by the other data collection methods. These included directories on the Homeless Link, Clinks and Women's Aid websites.

Data analysis

A database of FoI request and survey responses was compiled using Excel. Additional information from the internet searches was added once all the FoI requests and survey responses had been inputted. From this, individual services were identified, with duplicate reports deleted.

Services were then analysed by service type. Forty-four types of provision emerged from the dataset, with each falling into one of the five domains of support for substance use, mental ill-health, homelessness, offending or 'other'. The latter domain comprised support that more readily identified itself as addressing complex needs, such as support for women involved in prostitution and for women who have had children

removed from their care. At this stage, i.e. once the types of services that exist were known, it was possible to review the criteria for including services in the full data analysis and reporting.

The FoI request and voluntary sector survey asked for information about 'services specifically for women affected by substance use, mental ill-health, homelessness and/or offending'. Two amendments to this description were made to create a clear inclusion criterion:

• 'service' was replaced with 'support' as not all the types of support identified are a separate service. In reality, the vast majority of support found did come in the form of a formal service and so the terms 'support' and 'service' are used interchangeably throughout the report.

• the support must be 'designed and delivered' specifically for women.

The only types of support that was deemed to not meet these criteria was inpatient psychiatric services, including forensic secure units, and prison-based services. Inpatient mental health services were not designed for women but had to be created due to the 2010 requirement for all hospital accommodation to be single sex[5]. Furthermore, forensic secure units may be an alternative to prison, which were also not included in the study as they are not considered to be a form of support.

The next stage was to analyse by data. Local Authority areas in England and Wales (upper tier in two-tier authorities) were used to group services by location. For support that is based in one local authority area and serves the population of that area, this approach worked well. Other services, however, have a single base but take referrals from multiple areas, including some that are open to women from any part of either country, such as drug rehabilitation centres and national helplines. Equally, some support is delivered from multiple bases but are considered a single service (see Box 2 for more details). Therefore, in calculating numbers of support options, each service is only counted once regardless of how many local authority areas it is delivered in or is open to. For mapping purposes, however, services have been mapped where they are physically based, which may mean appearing once or in multiple areas, as this provides a more accurate picture of where local support is or is not generally available. Services that are deemed to be national have been included as one service in the tallying of support options but have not been included on the maps, as this could skew the visualisation of provision at a local level.

[5]Eliminating Mixed Sex Accommodation: From the Chief Nursing Officer and Deputy NHS Chief Executive. November 2010. PL/CNO/2010/3 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215932/dh_121860.pdf [accessed 20/06/17].

Box 2: National resources

Certain types of services have been designated as 'national resources' in this study. This means that they are in theory open to women across England and Wales rather than requiring service users to have a local connection. These are:

• Mother and baby units for women experiencing severe postnatal depression and/or postpartum psychosis
• Residential drug and alcohol treatment centres
• Refuges for women and children fleeing domestic violence
• National helplines such as the Women's Independent Alcohol Support Service that is based in Bristol.

Limitations of data collection and analysis

The data collection strategy included an element of triangulation and the collated information was reviewed on several occasions and analysed in multiple ways to be as accurate as possible. Changes in service provision, however, happen frequently and sometimes with short notice. Furthermore, small organisations that are not well advertised may have been missed.

Illustrating the provision of services on maps also has its limitations. The use of chloropleth maps, which indicate varying levels of provision across areas[6], was discounted for this study on the basis of the aforementioned complexities of mapping services by location. Such maps can also only reflect the numbers of types of provision that are based in a particular area; it does not provide an indication of the level of support offered, i.e. an area that runs a two-hour women's group in a drug treatment service would be coloured in the same way as an area that has an entire women-only substance misuse service. Moreover, the existence of a service in a particular location tells us nothing about the capacity of the service to support women. This information was sought as part of this study but in numerous services – particularly health – there is no limit on how many women they can support at any one time or in a particular timeframe; rather they must simply respond to need.

It was therefore decided to create simple maps that indicate if each local authority area in England and Wales is or is not home to at least one type of localised substance use, mental health, homelessness or offending support services. As such, the primary value of the maps included in this report is to highlight where absolutely no local provision is available, rather than comparing levels of provision across areas where support is available.

A further proviso about the data collected is that the quality of any service identified through this study also

cannot be commented on or guaranteed. Auditing for quality was outside the remit of this project.

It should finally be noted that the maps in this section were manually generated using free online mapping software. Unfortunately, the most appropriate software available did not include the ability to map the 36 metropolitan boroughs in England. These boroughs are represented collectively as their ceremonial county.

Findings

Support for women experiencing multiple disadvantage in England and Wales

Finding 1: All but nine (out of 173) local authority areas across England and Wales are home to at least one type of support for substance use, mental health, homelessness or offending

Finding 2: In only nineteen areas in England (none in Wales) do women have access to support for all of these issues

In total, 528 individual elements of support for women experiencing multiple disadvantage were identified through the FoI requests, the voluntary sector survey and internet searches. 438 services were in England, 12 in Wales and 78 have a national remit, i.e. they are accessible to women from every area of England and Wales. In a reflection of how siloed services remain, the vast majority of support fit neatly into one of four domains: substance use, mental health, homelessness or offending. A smaller proportion of support types (n=95; 18.0% of all services identified) more readily described themselves as addressing complex needs and are outlined in Box 2.

Table 1 provides a breakdown of numbers of support options by domain. Homelessness services appear to be the most numerous across the two countries (n=155; 29.4% of all services identified), with support for women involved in the criminal justice system being fewer in number (n=68; 12.9% of all services). As was highlighted in the methodology section, however, these figures should be treated with some caution. The existence of support offers no indication of the level of assistance available nor how many women can be supported at any one time. The more detailed findings about each of the support domains in the coming pages will offer greater insight into the actual levels of support available.

Table 1: Support by domain

Support domain	TOTAL = 528		By geographical coverage		
	Number	%	National	England	Wales
Homelessness	155	29.4	46	108	1
Mental health	127	24.1	15	110	2
Other complex needs (see Box 3)	95	18.0	0	94	1
Substance use	83	15.7	11	71	1
Offending	68	12.9	6	55	7

Box 3: Other complex needs support

95 services fell into the category of complex needs support. These include i) services specifically designed to support women with 'complex needs', ii) women's centres that historically have been commonly associated with support for women involved in offending, iii) vulnerable or safeguarding midwives who work with women that have a range of additional needs including those related to substance use or mental ill-health, iv) community based domestic and sexual violence services specifically for women with more complex needs, v) support for women involved in prostitution, and vi) support for women who have had multiple children removed from their care.

In terms of distribution of support provision, evidence of some type of support was found in all but nine local authority areas in England and Wales (see Box 4 for more details). For the areas highlighted as having no services, it is worth noting that:

• there may well be support that was not identified in this study, particularly in areas where the local authority or the Clinical Commissioning Group did not respond to the FoI request;
• women in these areas may have access to services in nearby authorities; and
• they may also be able to access support such as refuges and mother and baby units which have been classed as national resources and thus are not included in these figures. This is the case with Poole, for example, which is home to a mother and baby unit.

Nonetheless, these headline figures do suggest that there are very small areas of England and much larger areas of Wales where women may not have any support available to them and this, of course, is problematic.

Between the areas for which there is evidence of some type of support, there is much variation across the two countries. As is evident in Table 2, for example, in the majority of areas in England there is no support specifically for women affected by substance use or homelessness. In Wales, service provision is much more limited, with evidence suggesting that women in only a minority of areas have access to support for substance use, mental health, homelessness or offending.

Box 4: Areas with no evidence of support

England
(n=3, 1.9% of all local authority areas in England)
Poole
Southampton
Thurrock

Wales
(n=6, 27.3% of all unitary authorities in Wales)
Bridgend
Neath Port Talbot
Powys
Rhondda Cynon Taff
Swansea
Vale of Glamorgan

[6] More information about chloropleth maps can be found here: http://www.datavizcatalogue.com/methods/choropleth.html [accessed 20/06/17].

Table 2: Provision of support across local authority areas

Support domain	ENGLAND		WALES	
	Number of areas where local support is available	% (total unitary/ upper tier local authorities = 151)	Number unitary authorities where local support is available	% (total unitary authorities = 22)
Mental health	104	68.9	5	22.7
Offending	97	64.2	9	40.9
Complex needs	81	53.6	1	4.5
Substance use	74	49.0	5	22.7
Homelessness	57	37.7	2	9.1

As the figures in Table 2 also suggest, the diversity of support varies between areas in each country. In England, the majority of local authority areas (n=122; 80.8% of all local authorities) offer support in two or more domains, with the average being 2.8 (mean). In Wales, the density of services was even lower, with only four unitary authorities (18.2%) being home to services that provide support in two or more domains and the mean average being 1.0. Only in nineteen local authority areas in England (12.6% of all local authorities) can women access localised support across all five domains. These comprise:

- six London boroughs (Brent, Camden, Hackney, Islington, Lambeth, Southwark), which appears to be – at least in part – the result of funding for pan-London services such as the four London Rape Crisis centres. The overall average in London was also higher (mean = 3.5) than the national average reported above.
- the county of Surrey.
- three areas in the Tyne and Wear metropolitan county: the city of Newcastle-Upon-Tyne, Gateshead and South Tyneside.
- nine other unitary authorities: Birmingham, Brighton and Hove, Bristol, Kirklees, the city of Manchester, Nottingham, Oldham, St Helens and Trafford.

The concentration of support in some of these areas may be linked to population size, e.g. the city of Birmingham and Tyne and Wear metropolitan county have a population of over 1 million[7]. Another key factor is the location of women's prisons, which corresponds notably with the particular pockets of support in Kirklees and Surrey.

A further consideration about the identified distribution of support for women experiencing multiple disadvantage was the extent to which it correlates with levels of poverty. As a crude measure, the relationship between the number of domains of support an area provides and the area's average index of multiple deprivation score[8]. The correlation for unitary/upper-tier authorities in England[9] was tested using SPSS[10]. A very weak, statistically insignificant (p .176) correlation was found between the number of support domains and deprivation index score. This result is not entirely surprising, given that multiple factors may influence levels of support in any given area.

Coming back to the top line figures, they might appear encouraging but should be treated with a great deal of caution. The following five sections will paint a much fuller – and less rosy – picture about the types and associated levels of support offered within each domain covered in this study.

Substance use support

Finding 1: Just under half of all local authorities in England and only five unitary authorities in Wales report substance use support specifically for women

Finding 2: A weekly women's group within a generic service and specialist substance misuse midwives are the most common types of substance use support found across England and Wales

Data from the National Drug Treatment Monitoring System (NDTMS) indicates that currently around a third of people accessing drug treatment services are women, with the figure rising to almost 40% in alcohol-only support services[11]. Several FoI request responses in this study reported similar figures of female service users in their local drug treatment services.

As such, finding that only around half of all local authority areas in England (n=74, 49.0%) and five unitary authorities in Wales (22.7% of all authorities in Wales) are home to localised support specifically for women experiencing substance use problems is disappointing (Table 2 (p.10) and Map 1 below).

Map 1: Areas with provision specifically for women experiencing problematic substance use
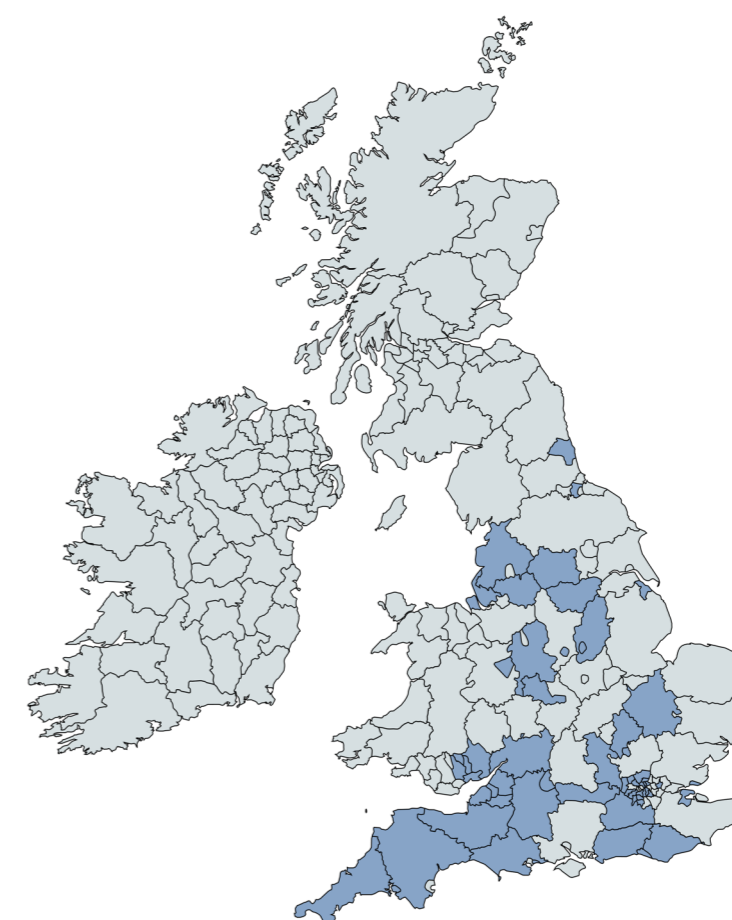
[7]Office of National Statistics (2016). Population Estimates for UK, England and Wales, Scotland and Northern Ireland. London: Office of National Statistics. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland [accessed 30/04/17].
[8]Department for Communities and Local Government (2016). English Indices of Deprivation 2015. London: Department for Communities and Local Government. Available at: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 [accessed 30/04/17].
[9]Average index of multiple deprivation scores for Wales could only be found broken down by postcode and so comparable analysis was prohibited.
[10]SPSS (Statistical Package for the Social Science) is a statistical software package used to conduct complex data analysis.

[11]Public Health England (2016). Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS). London: Public Health England. Available at: https://www.ndtms.net/Publications/downloads/Adult%20Substance%20Misuse/adult-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016.pdf [accessed 30/04/17].

A gloomier picture emerges when the support provided is broken down by type. In total, 83 individual sources of support were identified across the two countries. As Table 3 illustrates, however, a primary reported type of support was a women's group within a generic substance misuse service (n=28, 33.7% of all substance misuse services identified). From the information collected through the FoI requests, the majority of such groups are run on a weekly basis for a couple of hours. It is important to note that such groups generally constitute a space for women to be together rather than being integral to the formal recovery programme within an organisation that is underpinned by a theory or model of support. As described by one stakeholder interviewed for this study, such groups are "*something to tick a box rather than something [organisations] are committed to*".

"…a primary reported type of support was a women's group…run on a weekly basis for a couple of hours."

An equally common type of support for women affected by substance use in England was a substance misuse midwife (n=28, 33.7% of all substance misuse services found). In Wales, this was the most common form of women-only support around substance use mentioned with five midwives being available across Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen. This was an unexpected finding as the existence of so many specialist midwives was not previously known. It is possible that there are more specialist midwives, given that the internet searches conducted for this study found 128 health trusts that run maternity services, including some that specify a specialist midwife whilst their FoI request was returned stating that they deliver no services specifically for women. Moreover, specifically in terms of support for women who use substances, six of the nine identified services that were categorised as 'other type of substance use support' are for pregnant women. In total, this means 40.9% of the

substance use services available (n=34) are for pregnant women. Overall, support for pregnant women and women who have recently given birth counted for just over a quarter (n=136; 25.7%) of all the discrete sources of support identified in this study.

Beyond this, eighteen specialist substance misuse services for women (21.6% of all substance misuse services identified) were identified. Eight community-based services were found in England. Two are run by Brighton Oasis Project (see Case Study 1 on p.13). As the name suggests, the organisation is based in Brighton and Hove, but they have recently opened a second service in neighbouring East Sussex. Two services are based in Luton – the first is based with Stepping Stone and the support available comprises an alcohol mentoring service for women considering making change and group programmes for women using drug or alcohol, and the second is a women's team within the generic substance use service. There is a similar women's team in the generic services in Birmingham.

Three further organisations provide more structured support for women experiencing substance use problems The London-based organisation, EACH Counselling and Support (for more details see Box 5 on p.14) runs three services specifically for women from ethnic minorities who are experiencing problematic substance use alongside various forms of domestic and sexual abuse and the mental distress that accompanies such trauma. Addaction in North Somerset and Cranstoun in Islington also run a structured programme of support for women. Finally, in addition to these community services, ten women-only residential rehabilitation services were also identified. These are discussed further overleaf.

Table 3: Types of identified substance misuse support

Type of support	TOTAL = 83	
	Number	%
Women's group in generic service	28	33.7
Substance misuse midwife	28	33.7
Women-only residential rehabilitation facility	10	12.0
Other type of substance use support	9	10.8
Women-only non-residential substance misuse service	8	9.6

As with each of the support domains covered in this study, the picture of where support is available is complicated by the existence of services that do not require a local connection but are in theory open to women from other areas of England and Wales. In the case of substance misuse, a nationally available helpline for women experiencing problematic alcohol use run by WIAS (Women's Independent Alcohol Support) and ten residential rehabilitation facilities were identified. It was not possible to confirm exactly which areas the residential rehabilitation facilities accepted referrals from, as some have contracts with specific local authority areas. Nonetheless, as they are available to people from outside the area where they are based, they have been classed as a national resource.

Whilst research is lacking about women's stated preference specifically for women-only residential rehabilitation services, the findings of the consultation with women for this study (set out in Part Two) and other research[12] has repeatedly demonstrated that women do want women-only services. As such, it is disappointing that only ten of the 129 residential rehabilitation services listed on Public Health England's website[13] are solely for women. This equates to 7% of all such facilities whilst women accounted for 28.7% of people (n=1024) entering residential rehabilitation in 2015/6[14]. Similar to the lack of women-only community-based drug and alcohol services, there is a clear need to identify if women would prefer – and then be more likely to access – women-only residential support to address their substance misuse.

Case Study 1: Brighton Oasis Project

Brighton Oasis Project (BOP) has more than 20 years' experience of supporting women affected by drug and alcohol problems. The original service was set up in recognition of the fact that a women-only space enables women to feel safer and more able to openly discuss the issues affecting them. Staff understand the many related and complex reasons, such as abuse and trauma, that lead to women using drugs and alcohol. Childcare is provided on-site making it easier for women with children to attend and additional support is also provided to children and young people affected by parental drug or alcohol use. http://www.oasisproject.org.uk/

One of the posited reasons for the lack of women-only substance use provision is that in the current financial climate, there is insufficient funding for separate services specifically for women. This may be true in areas with a smaller drug and alcohol treatment population. In more densely populated areas, particularly large urban areas such as London and Greater Manchester where there are multiple substance use services, an argument could be made for Public Health departments across multiple local authority areas to pool funding for a specialist women-only service. Further reasons for the limited drug and alcohol support specifically for women are discussed in Part Two of this report.

[12]Holly, J. & Scalabrino, R. (2012). "Treat me like a human being, like someone who matters": Findings of the Stella Project Mental Health Initiative Survivor Consultation. London: AVA. Available at: https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Treat-me-like-a-human-being-SPMHI-survivor-consultation-report-June-2012.pdf [accessed 20/06/17]; Women's Resource Centre (2007). Why women only? The value and benefit of by women, for women services. London: Women's Resource Centre. Available at: https://thewomensresourcecentre.org.uk/wp-content/uploads/whywomenonly.pdf [accessed 20/06/17]; A summary of the findings of a consultation with women who have used mental health services conducted by the Women's Mental Health Network includes problems with mixed gender settings - https://www.womenatwish.org.uk/wmhn/key-themes/ [accessed 20/06/17].
[13]http://www.rehab-online.org.uk/england-drug-and-alcohol-residential-rehab.aspx [accessed 06/06/17]
[14]Unpublished data provided through personal correspondence with Public Health England.

Box 5: Diversity and multiple disadvantage

There is very little mention of diversity in the literature around multiple disadvantage. A recent review of women's risk across the lifespan[1] did highlight that women from ethnic minorities are at greater risk of poverty, are the most likely victims of forced marriage and so-called honour-based violence, and are more likely to attempt suicide and self-harm than white British women. There is also evidence that ethnic minority women are at disproportionate risk of custody and incarceration[2].

This project identified almost no provision for women from diverse backgrounds. The only support reported were mental health outreach and engagement projects with ethnic minority women in Hertfordshire, Manchester and Ipswich, and the services provided by EACH Counselling Support. EACH works with diverse communities across London providing specialist services to individuals and families to address their alcohol, drug, mental health and domestic violence concerns. EACH has provided specific support to women, predominantly in the form of specialist therapeutic support around substance use and domestic violence, for a number of years. In 2013 it set up a women-only group. This group differs from many of the women's groups run in generic drug and alcohol treatment services in that it has a more structured programme that aims to empower women to access and engage in treatment. A focus of the group programme is to address the particular challenges women face in accessing support for substance use problems, such as safeguarding and social services involvement, concerns about engaging in group work with male service users, cultural stigma and shame around substance use and mental health, and gender socialisation and values around the expected role of a woman. http://www.eachcounselling.org.uk/

Services for LGBTQI women, those with a physical or learning disability, who are refugees or asylums seekers, were absent in all the mapping data collected. This highlights an urgent need for a better evidence base about these women's experiences of multiple disadvantage and their support needs to inform decisions about funding for future multiple disadvantage services.

[1]McNeish, D. and Scott, S. (2014).Women and girls at risk: Evidence across the life course. London: Lankelly Chase and partners. Available at: https://lankellychase.org.uk/multiple-disadvantage/publications/women-and-girls-at-risk-evidence-across-the-life-course-2/ [accessed April 30th 2017].
[2]Home Office (2007). The Corston Report: A report by Baroness Jean Corston of a review of women with particular vulnerabilities in the criminal justice system. London: Home Office. Available at: http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf [accessed April 30th 2017].

Mental health support

Finding 1: Support specifically for women experiencing mental distress was identified in 104 English local authorities and five Welsh unitary authorities

Finding 2: Most mental health support identified is for pregnant women or women who have recently given birth

In 2002, the Department of Health published *Women's Mental Health: Into the Mainstream*, a strategy for improving mental health services for women. This was accompanied by a national programme of work to alleviate the mental health effects of abuse on women and children. This resulted in mental health professionals working in the NHS being trained in how to respond to disclosures of abuse and a women's lead being identified in each mental health trust in England. Given that women are more likely than men to report experiencing common mental health problems, and thus potentially comprise a large proportion of mental health service users[15], having a gendered understanding of mental health and responding more effectively to the needs of this group of patients is to be encouraged.

Recent research by AVA[16] and Agenda[17] has determined that the long-term impact of the women's mental health strategy and the subsequent violence and abuse work programme was short-lived and that with the exception of inpatient wards and secure units, public sector mental health services continue to be overwhelmingly gender-neutral. The results of this study replicate these findings. Simply reading the FoI requests responses as they were submitted, the view of the NHS as a whole being a universal service, and thus gender-neutral, shone through. Multiple Clinical Commissioning Groups, for example, explained their lack of commissioning services specifically for women on this basis:

"[T]he Clinical Commissioning Group works equitably on behalf of its whole population and does not commission services specifically for women."

"[A]ll our commissioned services are for men and women equally."

"A 'woman experiencing multiple disadvantage' as cited in this FOI request, who is seeking health services, will not…be treated any differently to the rest of the general population and also has the same opportunity to seek specialist services that are not routinely commissioned, to meet her needs."

"[This] CCG does not commission services specifically for women as it does not discriminate on the basis of gender (except for maternity/perinatal)."

Much could be inferred from these responses, particularly in terms of the poor understanding of the need to provide equitable rather than equal access to health services, which does indeed require treating people differently. The final quote, however, is most notable for its reference to maternity and perinatal mental health services.

"[S]upport for pregnant women or those with a young baby totalled 70 (55.1%) discrete sources of mental health support."

As can be seen in Table 4, mental health midwives, mother and baby units and perinatal mental health services (including two in the 'other mental health support' category) combined to account for 70 (55.1%) of all the identified support options specifically for women experiencing problems with their mental health. These figures also strongly contribute to the overall finding that – as already highlighted – across all domains, support for pregnant women or those with a young baby total 137 discrete sources of support, or 25.7% of all the services identified in this study. Despite being the most frequently reported type of mental health service for women (n=38; 31.0% of all mental health services), coverage for perinatal mental health services only reached 62 (41.0.%) local authorities in England and four (18%) unitary authorities in Wales. These figures add to the findings of a recent study commissioned by the Maternal Mental Health Alliance whereby 40% and 80% of areas in England and Wales respectively were found to have no specialist maternal mental health provision at all[18].

Table 4: Types of identified mental health support

Type of support	TOTAL = 127	
	Number	%
Perinatal mental health service	38	29.9
Counselling/therapy	30	23.6
Other type of mental health support	19	15.0
Mother and baby unit	15	11.8
Mental health midwife	15	11.8
Community engagement worker	5	3.9
Peer support	3	2.3
Crisis house	2	1.6

It is notable that, with the exception of The Bromley Women's Service, a psychotherapy service for women survivors of serious sexual abuse run by Oxleas NHS Foundation Trust and Drayton Park Women's Crisis House and Resource Centre at Camden and Islington NHS Foundation Trust (see Case Study 2 for more information), all the mental health services identified in this study for women delivered in the NHS are only for women because of biology, i.e. maternal mental health services and the inpatient wards/secure units excluded from this study, rather than services provided in a gender specific way.

[15]Mental Health Foundation (2015). Fundamental Facts About Mental Health. London: Mental Health Foundation. Available at: https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-15.pdf [accessed 30/04/17].
[16]Holly, J, Scalabrino, R. and Woodward, B. (2012). Promising Practices: Mental Health trust responses to domestic violence. London: AVA. Available at: https://avaproject.org.uk/wp-content/uploads/2016/03/Promising-Practices-mental-health-trust-responses-to-domestic-violence.pdf [accessed 30/04/17].
[17]Agenda (2016). Women's needs in mental health services: A Response to an FOI Request. London: Agenda. Available at: http://weareagenda.org/mental-health-services-not-considering-women-needs/ [accessed 30/04/17].

[18]Bauer, A., Parsonage, M., Knapp, M.,Iemmi, V., & Adelaja, B. (2014). The costs of perinatal mental health problems. London: Centre for Mental Health. Available at: http://www.centreformentalhealth.org.uk/costsof-perinatal-mh-problems [accessed: 30/04/17].

Case Study 2: Drayton Park Women's Crisis House and Resource Centre

Drayton Park Women's Crisis House was set up in 1995 as an innovative alternative to acute psychiatric admission. It is a residential service, designed and run exclusively for women. Staff come from a range of professional backgrounds who focus on the woman and her wider life experiences (in particular trauma and abuse) rather than the diagnosis she has been given. Women have access to alternative therapies and up to four children can stay at the house at any one time. This is in stark contrast to inpatient wards. Today, Drayton Park is the only women's crisis house in England or Wales. The only similar project, Foxley Lane in South London, closed this year. www.candi.nhs.uk/services/drayton-park-womens-crisis-house-and-resource-centre

The relatively widespread availability of gender-specific services in this domain – in a total of 104 local authority areas in England and five Welsh unitary authorities (see Table 2 on p.10 and Map 2 below) – reflects the important role the voluntary sector plays in supporting women's mental wellbeing. The voluntary sector delivers 52 (42.9%) of all the women's mental health services identified, with the support they offer having been created specifically for women on the basis of women-only spaces being a safe, more comfortable environment that women are more willing to access, rather than because of biology. Whilst NHS mental health services include psychology, psychotherapy and trauma services, the aforementioned Bromley Women's Service was the only counselling or therapy service specifically for women reported as being delivered in the NHS. The remaining counselling services identified in the study were all delivered by voluntary sector providers and predominantly for survivors of domestic and/or sexual abuse. It should also be noted that some of these services receive funding from Clinical Commissioning Groups that recognise the need for women-only provision.

Map 2: Areas with provision specifically for women experiencing mental health problems
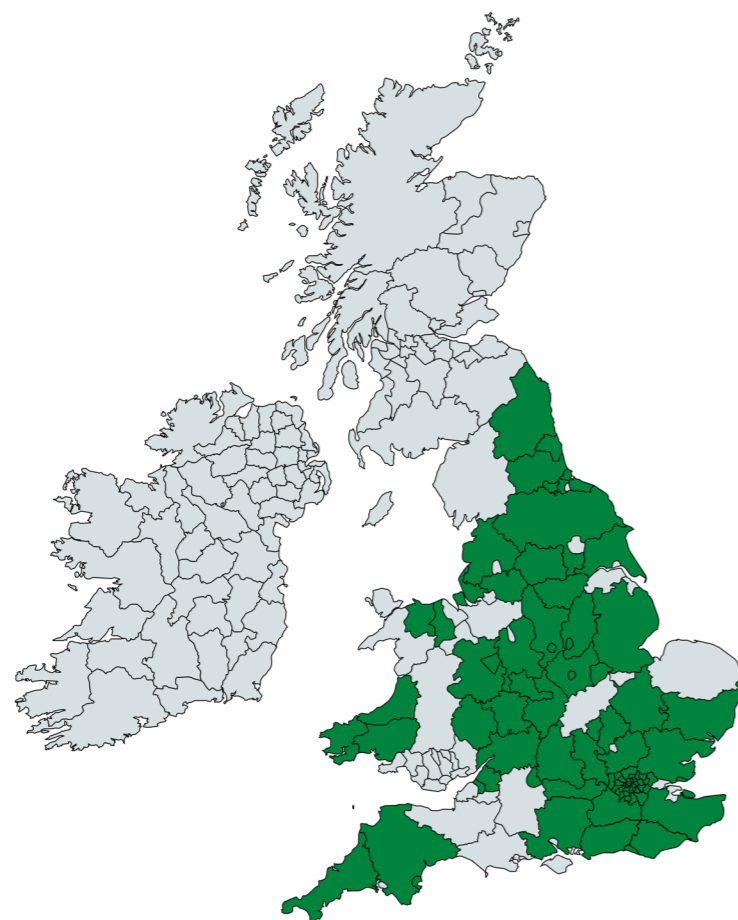
The voluntary sector was home to various additional types of mental health support. These include:

- community workers, particularly to promote engagement with women from ethnic minorities or young women.
- peer support initiatives.
- other support such as women-only drop-ins, groups, maternity clinics, and the advocacy services run by the national women's mental health charity, WISH (see Case Study 3 for more information).

In terms of national provision that is in theory accessible by women across the two countries, mother and baby units are the only such resources relating to mental health. There are fifteen mother and baby units in England; there are none in Wales. Similar to other services that are open to referrals from any part of both countries, women needing to access this type of specialist support may have to travel a long distance to be accommodated and run the risk of being isolated and losing support of family and friends that may be critical to their recovery. There are also issues with the capacity of such services to meet need across the country.

Case Study 3: WISH

WISH: A voice for women's mental health was established in 1987 and is the only national, user-led charity working with women with mental health needs in prison, hospital and the community. It provides independent advocacy, emotional support and practical guidance at all stages of a woman's journey through the mental health and criminal justice systems. It currently offers gender-specific advocacy at the Cygnet Hospital in Sheffield, Waterloo Manor in Leeds, and Calderstones in Clitheroe. Across Greater London, women leaving prison or secure hospital can access WISH's Community Link service. www.womenatwish.org.uk

Homelessness support

Finding 1: Refuge provision was the most commonly reported type of homelessness provision for women

Finding 2: Only 57 local authority areas of England and two unitary authorities in Wales were found to provide accommodation for women that is not a refuge

Collecting and analysing data about support for women who are either homeless or at risk of homelessness is both easier and more challenging than the provision that falls under the other support domains addressed in this study. On the one hand, for example, most homelessness support identified comes in the form of a hostel or supported accommodation that has a single base and a certain intake area. Mapping such services is a relatively easy task.

On the other hand, homelessness support, particularly accommodation, tends to be more holistic by virtue of only being available to people who are vulnerable for reasons such as being the victim of abuse, having drug, alcohol or mental health problems, or due to being released from prison. This gives rise to the question of whether, for example, supported accommodation for women who drink problematically should be classed as support for substance misuse or for homelessness. For the purposes of this study, such support has been put under the domain of homelessness.

Then there is the matter of refuge provision. Refuges offer accommodation and specialist support for women and children who are unable to remain safely in their own home due to domestic violence and other forms of violence commonly experienced by women, such as forced marriage and so-called honour-based violence. Refuges are usually funded through a combination of local authority contracts but also through housing benefit and direct funding from the Department for Communities and Local Government. This could raise an argument for refuges to be categorised as a type of national service provision, alongside the fact that most refuges are open to women from any other part of England or Wales.

Moreover, whilst refuges are a type of homelessness support, the inclusion of generic refuges in this project was the source of much discussion throughout the study. Firstly, they are only accessible to women who are homeless because of domestic violence rather than being open to women who find themselves homeless for other reasons. Secondly, refuges sometimes face criticism due to the restrictions many place on women with higher support needs – particularly around substance use, mental health and offending history – attempting to access their accommodation. AVA's study with Solace Women's Aid of refuge provision in London for women who use alcohol or other drugs or

have mental health problems[19] found that in 2012 many refuges lacked a comprehensive means of assessing a woman's substance use or mental health problems, but rather used the type of substance or psychiatric diagnosis to decide whether a woman was accepted into the refuge. This was combined with a finding that many refuges also operate a partial blanket policy relating to certain types of substance use and mental health diagnoses.

That said, the Women's Aid Annual Survey 2015[20] demonstrated that refuges are accessed by women with more complex needs; on their chosen census day[21] women with mental health support needs make up over a third (33.7%) of refuge residents, and those with drug and alcohol problems constituted 9.7% of women in refuge accommodation. It is unclear from the Women's Aid report, but these figures may include:

- women staying in one of the refuges in England and Wales that have specialist support for substance use or mental health, which currently accounts for between 10% and 22% of all refuges[22];
- women whose substance use or mental health support needs can be met by a non-specialist refuge service, either because they are not too high or by the refuge working closely with other relevant support services; or
- women who were accepted into the refuge as their drug, alcohol and/or mental health support were not identified during the referral process, i.e. they are in the refuge by default rather than being actively accepted into the service.

Taking all these points into consideration, it was agreed that generic refuge services would be included in the study alongside their specialist counterparts. As refuges do not require women to have a local connection to where they are based, for the purposes of this study they have been treated the same as other services that are open to women across the country, i.e. they have been included in the tallies of support provision but not included on maps.

Overall homelessness services were found to be more numerous than the support in the other domains covered in this study. A total of 155 services were identified, equating to 29.4% of all provision. This number is in line with the findings of Homeless Link's most recent review of homelessness services for single people[23], which found 11% (n=130) of the 1,185 accommodation projects identified were women-only. The figures are not directly comparable as some services in this study are for women with children. These include generic refuges, which most often accommodate women with children and were the most frequently reported type of homelessness support, accounting for 40 (25.8%) of all homelessness services in the study (see Table 5)[24]. A further sixteen (10.3%) services were for young parents. If these two types of services are excluded from the total, 99 services remain that predominantly are accessible only to single women (i.e. those without dependent children in their care).

Of the 99 services largely directed at single women, the largest category of provision was 'other' types of service (n=30; 19.4% of all homelessness services). This comprised accommodation described as being for 'vulnerable' women, for those with 'complex needs' or no further details being provided. A reasonably small number of services (n=24; 15.4% of all homelessness services) described themselves as having a remit that specifically matches the issues covered in this study. This includes four services exclusively for women who use drugs or alcohol, twelve that focus on mental health and two – one in Manchester and one in Leeds – were reported as being solely for women with a history of offending. Three refuges for women with complex needs and three for women using substances were also captured[25]- one such service is the Response to Complexity Project in Nottingham, which is outlined in Case Study 4. Whilst women with these support needs are not necessarily excluded from all other homelessness services, this type of specialist provision does appear to be limited in volume.

Table 5: Types of identified homelessness support

Type of support	TOTAL = 155	
	Number	%
Generic refuge	40	25.8
Other supported accommodation	30	19.4
Supported accommodation for young women	22	14.2
Supported accommodation for young mothers	16	10.3
Hostel	16	10.3
Supported accommodation for women with mental health problems	12	7.7
Supported accommodation for women who use drugs or alcohol	4	2.6
Refuge for women with complex needs	3	1.9
Refuge for substance-using women	3	1.9
Supported accommodation for women offenders	2	1.3

Case Study 4: Response to Complexity

In 2011, a review of refuge provision in Nottingham identified the needs for a complex needs refuge. In response to this, a Department of Communities and Local Government funded pilot of a new refuge with four bed spaces and wrap around support from multi-agency specialists, including substance misuse, mental health and homelessness health teams was designed. The Response to Complexity model is innovative in pulling together resources to support women in a fully joined-up, trauma-informed approach. The project evaluation found that of the 48 women referred to the service in a six-month period, six were supported to access settled accommodation and 21 women were 'engaged', i.e. had regular phone or face-to-face contact, with the service.

Harris, L. (2016), Response to Complexity (R2C) – Final Evaluation, (Nottingham: University of Nottingham) http://www.equation.org.uk/wp-content/uploads/2016/12/EQ-LIB-175.pdf

"[A] large number of areas in England (n=94; 60.6%) and the vast majority of Wales (n=20; 91%) appear to have no homelessness services specifically for women.

Women consistently account for up to a third of services users in the homelessness sector[26], not to mention the many women who are hidden homeless. Yet, as highlighted, only 11% of services for single people are women-only[27]. Of additional concerns is the limited spread of homelessness provision. As Map 3 indicates, a large number of areas in England (n=94; 60.6% of all local authorities) and the vast majority of Wales (n=20; 91% of all unitary authorities) appear to have no homelessness services specifically for women.

This is, in part, the effect of excluding refuge provision from the analysis by designating it as a 'national resource'. However, even if refuges are reintroduced into the picture, it still remains bleak, as they are at capacity and turn away approximately one in four referrals on any given day due to a lack of space[28]. Equally, women with more complex needs often cannot be accommodated. Moreover, whilst domestic violence, as well as other forms of violence against women and girls, is a leading cause and consequence of homelessness[29] it is not the only reason women become homeless and refuge is therefore not the only type of gender-specific accommodation that a given area should make available to women.

[19]Harvey, S., Mandair, S. and Holly, J. (2014). Case by Case: Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems. London: AVA & Solace Women's Aid. Available at: https://avaproject.org.uk/wp-content/uploads/2016/03/Case-by-Case-London-refuge-provision-Full-Report.pdf [accessed 30/04/17].
[20]Women's Aid (2016). Women's Aid Annual Survey 2015: the findings. Bristol: Women's Aid. Available at: https://www.womensaid.org.uk/research-and-publications/annual-survey-2015/ [accessed 30/04/17].
[21]Women's Aid census day for 2015 was September 24th.
[22]Routes to Support, the UK violence against women and girls service directory, is run in partnership by Women's Aid England, Women's Aid Federation of Northern Ireland, Scottish Women's Aid and Welsh Women's Aid. The directory listed 276 refuge services in England on May 1st 2017 and of these 63 (22.8%) listed specialist mental health support workers amongst their staff team, 30 (10.8%) listed specialist drug use support workers and 30 (10.8%) listed alcohol use support workers.
[23]Homeless Link (2016). Support for single homeless people in England: Annual Review 2016. London: Homeless Link. Available at: http://www.homeless.org.uk/facts/our-research/annual-review-of-single-homelessness-support-in-england [accessed 30/04/17].
[24]The total number of refuges across England and Wales is, however, much higher than figures reported here. Routes to Support, the UK violence against women and girls service directory, is run in partnership by Women's Aid England, Women's Aid Federation of Northern Ireland, Scottish Women's Aid and Welsh Women's Aid. The directory listed 276 refuge services in England alone on May 1st 2017.

[25]A total of five specialist refuges were identified. This, again, is an underreporting as already noted in footnote 23.
[26]Homeless Link (2013). Survey of needs and provision 2013. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/SNAP2013_Full_Report.pdf [accessed 30/04/17]; Homeless Link (2016), op cit; Hutchinson, S, Page, A, Sample, E (2014). Rebuilding Shattered Lives: The final report. London: St Mungo's. Available at: http://rebuildingshatteredlives.org/read-the-report/ [accessed 30/04/17] op
[27]Homeless Link (2016), op cit.
[28]Women's Aid (2017). Women's Aid Annual Survey 2016. Bristol: Women's Aid. Available at: https://www.womensaid.org.uk/research-and-publications/annual-survey-2016/ [accessed 07/07/17.
[29]Hutchinson, S, Page, A, Sample, E (2014), op cit; McNeish, D. and Scott, S. (2014), op cit; Reeve, K. with Batty, E. (2011). The hidden truth about homelessness: Experiences of single homelessness in England.

Map 3: Areas with provision specifically for women who are homeless or threatened with homelessness
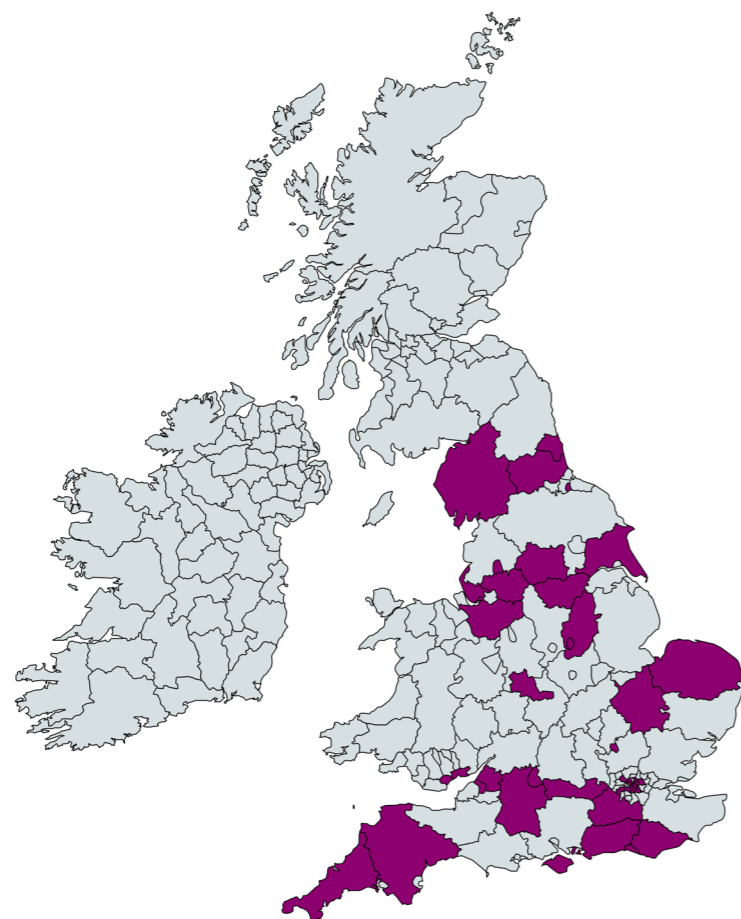
A range of single-sex homelessness provision – with and without support – is necessary. Most commonly this is achieved by designating a certain area of a hostel or other supported accommodation project as women-only. In reality, though, this usually means that several bedrooms and a bathroom are single-sex but the rest of the property is shared between all the residents. Furthermore, women's rooms may be allocated to men if otherwise they would remain vacant. For women who may be very vulnerable, this is not necessarily a safe place to live nor an environment that is conducive to addressing the numerous difficulties they have experienced, or continue to experience, in their lives. This point is returned to in Part Two.

Increased women-only accommodation is needed, whether in the traditional format of shared accommodation or more dispersed properties, as has been set up for women who drink problematically in Leeds. Alternative means of funding should also be considered to counter the perpetual cuts to traditional sources of financing for all types of homelessness provision[30]. A recent strategic guide on the role of local authorities in supporting women with multiple needs[31] highlights the use of social impact bonds and personal health budgets as ways of funding social housing.

Support for women involved in or at risk of offending

Finding 1: Support for women involved in the criminal justice system was found in 64.2% of England local authorities and 40.9% of Welsh unitary authorities

Finding 2: Twenty-three women's centres were found to offer support to women under probation supervision

The Corston Report, a seminal review into women in the criminal justice system[32], was published in 2007. Ten years on, Women In Prison has produced their second audit[33] (the first being on the fifth anniversary in 2012) of the progress made towards the recommendations made by Baroness Corston. Many of the findings of this project reflect the analysis presented in the Women In Prison report.

Specialist services for women involved with the criminal justice system were found to be more widespread in both England and Wales than support under the other domains addressed in this study. In England 64.2% of local authority areas (n=97) and in nine Welsh unitary authorities (40.9%) evidence of support for women with a history, or at risk, of offending was found (see Map 4). A total of 68 services were found across these areas.

The seemingly more extensive distribution of support for women who have had involvement with the criminal justice system does, however, warrant a word of caution. As noted in the introduction, a key limitation of this mapping exercise is that the identification of a service in a particular area offers no indication about the level of support provided nor the capacity of a service. An area is coloured on the map if there is an employment mentoring service or a women's centre providing a holistic and intensive programme of support.

"The seemingly more extensive distribution of support for women [offenders]…offers no indication about the level of support provided nor the capacity of a service."

[30]Homeless Link (2013), op cit; Women's Aid (2016), op cit.
[31]Prison Reform Trust, Association of Directors of Adult Social Services (ADASS) and Centre for Mental Health (2016). Leading change: the role of local authorities in supporting women with multiple needs. London: Prison Reform Trust, ADASS and Centre for Mental Health.
Available at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/localauthoritybriefinglo.pdf [accessed 30/04/17].
[32]Home Office (2007), op cit.
[33]Women in Prison (2017). The Corston Report 10 Years On: How far have we come on the road to reform for women affected by the criminal justice system?, London: Women in Prison. Available at: http://www.womeninprison.org.uk/perch/resources/corston-report-10-years-on.pdf
[accessed 30/04/17].

Map 4: Areas with provision specifically for women who have a history of offending or at risk of offending
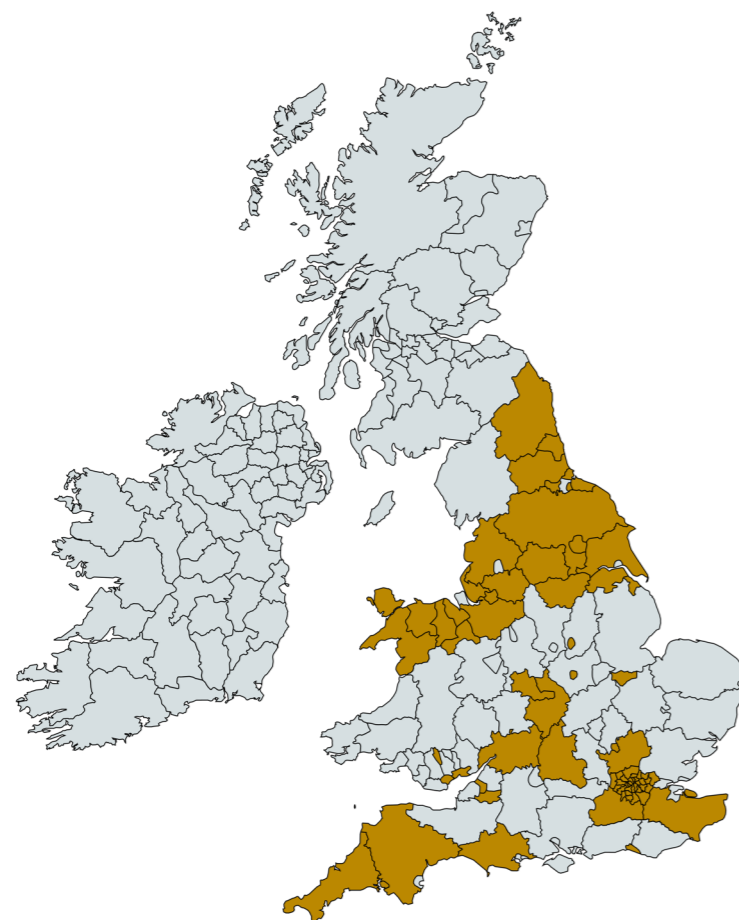
Before discussing the breakdown of service provision in detail, it is important to note that the majority of community services specifically for women involved in the criminal justice system are delivered through women's centres. Women's centres have a varied history, with some having been supporting women in various guises for over 30 years whilst others were set up in 2010 specifically as a 'women's community project', with ring-fenced funding from the Ministry of Justice and Corston Independent Funders Coalition Women's Diversionary Fund. Today, many women's centres offer a range of more generic wellbeing services or complex needs support in a women-only space rather than being restricted to women with a history of offending. As such, the women's centres themselves have been classed as 'other complex needs services' and are discussed further in the following section.

As set out in Table 6, the single most common type of support for women involved with the criminal justice system, for which evidence was found in this study, was gender-specific provision for women under probation. Twenty-three (33.8% of all offending support identified) women's centres were found to hold contracts with Community Rehabilitation Companies[34] to support women under probation supervision. This can include therapeutic groups, courses and one-to-one support. Some centres are contracted to deliver the Women's Emotional Wellbeing Rehabilitation Activity Requirement (WEWRAR), which can be attached to a community order or suspended sentence order as an alternative to a

custodial sentence[35]. Whilst positive feedback about the location of probation supervision and support in women's centres can be found, this must be balanced with the evidence from the organisations running the centres that highlights budget cuts, being asked to do more for less money, and in many cases not being funded to work with women on community orders or early intervention work with women at risk of offending[36].

Nine women's centres were also identified as the location of liaison and diversion schemes for women. Such schemes identify people who have mental health, learning disability, substance misuse or other vulnerabilities and divert them away from the criminal justice system. They have been welcomed by organisations working with women offenders, who advocate that community-based solutions should be standard for women given that the vast majority have committed non-violent crimes[37]. In practice, data published by the Prison Reform Trust suggests women are more likely to be diverted into these schemes, being 22% of those seen by liaison and diversion schemes but only 15% of adults arrested by the police[38]. This is a welcome development, however, as also noted by the Prison Reform Trust, *"[l]iaison and diversion schemes are required to develop specific referral pathways for women, which, to an extent, are dependent on the availability of, and their relationship with, a range of local services"*[39]. As this study has found, there is limited support specifically for women experiencing a range of difficulties in their lives.

Table 6: Types of identified offending support

Type of support	TOTAL = 68	
	Number	%
Gender-specific provision for women under probation	23	33.8
Other types of support for women offenders or those at risk of offending	9	13.2
Liaison and Diversion scheme	9	13.2
Approved premises	6	8.8
Peer support and mentoring services	6	8.8
Through the gate/resettlement support	5	7.4
Employment support	5	7.4
Offender mental health support	4	5.9
Maternity support	1	1.5

[34]21 Community Rehabilitation Companies took over the supervision of low to medium risk offenders from individual probation trusts (that ceased to exist) as part of the Transforming Rehabilitation reforms in 2015. High-risk offenders are supervised by the National Probation Service.
[35]The Nelson Trust Women's Centres run WEWRAR. More information about the programme can be found on their website: http://www.nelsontrust.com/community-based-services/womens-community-services/programme-services/rar/ [accessed 06/06/17].
[36]Women in Prison (2017), op cit.
[37]Women in Prison (2017), op cit.
[38]Prison Reform Trust (2017). Fair cop? Improving outcomes for women at the point of arrest. London: Prison Reform Trust. Available at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Women/Fair%20Cop.pdf [accessed 06/06/17].
[39]ibid, p.7

Whilst the evidence indicates many women's centres have counsellors who work from their premises, the only other area of provision relating to the mental health of women involved with the criminal justice system found by this study (n=4; 5.9% of all support services for women offenders found) falls under the auspices of the Offender Personality Disorder pathway. This programme, centrally managed by NHS England and the National Offender Management Service (NOMS), funds a mix of residential and non-residential services for women in four prisons (which have been excluded from this study along with all prison-based services) as well as the pan-London complex needs service for women offenders who have been diagnosed with a personality disorder, and two further community-based services: Together Women's mentoring and advocacy service across the North West and North Wales, and the mentoring service in Birmingham delivered by Anawim. Anawim provides additional mental health projects that are detailed in Case Study 5.

Case Study 5: Anawim

Anawim's mental health project started in 2012 in response to the high levels of mental health problems experienced by women involved in the criminal justice system. Anawim's mental health team support women in a range of ways, including attending meetings with health professionals, providing individual emotional support, and conducting home visits to women who feel unable to leave their home. Anawim also runs two programmes that specifically address common mental health problems that women experience. The first, *Trauma, Recovery and Empowerment* (TREM), is a 20-week recovery group for women who have experienced trauma. The programme supports women by providing information about the varied impacts of trauma, including on the body and on interpersonal relationships, and focuses on empowering women to trust their own perceptions. The second programme, *Stop and Think*, is a recognised social problem-solving course specifically for women diagnosed with a personality disorder. It provides a safe space to consider ways to manage problems in their everyday life. www.anawim.co.uk

Six services (8.8% of all offending services) were identified that were classed as being open to women across the two countries rather than requiring women to have a local connection. All six of these services were approved premises specifically for women. Two approved premises – Crowley House in Birmingham and Edith Rigby in Preston – were identified in the Department of Health's FoI request as being

Psychologically Informed Planned Environments (PIPEs). PIPEs are similar to the Psychologically Informed Environments that are increasingly commonplace in homelessness services. Both models acknowledge trauma as an underlying root to many of the difficulties people labelled as having 'complex needs' experience in their lives and offer a way of responding more effectively to the psychological and emotional needs services users may present with[40]. As discussed in more detail in Part Two of this report, models of trauma-informed practice are welcomed, particularly when working with women. Nevertheless, as Women In Prison[41] also note in relation to women-only bail hostels, despite being a valuable resource, access to such facilities is extremely limited.

Nine services (13.2% of all offending services) fell under the category of 'other' and included creative workshops, a floating support service, support to reunite women who have been in prison with their children, a programme in Warrington for young girls at risk of offending, and a pan-London services for women with additional mental health or other complex needs run by St Giles Trust.

Other complex needs support

Finding 1: Less than a fifth of services (18.0%) did not fall neatly into four support domains of substance use, mental health, homelessness and offending

Finding 2: The most common type of service identified was women's centres.

A relatively small proportion of services identified (n=95; 18.0% of all support reported) did not fall neatly into the four support domains. In some respects this is because the service has a wider remit, i.e. supports women experiencing multiple disadvantage more generally. More often, however, it is because the primary 'identity' of the women that the services support was not as a drug or alcohol user, as someone with a mental health problem, as someone who is homeless or involved with the criminal justice system. The services that have been placed in this domain are for women involved in prostitution, pregnant women with complex needs, women who are survivors of abuse and have more complex needs, women who have had their children removed, and finally women who experience more severe multiple disadvantage. Each type of services is outlined below.

As can been seen in Table 7, the most common type of service identified in this domain was women's centres. As outlined in the previous section, most women's centres have a long history of supporting women in a variety of ways. In the drive to improve women's experience of the criminal justice system, many centres received funding to become a 'women's community project' and deliver services to women in the criminal justice system. Some new centres were also created at this time. The network of women's community projects originally numbered 46[42]. This study identified 30 centres (31.6%% of all other complex needs services) now in existence. In most cases, however, the centres are open to any woman rather than exclusively for those with a history of offending. This appears to have occurred due to a need to diversify income streams as funding from central Government has dwindled, but also in recognition of the need to provide services to women at risk of offending and to provide a range of support to women from a single base. As such, women's centres are home to various services – such as those described in Case Study 6 below - all of which have been counted individually wherever possible in this study. The decision was taken, however, to also count the women's centres themselves as a separate source of support. This was done in recognition that the centres provide support

to women outside of the specific services they deliver, such as by having a communal area where women may come together, chat, have a cup of tea, or that women may stop by because they need to talk to someone if they are having a difficult time rather than having a formal support worker. As highlighted in the consultation with women that is set out in Part Two of this report, this aspect of Nottingham Women's Centre was particularly appreciated by the women consulted with there.

Case Study 6: The Well Women Centre

Based in the district of Wakefield, the Well Women Centre has been providing a range of holistic services to support women's health and well-being since 1985. Today, women in the Wakefield area can access counselling, courses on topics such as managing anxiety, understanding anger and using creativity to express yourself, peer support groups and complementary therapies in a woman-only space. The Centre also runs dedicated services specifically for women from ethnic minorities, young women at risk of sexual exploitation, and women with multiple and complex needs. www.wellwomenwakefield.org.uk

Support for women involved in prostitution was the second most common service type in this domain, accounting for just under a quarter of all the services (n=24; 25.3%). With the exception of Safer Wales' Streettalk service in Cardiff, all the services found were located in England. In terms of the forms of support offered, a range was reported including outreach and harm reduction support, drop-in services, more intensive individual keywork and advocacy services (see Case Study 7 for more details of how One25 provides these services in Bristol). Counselling support was also mentioned, including the London-based Streettalk counselling service. Nia's Safe Choices service, providing intensive support and a structured group work programme to young women experiencing, or at risk of, sexual exploitation, gang involvement and/or violent offending, was also included in this category.

[40]Breedvelt, J.F, (2016). Psychologically Informed Environments: A Literature Review. London: Mental Health Foundation and St Mungo's. Available at: https://www.mentalhealth.org.uk/sites/default/files/pies-literature-review.pdf [accessed 30/04/17].
[41]Women in Prison (2017), op cit.

[42]Ministry of Justice (2010). Diverting Women Away from Crime: A Guide to the Women's Community Projects. London: Ministry of Justice. Available at: https://www.cps.gov.uk/legal/assets/uploads/files/diverting_women_away_from_crime.pdf [accessed 30/04/17].

Table 7: Types of other complex needs support

Type of support	TOTAL = 95	
	Number	%
Women's centres	30	31.6
Support for women involved in prostitution	24	25.3
Midwives who support women with complex needs	15	15.8
Other complex needs support	11	11.6
Community-based domestic and sexual abuse services for women with complex needs	8	8.4
Support for women who have had children removed from their care	7	7.4

In addition to the specialist midwives who support women affected by substance use or mental ill-health already reported, fifteen midwives (15.8% of all complex needs services) whose remit includes women with complex needs more generally – including those using substances, with a mental health diagnosis, those who are homeless, refugees and asylum seekers, women with a learning disability and women who are HIV positive – were identified.

Eight community-based services for survivors of domestic and sexual abuse with complex needs and more generic complex needs services were identified (8.4% of all other complex needs services). Generic domestic and sexual abuse counselling services and refuges for women using substances and/or those with complex needs have been outlined earlier in this report, falling under the domains of mental health and homelessness, respectively. The community-based services for survivors with complex needs comprise i) domestic violence workers in two substance use services[43], ii) a specialist sexual violence outreach service run by Rape Crisis Surrey and Sussex, iii) Berkshire Women's Aid's complex needs domestic violence outreach service, iv) three counselling services for survivors with complex needs, and v) an Independent Sexual Violence Advisor for women with a severe and enduring mental health problem.

Case study 7: One25

One25 is a Bristol charity for women involved in street-based prostitution. They provide night out-reach, a drop-in centre and casework to over 200 women a year. The night outreach service is de-scribed as 'a life-line' for the women still involved in prostitution in the city. The drop-in centre, open in the afternoons, offers a range of support from basic needs such as food, clothes and healthcare, to advice and crisis care. Caseworkers provide in-dividual care in any area of need the woman has. A key aspect of the support they provide is the care they show women. As one service user describes: "I got food, a hot drink and a bit of warmth – they showed me the first glimmer of love, care and ac-ceptance I had known for a very long time." www.one25.org.uk

In terms of services for women with complex needs more generally, these eleven services were distributed across England from EACH's complex needs service in the London Borough of Ealing to the Derby-based service delivered by Women's Work. More complex needs services for women were expected to be found as a result of the Making Every Adult Matter areas and the Big Lottery's Fulfilling Lives programme[44]. The latter programme is funding initiatives in twelve areas across England with the aim of more effectively meeting the needs of people experiencing multiple and complex difficulties in their lives. However, in only one area (Brighton and Hove, Eastbourne and Hastings) do women appear to be explicitly identified as a specific target group.

The final type of support found in this study was a small number of services for women who have had their children removed (n=7; 7.4% of other complex needs support). With the exception of the Space Project run by Cambridge County Council, the other support identified are services run by Pause, a national organisation that has received direct funding from the Department of Education. Their website states plans to expand the service to 43 areas in the next five years. The Pause model includes a requirement for women to use Long Acting Reversible Contraception (LARC). This requirement has given rise to some criticism, particularly from the women's sector, as it is viewed as running contrary to the generally empowering ethos of women's organisations. The director of one women's organisation who was interviewed as part of the Mapping the Maze study set out the main objection: *"I don't have a problem with women using LARC but I do have a problem with not providing a service to women who don't want to do that. And it almost cherry picks the women. The Government has put a lot of money into Pause without enough thought."*

Map 5: Areas with provision that address other complex needs
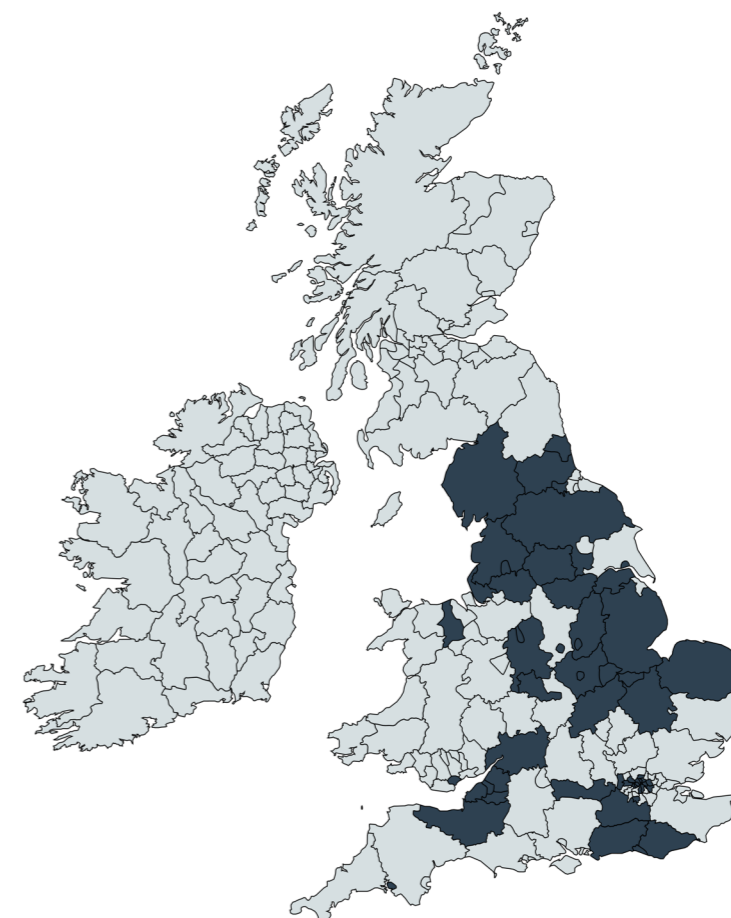
[43]The Welsh Government reported in their FoI request that they part-fund Independent Domestic Violence Advisors in substance misuse services in six unitary authority areas: Conwy, Denbighshire, Flintshire, Gwynedd, Isle of Anglesey and Wrexham. As these services are not gender-specific they have not been included in the findings of this study.

[44]https://www.biglotteryfund.org.uk/prog_complex_needs

PART 2. Developing a model of good practice for supporting women experiencing multiple disadvantage

The second part of the *Mapping the Maze* project comprised an exploration of what constitutes a 'good' service for women experiencing multiple disadvantage. This was achieved through a literature review, a consultation with women using a range of services in three areas of the two countries covered in the project, and interviews with key stakeholders with expertise in the issues addressed in the study. From the data collected, the *Mapping the Maze model* of supporting women experiencing multiple disadvantage was developed. As is evident by the concluding section of the stakeholder interview analysis, the *Mapping the Maze model* is not, however, the end of the road. Much work is needed for all services to adopt the gender-sensitive and trauma-informed approach that this project concludes is needed. Beyond this, further work is essential to identify what services are required in a given area to best meet the needs of women facing a range of difficulties in their lives.

From the wealth of data held in the following pages, three key points stand out as warranting particular mention. Firstly, the unanimous belief amongst the women who participated in the consultation that *"100% I think women's services are better"*. Moreover, as one woman stressed *"[w]e deserve better…we deserve to have people like you [i.e. a specialist women's service]."* Secondly, in some respects it is quite hard to identify what makes women's services better. One stakeholder described visiting a women's centre in the north of England as a *"fabulous place where you want to stay"* but what exactly made the *"vibe"* of the service so positive was hard to unpick. Equally, the qualities of the staff that are instrumental in creating an environment that women want to engage with were also somewhat elusive. This suggests that replication of services, of models of provision, must be approached with great care to ensure success.

Finally, from both the women who use services and the professionals who work in the services, one final message was made very clear: specialist services for women experiencing any kind of disadvantage are woefully under-resourced. Services are increasingly limited in the support they can offer as the number of people needing assistance rises whilst funding gradually evaporates. This impacts directly on service users. As one woman described of her stay in a refuge: *"This young girl came with….burns all over her. She was in such a mess. But there was no one there. No staff there at the weekends at all. . And I was left to try and help her. Which was hard because I was in a mess myself. By the end of the day both of us was in tears."*

The impact of the additional pressure placed on frontline professionals by the lack of resources was also noted by one woman: *"You can hear them sigh when you knock on the door."* For a woman whose self-esteem may already be at rock bottom, feeling that her presence is unwanted by professionals who are supposed to be supporting her can be very damaging. Moreover, however, working in such a stressful environment raises the risk of staff burning out and taking long periods of time off sick, which then directly jeopardises the critically important relationships they may have spent many weeks and months establishing with the women. There is an urgent need for funding contracts and grants to include sufficient resources for staff to be fully supported to continue assisting women facing multiple disadvantage.

Methodology

The process of developing a model of good practice for working with women experiencing multiple disadvantage comprised three strands of investigation:

- a literature review of the core components of a gender-sensitive service for women experiencing multiple disadvantage;
- consultation with women who have lived experience of multiple disadvantage; and
- interviews with professionals who have expertise in the delivery of services for women experiencing multiple disadvantage.

The literature review was carried out first to provide a guide for the topics to be covered in the latter two stages of this part of the study. The methodology for each strand is set out below.

Literature review

The literature review took as its starting point the five areas of disadvantage faced by women set out in the pivotal report '*Women and Girls at risk: evidence across the life course*'[45], namely: contact with the criminal justice system; experiencing homelessness; involvement in prostitution or sexual exploitation; experiencing severe mental health problems; and experiencing serious drug and alcohol problems. For the purposes of this review, the definition of disadvantage was also extended to include all forms of violence against women and girls, particularly given how closely experiences of violence and abuse are associated with the other issues covered in this study.

A small-scale systematic search strategy was employed. To be included in the review, documents had to meet the following criteria:

- Discusses service delivery for women (18yrs+) addressing *one or more* issue relating to homelessness, substance use, criminal justice system, mental health, prostitution, violence and abuse.
- Discusses service delivery for women in terms of any of the following:

1. Organisation values/service philosophy (includes core principles)
2. Service environment
3. Staff skills and competences
4. Programme components

- Qualitative, process evaluations, effectiveness studies if they contain process evaluation or qualitative component, literature reviews, personal accounts of women with lived experience, materials produced by specialist organisations or health and social care practitioners, policy document, service audit/assessment tools.
- Peer reviewed, non-peer reviewed publications, grey literature[46] and material produced online, published and unpublished material.
- National material and international material in English from high-income countries.

The identified documents comprised both peer reviewed and unpublished material. Fourteen articles met the inclusion criteria from the academic databases and a further 55 documents were found elsewhere spanning a wide range of research knowledge such as mixed method evaluations including social return on investment, service reviews, and national service standards. A large part of the literature involved testimony from women accessing services or with lived experience of multiple life stressors.

Consultation with women with lived experience of multiple disadvantage

In September 2016 three consultation meetings with a total of 27 women with lived experience of multiple disadvantage were conducted in Cardiff, London and Nottingham. The consultation meetings were run by partner organisations in each of the locations:

- Llamau, a housing association in Wales with a specialist women's service. Eight women attended the meeting in Cardiff.
- Nottinghamshire Women's Centre, which is home to a range of support for women across Nottingham and Nottinghamshire. Ten women attended the meeting in Nottingham.
- Solace Women's Aid, a domestic and sexual abuse charity working across London and which runs a specialist refuge for women with complex needs. Nine women attended the London meeting.

Women were recruited from among the organisations' own service users and through partners.

[45]McNeish, D. and Scott, S. (2014), op cit; Reeve, K. with Batty, E. (2011). The hidden truth about homelessness: Experiences of single homelessness in England. London: Crisis. Available at: http://homelesshub.ca/resource/hidden-truth-about-homelessness-experiences-single-homelessness-england [accessed 30/04/17].
[46]Grey literature means written material that is not peer-reviewed books and journals.

To promote consistency across the three sites, the partner organisations were provided with detailed guidance pack[47] on how to run the consultation meeting which also included a recruitment poster, participant information sheet and consent form. Formal ethics approval was not sought for the consultation meetings but the facilitators in each area were asked to follow a clear ethics protocol with actions relating to participant consent, data protection and the importance of safeguarding the participants' wellbeing. Each participant was compensated for their time and any travel expenses. Crèche facilities were made available where needed.

The meetings all lasted approximately 1.5 hours with a break in the middle. The format was semi-structured and the topic guide was informed by the findings of the literature review. As such, the questions focussed on the women's general experiences of services and individual professionals, and their views about the need for services to be gender-specific and trauma-informed. The meetings were recorded and the facilitators also provided written notes of their observations, both in terms of what was said and the dynamics between the women. The recordings and written notes were securely sent to the researcher, who transcribed and reviewed all three recordings, along with the accompanying notes, several times to allow for immersion in the data. Thematic analysis of the data was then undertaken.

Consultation with professionals

Between September 2016 and February 2017, individual interviews with 29 professionals with expertise in either/ or the delivery of services to women experiencing multiple disadvantage or in a related policy field were conducted. The professionals were identified using a snowball sampling strategy starting with the members of the project advisory board. The interviews were conducted by telephone or Skype, with the exception of one group interview with midwives that was conducted in person. Participants were sent consent forms in advance and asked to return them before the interview.

The interviews all lasted around one hour. Similarly to the consultation meetings with women affected by multiple disadvantage, the format was semi-structured and the topic guide covered key points from the literature review. The focus of the questions, however, was on how to practically deliver services that are accessible to women experiencing numerous difficulties in their lives as well as the strategic challenges involved in meeting the needs of this group of women. The interviews were recorded and additional notes taken. The data were then thematically analysed.

Findings

Literature review

The review highlighted that, regardless of which sector a service is based in, women are likely to present with a myriad of support needs. Women tend to enter some services (e.g. homeless and social support services) at a later stage than men, when problems have escalated significantly and they may be less ready to begin their recovery journey. Despite widespread evidence of the multiple forms of negative life experiences that women accessing health and social care services face, dominant service delivery models do not address the complexity of many women's lives in an integrated manner.

A number of key themes emerged from the review:

- The values and approaches underpinning the delivery of different services are as important as the delivery itself. This is neatly summed up by the mission statement of one Women's Community Centre which "seeks to work with partners and other agencies to challenge that which degrades and diminishes women".

- The quality of relationships emerges according to what women often value most in the provision of services. In particular, non-judgemental attitudes by staff were identified by both service users and practitioners as being important for building trust and successful relationships.

- The most successful services worked from a strengths-based empowerment model. The avoidance of behaviours that may replicate those of a woman's abuser is particularly important for women who have experienced controlling relationships from family members, intimate partners or pimps. Progress is also facilitated by relationships built on faith in the positive possibilities that each woman is capable of achieving.

- These approaches work best when they go hand in hand with practical service delivery which is holistic, addresses the multiple needs of women and is offered in a women-only space.

- Emotional safety can only be fostered when physical safety is provided. For women who have experienced violence and abuse, the male-dominated nature of many day centres and mixed gender substance treatment services makes them threatening and frightening. Women-only spaces are deemed crucial to facilitate safety on both an emotional and physical level.

- Holistic and needs-led interventions, where women do not have to identify and isolate specific issues to receive a service, emerge as a key theme, which is in stark contrast to the basis on which most services operate.

- Given that every woman's life, experiences and needs are different, it follows that holistic service provision means different things to different women, and so need to be tailored appropriately. This means collaborative and proactive working with a range of specialist organisations, and that staff need to be trained and supported to understand all the key issues and how they are related. This includes being aware of the individual but also relational and social contexts in which women operate.

- For Black and Minority Ethnic (BME) women, specialist BME services are highly valued and should be part of a tailored support package for this group of women.

- Women value having staff to advocate on their behalf with a wide range of external services, such as child protection and housing.

The review also explores the relevance of trauma-informed care principles in developing gender-sensitive services. Trauma-informed care is a "strengths based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment"[48].

The term is now well established within North American behavioural services and with its five core principles of trauma awareness, safety, trustworthiness, choice and collaboration, and building of strengths and skills clearly has much in common with the gender-focussed approaches explored in the review. Most significantly, in common with women-centred working, the trauma-informed approach recognises the wider socio-political influences in women's lives. What it adds to other models is an increased focus on the need to address the psychological impact of trauma in service delivery.

The review concludes that the way a service is delivered is as important as what is delivered, and highlights the strength of trauma-informed services and compatibility with women-centred working. It ends by identifying several gender-sensitive service assessment tools.

The full literature review can be downloaded from the Mapping the Maze website: www.mappingthemaze.org.uk.

Women's voices

The women consulted for this project had had contact with a range of support providers including various types of supported accommodation, primary and secondary mental health services, primary care services, substance misuse services, domestic and sexual abuse services, probation and the police. In response to general questions about their experience of services and several questions specifically about women-only and trauma-informed support, the women painted a consistent picture of the particular qualities of the good services they have encountered. Five key themes emerged from their discussions that strongly reflect the findings of the literature review. Each theme is discussed in detail below.

1) Caring people and relationships are paramount

The predominant theme across the three groups of women was the importance of people delivering the services they have contact with:

"What makes it a service: THE PEOPLE!"

"It comes down to my keyworker rather than the organisation."

There was also the recognition that having a positive experience with professionals was, to a degree, down to luck as it is a very individual experience:

"[I]t's like if you click with somebody, you're more likely to trust them. It's human nature sadly. You're not just going to click with everyone."

At the same time, the aspects of service delivery that the women valued most came through clearly in their discussions. In contrast to services where women described themselves as being treated as "a file" and "a number in a system" by people who "don't care… [a]s long as they get paid at the end of the month", the fundamental characteristic of a 'good' service is one where the professionals genuinely care about what happens to the women they have contact with:

The manager after a couple of days came and introduced herself, had a cup of coffee. [Other places] the manager has never even spoken to me…you know that personal how are you getting on, how are you feeling, I really felt like I was going to be taken care of. And you need that when you are feeling so desperate."

"[My keyworker] genuinely gave a shit about your life. She knew what you were doing, what you are interested in. She took the time to get to know you as a person and not just a case. She would feed you. She was so warm. You felt very homely around her. Whereas other keyworkers, you feel they…obviously you need boundaries but they put up so many boundaries that they are completely inaccessible and you can't talk to them."

"[My keyworker]'s really interested in you. When you come home [to the refuge], she's almost excited to see you. It's like when you go home and you see your parents. She's like 'what have you been doing today?' and like and really cares."

As two women suggest, the underlying message of being cared for is that you are a human that has worth:

"I didn't have friends until I came [here]. One of the key things, they kind of teach you that you are kind of like a person, like you're valued, that people are there to help you."

"You feel like (in this service) you feel like you're treated like a human being, like an adult."

One way in which a few women indicated that professionals demonstrated they cared was appearing to go above and beyond their role:

"Albert Kennedy Trust are really, really great. I contacted them and they saw me the next day and took it really seriously. They weren't going to be like, 'Ah, that's a shame, try here' (when I said I needed somewhere to stay), they took it upon themselves to find me somewhere. And when I didn't have anywhere to go that night so they paid for me to stay in a backpackers' hostel because they didn't have space at their night rough sleeping hostel. And they still follow up with me now."

"Rainbow Hamlets – really great. They took it really seriously. They didn't give up until something was resolved."

"My keyworker is great...She's helpful, she's helped me with funding, to get a new bed. She tries to help as much as she can with anything."

"They're right next to you through all your troubles."

2) Time is the key word

Several aspects of professionals' conduct that suggested to women that they were cared about and valued related to time. As one woman described:

"My doctor has been fantastic. I have a one-to-one every two weeks. She sends me a message from the surgery, my medication is totally on time, she referred me to IAPT … She'll never refuse to see me, she'll always give me time. And it's the same person every time."

As this example demonstrates, the GP has time, is on time and there is also the suggestion that the consistency of having the same GP over time has enabled a relationship to be built. These themes were reiterated across the board: women voiced a need for support that is timely, not rushed, and available in the long-term.

Domestic violence services were noted in two areas as being particularly good at addressing immediate need whilst mental health services were criticised for the long waiting lists:

"I'm still waiting for an NHS counselling referral. That was about two years ago."

"Waiting four years later for Post-Traumatic Stress Disorder therapy."

"I said to mental health, how long will it be before someone gets in touch, well, we'll send a referral through, oh alright then I've just tried to commit suicide. You send the referral through, in the meantime who's going to speak to me? Oh nobody? Okay, well hopefully I'll be alive when you call next."

The staff at the services who consulted with the women mostly (although not entirely) were identified as making time for the women using their services:

"[The refuge worker] was brilliant … There was never not enough time. She could always see me."

"Here staff will take time out, have a cup of coffee with you, listen, doesn't matter what's going on, there's always one member of staff that will talk to you, it doesn't matter what the problem is about. They do empathise, they do understand. Everyone, they genuinely care about you."

The strongest message relating to time, however, was the negative impact of the short-term nature of interventions:

"Sometimes it takes four sessions to get used to it, to build a relationship, and then you only have two sessions left."

"I've turned down a lot of counselling, I mean my doctors and things like that, have said you know I want you to do counselling through the [domestic violence]…I said I've only been through it once and it's the same again, I did a six or eight week course and by the time I'd started talking about everything it was the end of the six weeks and then I was left with all these feelings and nowhere to go with them or what to do with them. That was it so I've refused it since then. There's no point bringing it to the surface and then off you go…"

"It's like you've been here for three months now, you must be better now. Some people might be able to get over it in a couple of months but some people will take a fucking long time."

"I'm being told that by tomorrow I've got to make a decision and I don't feel that I can make that decision."

For some women, linked to this was the need for time to rest, which is often not recognised as a legitimate need to be met:

"It was regular contact, calling Women's Aid because I was so confused and the 1-to-1 support worker from here, and I finally feel ready to move into my own place and trust myself to not want him back in my life. But it takes a long time and sometimes people don't have that resting place, they have to move on and it's mentally destroying. And a lot of the time, people move away."

"Where I live now, it's…supported housing now. It's not ideal, there's a lot of people using around me. But I could rest. No one was telling me to move on. I could just be. There needs to be more of that."

3) Support needs to be flexible and accessible

The lack of longer-term support also formed part of wider discussions about the need for more flexible services that meet women's varying needs. The women vocalised strong concern about support ending and importance of having on-going contact with services, particularly as a safety net for if they encounter problems in future:

"It's really frightening, like where do you go from here [after the support ends]?"

"It's like shit, I'm not going to have someone to speak to every week."

"If you're then not in that service and having that session and then something major happens, it's very easy to go back to old habits, you no matter how much you try, you can put them off and put them off and put them off but eventually you'll start to have a drink or something."

"I know if I'm having a bad day, I can call the Women's Centre and speak to xxxx and in five minutes everything is fine. I know the Women's Centre is here."

Flexibility came across as an important factor in services being accessible, most often at the point of referral. Many women noted frustration that a missed telephone call, letter or appointment resulted in a long delay in being able to access, or being discharged from, a service. Examples of practice that supported women's engagement were, however, also cited:

"I've had the situation where I've not had the letter and not turned up and you have a letter from probation saying you're breaching probation, but I've not actually had the letter. But then I came in…and they agreed to text me and it's been okay from there."

"I found out a couple of months ago that my [community psychiatric nurse]…when I was at my completely poorliest then she would, because I couldn't even hold eye contact, she told me a couple of months ago that she would take me out for walks so I could walk side by side with her so that was really helpful."

Access generally was an issue, with one woman describing it as "like pulling teeth sometimes". Being able to access support came across as a lottery rather than a process women have control over:

"It's like you go to one service, and you just get passed around as many services as possible until someone will be like, 'yep, I'll deal with it'. It's never like, I've seen this service and they're really great and I'd like them to help me."

Equally, several women noted services' inability to intervene in order to avert a crisis but rather would get involved only after a crisis had occurred:

"There was this one day, I was at breaking point. I said I need some help or I'm going to hurt [my son]. That's why I'm phoning you, I want some help. Oh well, until you've actually touched him, we can't help."

"When I've called the crisis team I've been told I'm not in crisis yet so they can't help me. You either have to be harming yourself to be in crisis. I said I am going into crisis so they gave me the number for the Samaritans or something."

"It's a shame that I have to hit my rock bottom to know that you're here for me."

The types of support women had been offered were raised as being problematic, with several comments referring to the need for support to carry out every day activities, such as washing clothes and going to the

shops, and "not just sitting down in that stupid office." The predominant criticism, however, focused on the readiness with which GPs *"prescribe lots and lots of pills but they can't make one counselling referral"*. For women who have used substances problematically, this was particularly concerning:

"When I had panic attacks they gave me diazepam, which is also addictive. So they give you what they think is best for you but they don't take into account that that could actually be the worst thing for you…they don't think about the fact that they are literally swapping one addiction for another…it's really quite scary because you're putting your trust in them."

The lack of joined up care was also lamented in each area:

"I think I have just been pushed from pillar to post. You've got this going on and this going on and this going on so we'll deal with this. So we've got lots of things going on but nobody knew the whole thing. Nobody was looking at the whole picture and how, yeah, I might seem fine, but you don't know what's behind the scene. So, discharged from one, go back to another. Discharged from another, go back to another."

"The thing is these services need to work together because we are whole people. And we do need these different…services and sadly a lot of the time we need them at the same time not just a bit of this and a bit of that. You often need them side by side."

There were isolated examples of positive practice, such as the value of MARACs[49] enabling agencies to work together and reduce the need for women to *"keep telling my story."*

4) The importance of being heard and understood

A theme that arose in all three areas was the need for women to be heard – both to have a voice and to be listened to – and to be surrounded by people who had had similar life experiences to them.

There were many references to women not being able to vocalise what they believe they need in terms of support. In some cases this was due to rushed appointments and a lack of confidence in challenging professionals, particularly GPs and psychiatrists. The need for advocacy services for women was clearly demonstrated, as in this example with a dentist:

"I can come across as strong and confident here on 1-on-1 with the girls but if I'm in a situation, and it is to do with males, I can shrink inside, so having that support [from my keyworker]…was amazing. I was respected then. He had to show me respect then. Whereas when I didn't have her, I felt I might as well be invisible, insignificant…completely over his head. It was his way or no way."

Beyond advocacy, the women highlighted the positive way in which the women's services they currently used balanced the need to get things done with empowering women to build their own voice:

"I had to go from being in a relationship to having to be a single parent, having to cope with bills, and all that came with it, and I wasn't in the right frame of mind. But Llamau came in and they took control. Not so that I could just sit back with my feet up but they helped me so that I was able to pick up the phone and be able to go out and face…they've been guiding me so I could make phone calls."

"Sometimes you don't like to ask for help, so sometimes someone making a suggestion, not being told…it helps, a gentle push, your voice can be heard. So it's easier to ask now."

The women also put great emphasis on being listened to; in doing so it suggests that they often feel they are not heard:

"Mainly the listening was most helpful… Actually listening to me, and actually seeing me, not just okay, quick fifteen minutes, tick that box, get you going. Actually talking to me." [about seeing a counselling psychologist]

"One day I came to see [the hostel] and the next day I was moving in…it was very traumatic…I kept going back to [hospital] for follow ups so they discharged me to put me on long term leave. And that really worked, helped me in quite a difficult situation. I felt they listened and realised how traumatic it was and did something about it."

Many of the experiences of services – both positive and negative – that the women shared point to a need for organisations and professionals to have an understanding of women's lives. In most cases understanding was demonstrated through the care women were shown, how professionals respond to the reality of women's lives in ways that promotes their engagement in services, how they listen to what women need and do their best to make that happen.

The women in two groups, however, suggested that in order to have the required understanding, professionals needed to have had similar lived experience:

"They have been to uni, they have been taught about the field…but they haven't been through it. They can't relate. They go 'ah, I know what you're going through.' No you don't because your boyfriend didn't beat you up last night. Your kids aren't in care. They haven't got the empathy, you know what I mean. They have a four-bedroom house, two kids and a car in the driveway and they don't get it. But they want to tell me they've got empathy for my life."

"When you go to these places you actually want someone who's been in your shoes to talk to."

"One worker had been through domestic abuse, had substance misuse issues as well and I saw her every week. Outside of refuge that's what I clung to."

This was linked to more general comments about how supportive they found it to be around other women who had been through similar situations:

"I didn't necessarily go [to the drugs service] for the groups, I went to connect with others after the group. Women…made that connection. Someone understanding what you've been through and that you can get through it. And I'm here, you can ring me, I'm here."

5) Feeling safe in a women-only space

Connecting with other women who would understand was noted as a key benefit of having women-only spaces. This was particularly the case for the women who had been part of mixed-gender groups in drug or alcohol treatment services. In part this was because women are the minority in such groups and so feel uncomfortable or that the discussions are not as relevant:

'There have certainly been times at [the drugs services] when I haven't been to groups because I'm the only woman. I'm just not feeling it.'

'I've only been one time to AA and I couldn't deal with it. It was a really horrible feeling. It was all about how men feel drinking…going to the pub with your mates…'

Men's understanding of women's lived experiences was also brought into question:

"In the issues we've been talking about, domestic violence, rape, substance use…it's not that men don't, but more women do."

"How can they truly understand a woman's experience? They're not a woman. They're not a mother. Only another woman can truly understand."

[49]MARAC (Multi-agency risk assessment conference) is a multi-agency meeting of professionals where high-risk cases of domestic abuse are discussed with the aim of reducing the risk of further harm.

"We can empathise with each other. Men put their macho side up. But I wouldn't feel happy discussing what's happened to me with another male in the room. It's very personal."

"You're talking about the things [the perpetrator] has forced you to do. You can see the look on their face, did they really?"

More critically, safety was raised as the main reason for women wanting to be in a women-only space. This point was raised exclusively in relation to women having been affected by domestic abuse, which was found to be a common experience in each group:

"What if you have people in a drug or alcohol rehabilitation group who are violent? Or are ex perpetrators? I just think you have to take that into account."

"For someone who's been abused…by a male…you need a place to feel safe and secure with no males coming in."

"[Domestic violence] gave me mental problems and once I get into a state I think every guy in the world is trying to kill me. You could be a doctor, police officer, so…"

"If it's professional and it's a male, I have to call my worker to come with me. I'm still struggling with that."

For some women, mixed-sex environments or being forced to be in near contact with men acts as a barrier to accessing services:

"I'd already asked specifically that I didn't want to be in a room by myself with a man. And the first person I saw was a man. And I said, 'Can you leave the door open? What I've been through I don't feel comfortable with the door shut.' He said sorry, it's a private conversation and closed the door. I upped and walked out."

"When I was in hospital and they said come to [here], I didn't want to because last time I was here it was mostly males. I just thought it was going to be like that again and I thought it would be uncomfortable and stuff. But I thought I'd give it a go and I have to say it's the best decision I ever made. The support here is amazing. Being in a woman-only hostel is helpful."

Professionals' views

The professionals interviewed were chosen for their experience of developing policy or delivering services to women affected by the issues covered in this study. They included i) chief executives and directors of women's organisations providing support around

offending, substance use, mental ill-health, domestic and sexual abuse and involvement in prostitution, ii) senior managers in generic organisations that deliver women-only services, iii) local authority strategic leads, and iv) policy experts. The content of the interviews focused on three broad topics: their experience of what support women experiencing multiple disadvantage need, the current reality of trying to meet the needs of these women, and what needs to change for the support women receive to improve. Each topic is discussed in turn below.

1) What women need

A focal point of the interviews was ascertaining what the organisations and services that specifically work with women experiencing multiple disadvantage do differently that enables them to engage with women more effectively than other service providers. Asking the professionals who have been involved in service delivery to reflect on what they thought made women come to their services in the first place and, possibly more importantly, what made them come back shed significant light on the measures providers take to create an environment and model of service delivery that women want to engage with.

Various aspects of accessibility were discussed, including services physically being made available to women either in terms of their location, particularly by going to where women are rather than expecting them to come to a service, and having an open door policy that enables women to access support immediately rather than operating waiting lists. The latter reflects a key message from the women themselves that support is most effective when it is made available at the point when they need or decide they want it. At the same time, however, there was some discussion about the need to slow down the pace of interventions or, alternatively, provide a space for women to engage with a service to the degree that they want, sometimes *"support[ing] someone gently when they bob in and out"* for months or even years before accessing a formal service. It appeared that this type of support was more greatly needed for women experiencing multiple disadvantage than other women, possibly due to the longer time it took for them to build up trust with a service or provider.

Beyond this, there was an emphasis on conveying the underlying values and principles of an organisation to women from the moment they walked into a service. As summarised by a housing services manager, two very important aspects of a service that many organisations wanted to impart was that their service(s) is/are a safe place and somewhere for women to feel comfortable:

"The main thing for me is having the opportunity to have an all-female environment first and foremost, which goes slightly above and beyond that safe environment…it's about that first impression – how do you get women over the threshold, through the door. You know there's going to be apprehension and fear, but for them to actually feel okay walking in. An all-women environment, unfortunately, still, in my view, remains more welcoming and empowering."

The director of a women-only substance misuse service, reiterated concerns about safety, particularly in terms of there being *"perpetrators in groups looking to exploit others."* Moreover, she reflected the findings of an evaluation of a women-only group therapy programme[50] at the London-based drug and alcohol service, EACH, in highlighting that in single-sex groups *"women feel less isolated and less ashamed."* Interestingly, in both instances, the issue of gender socialisation was also touched upon, with the same interviewee noting that *"[women] don't have a sense of their own identity, and I think they're allowed to think about that in a women-only group, whereas in a mixed-gender group they revert to type…they make a cup of tea and flirt a bit."* More broadly, another interviewee explained the value of a women-only services as being that they offer *"a place for women to be women. A place for women to explore the dynamics of power that have created the inequitable outcomes for them."* This highlights that women-only spaces are not only vital in terms of physical safety, but also in terms of providing a space where women can reflect on the impact of experiencing the world as a woman, to unpick the power inequalities and social expectations placed on them, and how this all impacts on their well-being.

Another crucial aspect of service delivery that many interviewees emphasised was the need for staff to genuinely care about the women they work with. The director of one women's centre highlighted that this begins when a woman walks through the door for the first time: *"[I]t's crazy busy but you don't leave someone outside waiting, you make sure they have a drink.".* Beyond this, she also noted that *"the first conversation is really important. We teach all our staff how to conduct an assessment – head up, don't tick boxes."* This approach tallies with one aspect of the women's views about what made them feel that they mattered and were not simply a number to an organisation.

More widely, caring for the women using their services was described in various terms from – in one case – showing women *"unconditional love"* to more specifically ensuring staff listen to the women, follow through on what they said they would do, are accepting, and offer support no matter what happens in a woman's life.

Emphasis was also put on the more general culture or environment of a service, with interviewees seeking to generate *"a feeling of people belonging"* and *"a family-type dynamic"*. In relation to the latter point, the director of a service in the South East highlighted how the value of simply letting a woman know you have held her in your mind should not be underestimated:

"When the worker told the woman that we had come to visit her at home because we care, she just was shocked and surprised that people would make that effort. That's an experience of a lot of our clients. They don't have a lot of people to rely on, turn to. You might tell a women you were thinking about her and her response will be, 'Oh really, you were?'"

At the core of creating a caring environment for women to be supported in is the relationships between the women who work in a service and those who attend it. Women who experience multiple disadvantage were described as *"invariably need[ing] relational based support"* and the people delivering the service were seen as crucial to its ability to engage with the women. The focus was on women-only organisations that are *"populated by real life women…[who] feel more open and less guarded"* and staff putting themselves forward *"as a woman"* rather than a professional. This approach to service delivery also stemmed from a desire among the interviewees to minimise hierarchies within the organisations they lead and to promote a sense of equality among all the women working in and using a service. Equality was a particularly important aspect of service delivery for the chief executive of one women's centre who described the women using the centre as having *"internalised being inferior"*. Others referred to women lacking self-esteem, feeling like "they are on the other side of the fence" and the need to build a *"pro-social identity"*. Central to addressing these issues was the need for the women to have relationships with people from all backgrounds, the opportunity to speak with other women who have had similar experiences (including staff), and most critically, to be empowered and have more control over their lives. As one interviewee described, services can support this by being a place where *"[women] can lead rather than necessarily be led."*

Women's empowerment was a much-discussed topic across many of the interviews, with organisations adopting a wide range of approaches. In general terms, being empowering was understood to mean listening to the women, supporting them to identify for themselves what they wanted to do, and assisting them to achieve their goals. For others there was a focus on enabling women to participate in the running of the

[50]Cambridge Policy Consultants (2016). Women's Experiences of Recovery from Substance Misuse. A review of women's only group therapy. EACH: London.

[51]A recent study of Together's peer support in Hampshire was found to have improved the well-being of service users and the peer support-ers. More details can be found here: http://www.together-uk.org/study-finds-togethers-peer-support-value-worth-five-times-money-spent/ [accessed 17/08/17].

organisation. At one of the Together Women centres for women in Yorkshire and Humberside region of England, for example, the women run a breakfast club for themselves. Inspire Women Oldham has a more cooperative structure whereby women are members, rather than service users, who can move along a pathway to become associates and have a much greater input into the design and delivery of the activities offered than in the majority of services that follow a more traditional delivery model. The value of such peer involvement schemes is well documented[51], but for the peer themselves, the director of one organisation clearly pointed out *"[t]here's nothing more disempowering than always taking and not being able to give. Lots of women come back to us to give back."*

In a somewhat similar vein, there was an overall emphasis on strengths-based approaches to supporting women. In part this involved enabling women to recognise the level of resilience they possess to keep going despite the manifold difficulties they have experienced in their lives. As one interviewee noted, this means acknowledging *"[t]he fact that a woman's gotten out of bed, got into town and walked through your door; it's a massive step for a lot of the women we work with. And then we build on that."* The extent to which many organisations take a fully strengths-based approach was questioned by one interviewee who suggested that "a shift in ideology for practitioners from fixers to catalysts that focus on abilities rather than problems, facilitating rather than supporting" was still needed.

Following the findings of the literature review, a specific focus of the interviews was on whether support for women experiencing multiple disadvantage should be trauma-informed. Across all the interviewees there was unanimous agreement that all interventions should be grounded in an understanding of trauma and how it impacts on people, given the widespread experiences of violence, abuse and trauma among the women who used their services. In many cases, there was a perception that *"[a]nyone who has been working in this field has been working like that forever"*, and following a trauma-informed approach was deemed to be *"unconscious"* and *"instinctive"*. At the same time, several interviewees noted that there is a need for services to consciously reflect on how trauma-informed their practice is and actively consider how to make improvements. Among the organisations that have taken specific steps to be more trauma-informed, work includes:

- initiating follow-up work after attending talks by Dr Stephanie Covington[52] at Brighton Oasis, a women-only substance use service;
- using a service away-day to plan implementation of identified principles of trauma-informed practice for women[53] at Drayton Park Women's Crisis House and Resource Centre in London;
- piloting a Psychologically Informed Environment (PIE) in Solace Women's Aid's London-based refuges; and
- working towards the Royal College of Psychiatrists' Enabling Environment Award[54] at Anawim, a women's centre in Birmingham.

Critically, many of the examples interviewees cited as evidence of being trauma-informed result not simply from staff being trained about trauma and its impact, but from the organisation as a whole adopting a trauma-informed approach. This includes, for example, the physical environment – *"soft furnishings, comforting, soothing fabrics"* - and thinking about *"how you word a poster, or writing an allocations policy for accommodation that isn't just a list of rules."* Most importantly, however, is support for staff working directly with women who have often been repeatedly traumatised. In several cases, access to clinical supervision was noted, as well as service managers who have a thorough understanding of trauma-informed practice being available to provide advice and support on a daily basis. Throughout the interviews, the overall picture of a well-supported team that understands women's behaviour as a manifestation of their experiences of trauma and of unhelpful responses from many services was painted as being crucial to enabling the vast majority of women to engage with their service. The manager of one service for women involved in prostitution, for example, noted *"it's very, very rare that a woman is excluded. Behaviour can be managed by being honest and transparent…we're a sounding board for women. We don't take insults personally but reflect on why a women behaves in the way she might. We don't want to be too punitive."*

2) The challenges of delivering to services for women experiencing multiple disadvantage

Overwhelmingly, the challenges of supporting women who are experiencing diverse difficulties in their lives were structural in nature, with funding cuts and contract requirements being the most commonly discussed issues. A key challenge is the apparent lack of understanding among local authority commissioners, in particular regarding what women experiencing multiple disadvantage need from support services and how services should be designed to engage with women.

The impact of substantial funding cuts and the subsequent pressure on services was summed up by the director of a London-based service when discussing the issue of slowing down the pace of interventions with women experiencing multiple disadvantage, particularly when they first attend a service: *"How can you stop and have a cup of tea [with a woman] when you have so many people coming in? We have 11,000 service users a year and only 140 staff."* For even the most gender-responsive and trauma-informed service, such high levels of understaffing is bound to impact on the amount of time and attention that can be afforded to each individual woman. This is particularly crucial, given the importance women placed on being made to feel they matter and are not simply another case to be dealt with.

Echoing the women's voices outlined earlier in this report, several interviewees also denounced the move to increasingly short-term interventions. One interviewee noted that the commissioning process does *"not acknowledge that some people's needs aren't met by sixteen, twelve weeks with an hour a week. The person might not have a phone, no means of contact, and other people have a lot going on."* There was an additional concern that the pressure to get people into, and out of services, is adding to the long-term problem of workers closing cases when initial contact cannot be made. The violence against women lead in one local authority noted that *"even cases that come to the MARAC, we hear that a service offered her three appointments and she didn't attend so we closed the case"*. As highlighted in the previous section, the need for services to officially close cases is problematic in itself, considering the evidence from women and professionals that the nature of many women's lives mean they may need to access services on multiple occasions, often at short notice due to a particular problem or crisis occurring. Whether the focus on closing cases stems from contractual requirements or is part of the culture of a service, this issue needs to be addressed. Developing a case management system that allows for cases to be held effectively inactive, rather than officially closing them, so that women could more easily access support at a later date, would go some way to alleviating this problem.

For the stakeholders interviewed who predominantly work with women involved in the criminal justice system, the Ministry of Justice's Transforming Rehabilitation strategy and the creation of Community Rehabilitation Companies (CRCs) to supervise low- and medium-risk offenders was raised as a particular concern. One interviewee with extensive experience of working closely with the criminal justice system across both England and Wales was clear that *"Transforming Rehabilitation has reduced ability to be women-centred, forcing short group work programmes on women rather than enabling long-term one-to-one support that has been shown to be effective."* The picture does however vary across the two countries, with CRCs in some areas sub-contracting the group work programmes to specialist women's services and locating women's probation officers in the same service with some success. The women in Nottingham consulted for this study, for example, were extremely positive about their experience of such a model. As described by the women themselves, the benefits of this approach were having a women-only space that they could access at other times and for support relating to difficulties in their lives that are not directly linked to their offending behaviour.

The challenge of this model is that it relies on the existence of women's services and their ability to pull in other funding to offer a more holistic package of support to women who are under probation supervision, as the CRCs generally only fund the compulsory group work programmes. In areas where i) the CRC has not contracted out support separately for women, ii) where a specialist women's service did not win the contract or did not want to deliver the contract, given that the provision runs contrary to their ethos, or iii) where there are no specialist women's services, concern was voiced about the quality of the intervention. The director of one women's centre, for example, noted: *"The CRCs will only pay for group work and it will happen in a community centre. The evidence says the relationships with workers and other women and a women-only space is what women really want, and this is what they have stripped out."* In one part of England, evidence was cited of higher breach rates for women and increased two-week recall figures that were viewed as resulting from the reduced support provisions for women. As alluded to above, the shift away from central Government funding to multiple contracts with local commissioning and contracting bodies, as well as charitable trusts, has also put pressure on the women's centres set up following the Corston Report. One specialist women's organisation, for example, has *"twenty five different*

[52]Dr Stephanie Covington is a clinician from the U.S. who has pioneered models of gender-responsive and trauma-informed work with women. Predominantly based on her work with women in the criminal justice system, she was invited to speak and train in the U.K. in 2014-15. More about Dr Covington's work and free access to her research and assessment tools can be found here: http://stephaniecovington.com/ [accessed 14/06/17].
[53]A paper by Denise Elliott and colleagues was used in this exercise. The article can be downloaded here: http://hcet.info/wp-content/uploads/2015/11/Trauma-Informed-Care-Services-for-Women.pdf [accessed 14/06/17].
[54]The Enabling Environments Award (http://www.rcpsych.ac.uk/quality/qualityandaccreditation/enablingenvironments.aspx) is a "quality mark given to those who can demonstrate they are achieving an outstanding level of best practice in creating and sustaining a positive and effective social environment". The Enabling Environments model has been described as forming the basis of the psychologically informed movement in the U.K. (Breedvelt, J.F. (2016). Psychologically Informed Environments: A Literature Review. Mental Health Foundation: London.)

[55]Women in Prison (2017). The Corston Report 10 Years On: How far have we come on the road to reform for women affected by the criminal justice system?, London: Women in Prison. Available at: http://www.womeninprison.org.uk/perch/resources/corston-report-10-years-on.pdf [accessed 30/04/17].
[56]Prison Reform Trust and Women in Prison (2016). Home truths: housing for women in the criminal justice system. London: Prison Reform Trust and Women in Prison. Available at: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Home%20Truths.pdf [accessed June 15th 2017].

contracts…[with] the National Offender Management Service and the Department of Health, contracts with the Big Lottery, five different contracts from CRCs, [local health] funders. How can small organisations manage all those contracts? They're all quite small contracts too." Furthermore, for one interviewee there was also a sense that some charitable trusts, namely those that have traditionally funded the women's centres, "don't want to prop up CRCs…support them to achieve their outcomes".

Another challenge raised by several interviewees was reduced access to housing, including social housing, for various groups of women. Women in Prison's recent review of the Corston Report noted that "[t]he housing situation for women leaving prison is even more desperate today than when the Corston report[55] was published ten years ago." Equally, the 2016 briefing from the Prison Reform Trust and Women in Prison on housing for women in the criminal justice system[56] sets out evidence of local authorities gate-keeping housing stock, in some cases deeming women intentionally homeless on their release from prison. The lack of social housing stock, which is particularly chronic in London, as well as wider housing affordability issues and benefit reductions, has also been highlighted as a cause of the increased difficulties that women leaving refuge accommodation – many of whom have additional support needs relating to mental distress and substance use – face in accessing secure accommodation. A study by Solace Women's Aid[57] in 2015/16 found that only 38% of women who had a secure tenancy on fleeing domestic abuse received an equivalent council or housing association tenure on leaving the refuge. 62% faced long-term housing insecurity by being placed in temporary accommodation, a hostel or staying with family and friends. Given the plethora of evidence demonstrating that homelessness is both a consequence and strong contributor to mental ill-health, lapse in recovery from substance use, reoffending, not to mention a reason why victims of domestic violence may return to an abusive partner, options for creating specific pathways into secure housing for vulnerable women and their children should be explored as a priority both nationally and locally.

A distinctly different challenge cited, but one that echoes the findings of the mapping exercise carried out for this project, is the continued compartmentalisation of services. Service providers are often constrained by funding streams that remain largely siloed by issue, such as substance use, mental health or domestic violence.

For women experiencing more than one difficult life circumstance, this is particularly difficult, as illustrated by the manager of a homelessness service: "women… have to be given a label before they take that first step. And that's a struggle I've noticed over my career. It's a problem for women with multiple issues, which one do I identify with? Which one will get me the best service? Which one will get me through the door for that agency, but are they going to look at those issues?" The evidence from this study suggests that the women's centres are the only services that appear to have been able to shed, at least to a degree, the requirement to support women who have a certain identity or label. As an example, the director of one such centre stated that: "[our centres] have open doors, they are not about you are here because you are high risk, or you have very challenging behaviour, but that you are a woman and this is your space."

Whilst most women's services do still have a strong identity as either a homelessness, substance use, mental health, domestic abuse support provider, or are open specifically to women involved in the criminal justice system or in prostitution, they tend to provide as holistic approach as possible to address women's multiple needs. The importance of partnership working – "we can't address everything. We are reliant on drug and alcohol and mental health services." – was noted by several interviewees. The need for very tight and co-ordinated partnership working was also emphasised so that "plans for all the different agencies are reduced. There should be an overarching plan that everyone contributes to, to ensure this individual, in this case this woman, can move forward."

The model of co-locating services or bringing generic services into "safe, physically safe spaces", such as women's centres, refuges and one stop shops for domestic violence victims, was applauded by several interviewees. In one area, though, it was highlighted that cuts to all public services means that "services are lacking to come to the centre. We used to have drug, alcohol services, sexual health coming in every week but funding means they can't do that. We've had to upskill the current staff to do everything." This is likely the case in other parts of both countries as either the capacity of services continues to be eroded or they are decommissioned completely.

Persuasive arguments for continued close partnership working, including organisations allowing outreach to, and the co-location of staff in, other services, need to be found. Some examples can be found in the next section of this report. Beyond this, however, partnership work is not easy. AVA's work for over a decade to increase partnership working between the violence against women, substance use, mental health and homelessness sectors clearly documents the challenges of overcoming different cultures, perspectives, working practices and, more practically, incompatible IT systems[58]. Some of the same difficulties were raised by the Mapping the Maze interviewees, including the time it takes to build strong relationships, some agencies' tendency to quickly close cases when someone does not engage with a service, and differing views on how to support transgender women.

Intersectionality was raised more broadly by several interviewees, with questions posed about the existence of support for women with disabilities who have substance use and mental health problems, as well as some discussion of how to engage with younger women and with older women who "have lived with this identity all their lives and are often resigned" to living the rest of their lives facing the same difficulties.

In relation to substance use services, the following point was also raised about women with children and the lack of childcare offered: "Women with children often have no one else to care for them so have to bring them to a generic service. There are schedule 1 offenders, fairly unboundaried people here. We ask women to safeguard their children, but then ask them to come to places that aren't safe." Such comments point to the critical need for people designing and funding services to understand women's experiences of the world more generally, and to understand the specific needs of different women. As well as drawing on the evolving body of research about the needs of women, involving women in the commissioning process – from consultation before service specifications are drawn up to participating in the scoring of some questions in submitted tenders – could result in improved service design for women experiencing multiple disadvantage.

3) The way forward

The final theme that emerged from the interviews with stakeholders was ways to improve the current situation and increase women's access to high quality services that effectively meet their needs.

Whilst overall there was a sense that the need for gender-specific models of support was generally recognised by commissioners and funders, frustration was voiced about the fall-back position that insufficient demand exists to warrant funding women-only services. With women, for example, consistently accounting for up to a third of service users in the homelessness sector[59] and the drug and alcohol treatment system[60], it seems inaccurate to suggest there is a lack of demand. Moreover, in a case of 'chicken and egg', if these services were less dominated by men, more women may come forward to access them. An example of this precise scenario was recalled by one interviewee who was instrumental in the opening of a women's hostel in Bristol the late 1990s: "initially no one believed that a twenty-bed women's hostel would be filled [which it was]. The generic hostel has ninety spaces with four for women and the latter weren't filled…surprise, surprise."

An added challenge is the largely anecdotal evidence that, in consultations and surveys, women often say they are happy using generic, mixed-gender services, which may partially stem from not having used a women-only service and thus not actually being able to make a comparison or state a preference. As such, it is important that consultations with service users as part of the commissioning cycle enable women to understand the potential benefits of a women-only environment, as well as broader research demonstrating women's preference for single-sex services being made available to policymakers and commissioners.

It is interesting to contrast the aforementioned situation with that of the criminal justice system's approach to supporting women offenders. Women constitute a much smaller proportion of all offenders, yet gender-specific services appear to be relatively more prevalent. As a point of discussion in the latter interviews, there was a sense that the strong leadership, i.e. Baroness Corston and her review of women in the criminal justice system, was pivotal in raising awareness of the need for and jumpstarting funding for gender-specific models of support, even if subsequently the sector has had to

[57]Solace Women's Aid (2016). The Price of Safety: How the housing system is failing women and children fleeing domestic abuse. London: Solace Women's Aid. Available at http://solacewomensaid.org/wp-content/uploads/2015/11/Solace-Womens-Aid-housing-report_The-price-of-safety_Mar16.pdf [accessed June 15th 2017].

[58]Horvath, M.A.H., Hansen, S., Adler, J.R., Rogers, S.A. (2013). "Before the project everything seemed a little bit wooly – now we are definitely clearer in terms of pathways for women" – Evaluating the Stella Project Mental Health Initiative. London: Middlesex University. Available from: https://avaproject.org.uk/wp/wp-content/uploads/2016/03/SPMHI-Final-evaluation-report.pdf [accessed 17/08/17].

[59]Homeless Link (2013). Survey of needs and provision 2013. London: Homeless Link. Available at: http://www.homeless.org.uk/sites/default/files/site-attachments/SNAP2013_Full_Report.pdf [accessed 30/04/17]; Hutchinson, S, Page, A, Sample, E, (2014). Rebuilding Shattered Lives: The final report. London: St Mungo's. Available at: http://rebuildingshatteredlives.org/read-the-report/ [accessed 30/04/17]

[60]Public Health England (2016). Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS). London: Public Health England. Available at: https://www.ndtms.net/Publications/downloads/Adult%20Substance%20Misuse/adult-statistics-from-the-national-drug-treatment-monitoring-system-2015-2016.pdf [accessed 30/04/17].

[61]More information about both schemes can be found on p.5 of this Clinks briefing on national policy initiatives for women in contact with the criminal justice system: http://www.clinks.org/sites/default/files/basic/files-downloads/national_policy_activity_to_improve_outcomes_for_women_in_contact_with_the_criminal_justice_system_november_2015.pdf [accessed 16/06/17].

"shout long and hard for gender-specific services." This point of view was supported by the manager of one service in London, who remarked that "a moment with powerful people" gave rise to her service and has also helped to protect it since then. Conversely, reflecting on the lack of women-only provision with the drug and alcohol treatment system, two interviewees concurred about the male-dominated leadership of the drug and alcohol sector and their "blindness" to women's lived experience. Historically, it was also suggested that a perception of women surviving in a drug-using world was one of "oh yeah, she's able to look after herself rather than she's vulnerable…and this is where we are now, what we've got." As a whole, this evidence suggests that for significant change to occur, national leadership is needed, particularly for the substance use sector where women-only provision is largely absent, as well as an end-to-end model of support across a local authority for women experiencing multiple disadvantage.

The development of such a model was welcomed by several interviewees. Whilst the Mapping the Maze model (see p.44 provides a framework for good practice for any service working with women experiencing multiple disadvantage, it does not outline the types of service provision that need to be available in a particular location. There are examples of similar models being developed in some areas but these tend to be by sector, such as the Greater Manchester Pathfinder Project for women at all stages of the criminal justice system and the Integrated Offender Management Cymru Women's Pathfinder[61]. Equally, many areas have developed a more co-ordinated response to domestic abuse, with various interventions being funded – albeit in increasingly smaller numbers due to public sector funding cuts – such as specialist advocates in health services, alongside other community-based support and refuge provision. There is little evidence, however, of combined whole-system and whole-area approaches to addressing women's multiple disadvantage.

Certainly any model would need to be adapted to reflect the local context, but in the course of its development it should, as standard, provide an opportunity to consider the pathways into and through services that women currently use and those that are lacking. This approach was successful in Nottingham and led to the creation of a new model of supporting survivors of domestic abuse who have substance use or mental health problems. The violence against women lead in Nottingham described the process:

"We realised that women using drugs didn't self-refer to the refuge or come through police, but they were identified by drugs services. We were able to show drug

services, and also mental health services, that it was their service users that would be supported in the refuge. This meant they completely bought into coming out to provide support in the refuge which is out of the usual practice as it helped them out."

In Manchester, a similar argument was put forward to encourage health services to contribute financially to the Greater Manchester Women Offenders Alliance: "We're working with 1,500, 1,600 women annually and 7-800 at any one time, and we think, um, we also know that that same cohort is the cohort health providers find some of the hardest to reach… so we're saying those people you are desperate to engage with, we've got them engaged, we're already delivering better outcomes, if you want to have better outcomes, help fund these centres."

Such a model may also assist in raising awareness about the full value of women-only services, which several interviewees doubted that local policymakers and commissioners understood. As well as delivering specific services, a senior local authority civil servant neatly summed up the added value of specialist women's services, such as women's centres for women in contact with the criminal justice system:

"It is really hard to quantify what a women's centre does. It's very easy to say, well, the housing providers have housing outcomes, the employment provider has employment outcomes, the drugs service got the substance misuse outcomes and so forth, whereas… without the women's centre, those women wouldn't have engaged with those services in the first place, and if they did engage they would have dropped out of them."

The issue of outcomes was raised several times during the interviews. There is robust evidence of gender-informed services achieving better outcomes for women than generic services[62]. There was also an emphasis on the need to capture so-called softer outcomes, as well as an "acceptance [among commissioners] of incremental change." The director of an organisation that supports women involved in prostitution talked of "tiny, tiny changes…a woman beginning to make eye contact." For a woman who may have experienced trauma throughout her life and may struggle greatly to trust and communicate with others, this is a huge step forward but how is such an outcome measured and monitored? A whole area model of support would need to include relevant outcomes for women experiencing multiple disadvantage that a range of services should collectively works towards. Using the Outcomes Star[63]

as an example, a composite star for women's multiple disadvantage could be devised that incorporates elements of well-being from other stars, such as 'identity' and 'self-esteem' from the mental health outcomes star.

A whole area model of support for women experiencing multiple disadvantage would draw on a mix of generic and specialist service provision. Generic, universal services were highlighted by several interviewees as "need[ing] to up their game", as they are currently seen as being poor at recognising and responding to the range of problems women experiencing multiple disadvantage present with. In relation to specialist services, a note of concern was also voiced in relation to the expansion of some organisations – usually in a bid to keep their doors open – into new areas of work. This, it was suggested, "runs the risk of one organisation doing everything", which could lead to some women feeling excluded. Women involved in prostitution and those using drugs in particular, it was felt, benefited from having a specific "place where they don't have to explain themselves" due to the stigma they sometimes experience from other women.

Ultimately, the austerity measures introduced by the Coalition Government have led to a significant reduction in the support available to people facing many different health and social care needs. As cuts to the public sector continue to limit the support services can provide, alternative funding streams also need to be considered. There was some positive feedback about the greater role health is taking in funding interventions that do not have a direct impact on people's physical health and mental well-being. For other organisations, a move towards social enterprise is being considered. This approach can be beneficial in i) offering some financial freedom if successful, and ii) encouraging service users to become more involved in the running of an organisation, which can be a very positive experience for them. Finally, grant funders that tend to have a better understanding of the need for more flexible funding to develop innovative approaches to supporting women were flagged up as being vital to the continued existence of some of the organisations consulted with for this study.

While these mixed options may plug some gaps and offer space for innovation, the continued patchy response will only further the confusing maze of services outlined in this report. The absence of well-resourced and easily accessible services that are joined up to support a woman as a whole rather than as an assortment of needs leaves the women delivering and using support services exhausted, burnt out, fed up and unsure of the future. Without a clear commitment from central Government to lead change across the board – without a minister responsible for driving forward this area of work and dedicated funding – the message will keep being sent that responsibility for

women experiencing multiple disadvantage being able to successfully navigate their way into, through and out of the bewildering maze that has been created for them lies with the women themselves.

[62]The introduction of a Women's Strategy at St Mungo's, for example, was found to improve women's outcomes. See p.8 of Hutchinson, S, Page, A, Sample, E, (2014). Rebuilding Shattered Lives: The final report. London: St Mungo's. Available at: http://rebuildingshatteredlives.org/read-the-report/ [accessed 17/08/17].
[63] The Outcomes Star (http://www.outcomesstar.org.uk) is widely used in a range of public services to measure the progress service users make. There are various stars, including for domestic violence services, mental health, criminal justice and housing.

Mapping the Maze model: a framework for good practice

The Mapping the Maze model – a framework of good practice for delivering interventions/services for women experiencing multiple disadvantage – has been developed to inform and guide the commissioning and delivery of services for women experiencing multiple disadvantage. It should be viewed as a starting point for further discussion with women about the design and development of services that meet their specific needs in a given geographic area.

The model has been designed by integrating the gender-responsive and trauma-informed approaches to service delivery that were identified in the literature review and tested in the consultation with women with lived experience, and that of relevant professionals, undertaken for this project. Many aspects of the two approaches overlap, with elements such as safety, respect and dignity, collaboration, and choice and control featuring in both.

Covington and Bloom[64] describe being gender-responsive as *"creating an environment through site selection, staff selection, program development, content, and material that reflects an understanding of the lives of women and girls and responds to their strengths and challenges."* This reflects a key finding of much of the literature and what the women said – the organisational culture in which services are delivered that understands what a gender-responsive approach is and why it is needed is vital. The Mapping the Maze model is built on this premise.

The Mapping the Maze model has four broad components: organisational ethos, safe and enabling environment, approach to working and organisational practice:

1) Organisational ethos: commitment to delivering gender-responsive services and interventions.
This means:
o having specialist knowledge of women's lives and experiences
o recognising multiple disadvantage, including diversity issues
o understanding inter-related needs requiring individual holistic care
o recognising impact of trauma, particularly in terms of violence and victimisation
o accepting women - viewing behaviour as adaptation and resilience rather than symptoms and pathology

2) Safe and enabling environment: provision of support in places where women feel safe and welcome.
This means:
o women-only space
o physically safe, particularly when women may be affected by violence and abuse
o prioritising emotional safety that minimises the risk of re-traumatisation
o an environment that promotes dignity, self-respect and wellbeing

3) Approach to working: how interventions are delivered is as critical as what support is facilitated.
This means:
o safety, respect and acceptance are paramount
o trust is a key priority, built through consistent relationships
o working with the individual, including being culturally competent
o build on strengths and ways of coping
o enables choice and control, which in turn builds self-efficacy
o collaboration – building a plan with a service user not for, and working with other agencies
o offering time and flexibility

4) Organisational practice: structures are in place to enable gender-responsive interventions.
This means:
o recognising challenges of working with women experiencing multiple disadvantage
o providing sufficient staff support – informal and line management/clinical supervision
o continued staff development
o engaging with partners to develop integrated multi-agency responses
o challenging and working to eliminate causes of women's multiple disadvantage
o being aware of the need to develop cultural competence and address issues relating to intersectionality

[64]Covington, S. & Bloom, B. (2008). Gender Responsive Assessment Tool. La Jolla: Center for Gender and Justice. Available at: http://centerforgenderandjustice.org/assets/files/2013/GRProgramAssessmentTool-CJ-Final.pdf [accessed 20/06/17].

Recommendations

All of the evidence from Mapping the Maze points to a need for significantly improved support for women experiencing multiple disadvantage.

There needs to be step change in approach right across the piece, from central government to local service deliverers, to ensure that women experiencing multiple disadvantage get the support they need and deserve.

National Governments

From the Governments of England and Wales, we call for:

1. A cross-government approach to women experiencing multiple disadvantage
A high level of political will from across government departments is required to ensure that the specific needs of women experiencing multiple disadvantage are addressed in relevant areas of policy and funding programmes. As this report highlighted, a more sustained commitment to supporting women involved in offending stemmed from Baroness Corston's high profile report on women's experiences of the criminal justice system. To achieve a similar approach with regard to women experiencing multiple disadvantage, there is a clear need for a national champion on this issue to be appointed and for a named minister to be given responsibility for driving forward cross-departmental work on this matter.

2. Central government funding streams that are gender- and trauma-aware
A significant amount of funding for services that women experiencing multiple disadvantage would benefit from originates with central government. Central government should, in its tendering and bid documents, do far more to actively encourage bidders to show that they have taken into account the need for trauma-informed and gender-responsive services. A recent positive example of this was the Department for Communities and Local Government's Violence Against Women and Girls Service Transformation Fund that gave weight to applications addressing complex needs. This is an unambiguous way for central government departments to make it clear that this group is a priority and to incentivise the development of appropriate and much needed services.

More specifically, central government funding, whether in terms of specific initiatives or general funding arrangements (e.g. for local authorities) must recognise that increasing staff workloads and reducing staff salaries impedes the delivery of truly gender- and trauma-informed services. If services cannot provide what women experiencing multiple disadvantage say they value and is key to helping them engage with services, i.e. empathetic staff that have time to listen, poor outcomes will be achieved and lives will be wasted.

3. A cross-departmental funding stream for services to support women experiencing multiple disadvantage
Consideration should further be given to creating a cross-departmental funding pot for services supporting women experiencing multiple disadvantage. This would work to overcome some of the silos inadvertently created by the separation of current funding streams. This pot could be used to incentivise the development of joined-up, holistic, gender-informed services, by making the engagement of multiple services across an area a condition of funding. Additionally, this approach could encourage more joined-up commissioning at a local level.

4. Joined-up funding across areas
A lack of critical mass in demand for some specific services was identified in the report as a barrier to commissioning and providing women specific services. Incentivising the creation and delivery of services across larger areas could overcome this challenge. In health, for example, recent shifts towards commissioning based on Sustainability and Transformation Plans (STPs) could enable the development of women specific services.

Commissioners

We call on commissioners to:

5. Adopt the Mapping the Maze model
A key message from this project is that how services are delivered is as important what is provided. The Mapping the Maze model offers a framework for how services should be delivered to optimise engagement with and outcomes for women experiencing multiple disadvantage. The individual aspects of service delivery could be incorporated into the tendering process with bidders being asked to evidence how they would meet each of the points in the model.

6. Be gender aware
On the evidence of this (and other) reports, gender blind commissioning for multiple disadvantage does not work and commissioners need to recognise this. In designing service specifications to go out to tender, commissioners should draw on the evidence directly from women (see below) as well as research – such as that in this report and the accompanying literature – about what works for women experiencing multiple disadvantage. All commissioners should also be aware that the provision of services designed specifically for women does not breach the Equality Act 2010.

7. Promote trauma-informed services
There is evidence of commissioners in some areas are preparing service specifications that include a requirement for services to be psychologically informed environments (PIE), a model of service delivery that is underpinned by an understanding of trauma. Whilst such a move is generally welcomed, there is also concern about how bidders will evidence their ability to create a PIE. Moreover, there is a lack of evidence of a PIE approach that takes into consideration women's experiences of trauma[65]. In designing services, commissioners are therefore encouraged to adopt the Mapping the Maze model as this is both trauma-informed and gender-sensitive.

8. Commission for quality
The findings of this study clearly demonstrate that women experiencing multiple disadvantage respond best to professionals who genuinely care and have time for them. Commissioners must recognise that reducing salaries and increasing staff workloads impedes this valued support and ultimately costs the state more as women do not engage as thus do not get the support needed to address the difficulties in their lives. The providers we have spoken to for this report are clear that it is commissioning practices that are driving this race to the bottom.

9. Empower women to participate in the commissioning cycle
Service users can potentially be involved at various points in the commissioning cycle. Engaging with women in developing the specification for commissioned services is absolutely key. This enables commissioners to be sure that the tender that scores the highest will be the one that best meets the needs of service users. Enabling participation involves considering issues such as i) if childcare can be made available, or if women can bring children with them, ii) supporting women who are less literate to participate, iii) are venues for face-to-face events easily accessible to women who may not feel able to travel far due to mental health difficulties or because they cannot afford to travel somewhere further than walking distance. Commissioners might also give consideration to involving women with lived experience of multiple disadvantage in helping to score tenders.

10. Practice joint commissioning
Women experiencing multiple difficulties in their lives will need various types of support at different times. Services need to be delivered in a similar fashion, with funding enabling women to be supported as whole individuals rather than one service dealing one issue entirely independently from another service. Joint commissioning is essential for enabling holistic service provision. Beyond this, commissioning across localities to enable the provision of services in areas that otherwise may not have sufficient demand for a specific service.

11. Improve access to services
The report has identified a number of ways in which both information about services and the services themselves are difficult to access. Commissioners need to consider how they can build ease of access into the design of tenders e.g through the creation of posts aimed specifically at helping women navigate the system or asking bidders to show how they will ensure ease of access to services.

12. Enable long-term support options
Complex lives need flexible solutions. Tenders need to build flexibility in to allow successful providers to deliver the right support for service users even when it does not fit neatly with short-term targets. Equally, women who have experienced multiple disadvantage often face a long recovery where even incremental gains are a huge achievement to be celebrated as a milestone on the road to recovery. Commissioners need to recognise this and build performance measures into tenders that are longer term, but also recognise the incremental nature of recovery for this group of women.

Service Providers

We call on service providers to:

13. Adopt the Mapping the Maze model
Service providers are encouraged to take time to understand what being gender-responsive and trauma-informed actually means and to reflect on the extent to which their organisation and the services they provide are as informed as they could be. The Mapping the Maze model is a good starting point and further resources to guide service managers and practitioners can be found in the Resources section of the Mapping the Maze website: www.mappingthemaze.org.uk.

14. Create a trauma-informed culture
The literature review and the interviews with service users and service deliverers all point to the importance of organisational culture in delivering effective services. In part, this means having appointment and appraisal processes for staff that value and reward empathy and good customer relations. It also means ensuring that staff are properly supported to be supportive themselves. The psychologically informed environment (PIE) is one model of service delivery that can be used to promote a trauma-informed culture and practices. A soon-to-be published evaluation of a project to create a psychologically informed environment across the refuges run by Solace Women's Aid shows that a whole organisation approach can deliver significant improvements for women using the services as well as enhancing the skills of the staff.

15. Commit to providing holistic women-only support
Where commissioning does not incentivise the provision of holistic women-only support, service providers should still seek to deliver this. This may involve thinking creatively about how to carve out a genuinely women-only space within an otherwise mixed-gender service, or how to allocate staff to provide a women-only service.

16. Build strong partnerships
Service providers should seek to form partnerships across disciplines to enable more woman centred joined up working even where this means going to multiple funders to fund the service.

17. Speak to women directly
Involvement of women with lived experience is key in developing services. The sense that services are designed by others who do not understand their lives and moreover do not truly care about them comes out really strongly in the report. Both points are undoubtedly a barrier to engagement and thus individual recovery and effective service outcomes. Women want to be listened to, not only in terms of their own individual support but in order to improve services for other women.

[65]Breedvelt, J.F. (2016). Psychologically Informed Environments: A Literature Review. London: Mental Health Foundation. Available at https://www.mentalhealth.org.uk/file/1605/download?token=lGmF-rX_ [accessed 16/08/17].

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