Centre for Justice Innovation

STAFFORDSHIRE UNIVERSITY

Exploring women's experience of drug and alcohol treatment in the West Midlands

Contents

Foreword

I am pleased to present this research report on the experience of women, in relation to substance use treatment services in the West Midlands. As Police and Crime Commissioner, it is my duty to safeguard and promote the welfare of all people in our community. This includes addressing the unique challenges faced by women, in the context of problematic substance use. This work builds upon my commitment to establishing, a whole systems approach to women and girls in the criminal justice system locally.

Overcoming an addiction to drugs or alcohol is a difficult journey. It is further compounded for women, who face a variety of wider issues, which impact upon their ability to successfully engage with substance use treatment services. This important research, involves work with lived experience women, alongside people involved in directly supporting them. It not only identifies the additional barriers faced, but sets out recommendations that, if implemented, will enable women in such circumstances, to both engage with and complete the treatment journey.

I express my gratitude to the Jabbs Foundation, for generously co-funding this research, to Stephen Whitehead and Hannah Jeffery from Centre for Justice Innovation and Sarah Page and Fiona McCormack from Staffordshire University, who undertook this research. Their commitment to addressing the specific needs of women, who misuse substances is commendable. I am confident that the findings of this research will contribute to the development of more effective and tailored treatment services in our region.

The recommendations contained within this report have been framed in consultation with a wide range of partners. I call upon commissioners and providers alike, to give careful consideration as to how they can progress them in their own local context. By understanding the unique challenges faced by women and implementing evidence-based practices, we can take the action needed to ensure a more inclusive and effective treatment system, that supports the recovery and well-being of all people in our community.

Simon Foster
Police and Crime Commissioner for West Midlands

Executive Summary

Women who use drugs and alcohol have different needs than men. They face greater stigma, are more likely to carry the trauma of domestic abuse and are more likely to be caring for children. All of this taken together means that they may struggle to achieve recovery in a treatment system where they are outnumbered by men two to one.

The welcome restoration of treatment funding through the Government's 2021 drugs strategy, *From Harm to Hope*, offers a vital opportunity to ensure that treatment services can meet women's needs. But, while the strategy does acknowledge the difficulties facing women in treatment, it offers no specific measures aiming to address this gap, nor a clear picture of what effective practice for women would look like.

Our research set out to expand the evidence base on the needs of women who use drugs and alcohol and the ways that those needs are currently being met through a qualitative research project focused on the West Midlands. We spoke to women currently in treatment as well as the practitioners who support them and people working in specialist women's services in the region. This research was commissioned by The JABBS Foundation and the Office of the West Midlands Police and Crime Commissioner.

Findings

To have the best chance of achieving recovery, women need treatment in safe, appropriate spaces, which respond to the complex inter-relationships between issues like drug and alcohol use, trauma, abuse, poverty, and homelessness. Women need holistic treatment that addresses the physical, mental, emotional, and financial harms that they have experienced.

We found that many of the drug and alcohol community treatment services that contributed to this research, were not able to fully meet women's needs. While we encountered many practitioners who were highly motivated to provide effective, gender-responsive services, we encountered a range of practical concerns that called into question whether current provision was fit for purpose. In particular, we found that:

- Services were delivering treatment in mixed-gender spaces which women could find to be chaotic, intimidating, or unsafe. Some women reported being targeted by predatory male service users while accessing treatment.
- Although women emphasised the value of doing group work in an all-women environment, some treatment services only had mixed-gender groups.
- Not all services offered women the option of having a same-gender key worker.
- Many women found that the way that services were set up meant that it was difficult to manage treatment alongside childcare responsibilities.
- Resource constraints have led to a system which is not flexible enough to respond to the needs of women with significant trauma. Women might not have time to build a trusting relationship with their key workers or be excluded from services due to missed appointments or behaviour interpreted as 'disruptive'.
- Treatment services tended to work in silos rather than in partnership with other important sources of support in women's lives such as women's centres, mental health treatment or domestic abuse organisations. Many of these other organisations would not offer support to women who were using substances.

It is clear from our findings that further work is needed to improve drug and alcohol treatment for women. Services need to meet basic standards around providing care in safe, appropriate spaces in a way which is accessible to women, and which offers all women the option of gender-specific group work and a same-gender key worker. However, to be effective, services also need to develop their capacity to respond to women's specific gendered needs, developing staff expertise in trauma-responsive care and domestic abuse. Beyond improving their own delivery, services need to develop their links with the other agencies in order to help women access the full range of support which they need to achieve sustainable recovery. There is also the potential to go further by implementing a whole systems approach which seeks to ensure that every woman has timely access to whole-person, gender specific care provided through women's centres.

Recommendations

1. All treatment services must ensure that their offer to women meets four basic standards:

    a. Treatment is provided in a safe, accessible, appropriate and non-stigmatising space that is accessible to disabled users and women with children.

    b. All women have the choice of attending women-only group work sessions instead of mixed-gender sessions.

    c. All women have the option of a same-gender key worker.

    d. All women have access to appointments where the timing and delivery makes it possible for them to attend alongside their other commitments (e.g. childcare and work).

2. Treatment services should expand their capacity to meet women's gender driven needs by:

    a. Incorporating key principles of trauma-informed care into their work with women.

    b. Training all key workers working with women to recognise and respond appropriately to signs of domestic abuse and sexual violence.

    c. Working with services that specialise in supporting under-represented ethnic groups in order to develop effective strategies for promoting access to treatment among these women.

3. Treatment services should explore the potential to facilitate women's access to other relevant services such as women's centres by hosting these services in their own treatment locations, or delivering treatment from the location of other services, such as women's centres.

4. Providers of services which are vital to women's recovery from drug and alcohol use, including mental health treatment, domestic abuse refuges and social housing, must ensure that use of substances does not prevent women from accessing the support they need. Providers of mental health treatment should ensure that their service offers women timely access to trauma-focussed interventions such as Eye Movement Desensitisation and Reprocessing (EMDR).

5. Local combating drug partnerships should seek to implement whole systems approaches (or collaborate with existing approaches) in order to ensure all women who use substances are able to access timely, joined-up, gender responsive support.

1. Introduction

Women's drug and alcohol use differs significantly from that of men in terms of its causes, its presentation, and its impact. Women are less likely than men to use substances, but when they do it is more likely to be as a response to trauma or abuse[1], or because of the influence of a substance using partner. Those women who do use substances face a greater degree of health issues and more severe social consequences than their male counterparts.[2]

All this means that when women access drug and alcohol treatment they have very different treatment needs than their male counterparts. They may struggle to achieve recovery in a treatment system where they are outnumbered by men two to one.

The government's recent drugs strategy *From Harm to Hope* brings a welcome increase in funding available for local authority commissioned treatment services, seeking to fund 54,500 new treatment places across England and Wales.[3] However, while the strategy does acknowledge that women have not always been well served by the treatment system, it touches on this point fleetingly and offers little in the way of specific recommendations on how to address it. This project seeks to address this gap in thinking by drawing on the experience of women in drug and alcohol treatment and the practitioners who support them.

The Centre for Justice Innovation, Staffordshire University and Expert Citizens have received funding from The JABBS Foundation and the Office of the West Midlands Police and Crime Commissioner to explore the current landscape of drug and alcohol treatment for women in the West Midlands. We undertook a literature, policy and data review and conducted interviews with specialist women's practitioners and with women with lived experience who were currently accessing services. We hope that this research will offer insights to policy makers and commissioners nationwide.

The evidence around women's drug and alcohol use

We conducted a rapid literature review of studies that focus: on gendered patterns of drug and alcohol use; the barriers women experience to accessing and engaging in treatment; and components of gender-sensitive treatment that have been identified and recommended.

We found that women's drug and alcohol use motivations and behaviours, and their experiences of treatment, are currently poorly understood compared to men's. However, while there is a general lack of research examining women's drug and alcohol use, emerging evidence suggests that men and women: (i) often exhibit different rates of use; (ii) use substances for different reasons; (iii) are impacted differently by use; (iv) experience different barriers to entering treatment; (v) have different experiences of treatment; and (vi) achieve different outcomes in treatment through different mechanisms.

Women's drug and alcohol use

Research has found that women are less likely to use most types of substances than men and are less likely to engage in poly-drug and alcohol use.[4] Recent data covering England and Wales showed that one in 14 women (6.9%) reported taking any drug in the last year compared with one in eight men (11.9%)[5] The most recent data on alcohol-related admissions to hospital from the Local Alcohol Profiles for England show that women are admitted to hospital at almost exactly half the rate of men.[6] However, there is evidence that women are more susceptible to using particular substances in a harmful way such as methamphetamine, prescription opioids,[7] anxiety medication and sleeping medication.[8]

Although women are less likely to use drugs and alcohol than men, they are just as likely to experience drug and alcohol use disorder and addiction once they are using.[9] While men have been evidenced to be at a greater risk of overdose, being hospitalised and reaching a state of dependence,[10] women's use has been evidenced to escalate to 'dependency' quicker than men's.[11] Research also suggests women may be at a greater risk of experiencing cravings and relapse.[12] Men are typically addicted to substances for longer periods of time than women, and are older when they stop using, whereas women

tend to experience a longer period of severe use within the overall period of addiction.[13] Women's drug and alcohol use has been evidenced to stabilise at higher doses compared to men's.[14]

Women's drug and alcohol use can be linked to mental health issues. Women are more likely to report co-occurring depression, post-traumatic stress disorder (PTSD), borderline personality disorder (BPD) and anxiety than men, and are more likely to report using substances to 'self-medicate' ongoing mental health issues than men.[15]

Profiles of women who use drugs and alcohol

Studies have found that, compared to men, women using substances are typically younger, less well educated, in receipt of lower incomes and are more likely to be married or cohabiting with a partner. They are also more likely to have children living with them,[16] which research suggests may be associated with increased harm from drug and alcohol use. A recent UK study which compared the patient records of mothers and non-mothers in drug and alcohol treatment found that, compared to women without children, mothers were more likely to report suicide attempts, hospitalisation due to mental health issues, social isolation, domestic abuse, and housing issues (though not all the mothers in the study had children living with them).[17]

There has been limited exploration of drug and alcohol use and treatment for specific subgroups of women and the bearing of intersectionality on women's experiences is not well understood. There is a dearth of research exploring the experiences of Black and Minoritised women, LGBTQ+, single women, and older women.[18] Some research has found that LGBTQ+ women have been evidenced to be at greater risk of drug and alcohol use disorders than heterosexual women.[19] Research has found that LGBTQ+ women's use and access to treatment is complicated by issues of family rejection and lack of social support, stigma and minority stress, as well as abuse and harassment.[20]

Women's drug and alcohol use and intimate relationships

Studies of women have evidenced a link between addiction and having an intimate partner who uses substances, suggesting that women are more likely to use substances due to the influence of a partner.[21] This is further supported by research undertaken by domestic abuse charity Agenda which found that relationships can be an instigator for women's drug use: while men are more likely to first use drugs with friends, Agenda's research found that women are more likely to start using drugs with a partner.[22]

The link between women's drug and alcohol use and their relationships is particularly pronounced when those relationships feature gendered dynamics of abuse and trauma. Research by treatment provider We Are With You found that women commonly reported experiences of early trauma as a key driver of later drug and alcohol use.[23] A particular link has been evidenced between women's drug and alcohol use and experiencing emotional, physical, and sexual abuse, often perpetrated by a partner or family member. In one of the first studies on women with drug and alcohol use issues and trauma, 74% of the women reported sexual abuse, 52% reported physical abuse, and 72% reported emotional abuse. Moreover, women in this study who used substances were found to have been abused sexually, physically, and emotionally by more perpetrators, more frequently, and for longer periods of time than their counterparts, and reported more incidents of incest and rape.[24] Drug and alcohol use can also be linked to ongoing abusive relationships in adulthood; research by domestic abuse charity Agenda has found that women who have experienced domestic abuse are eight times more likely to develop harmful drug use than women who have not.[25]

Once established, abuse and drug and alcohol use can become a mutually reinforcing cycle. In a research project examining couples in which one or both partners in a relationship are using substances, researchers described many different forms of drug and alcohol use-related abusive behaviour, including: spending or stealing family resources to fund substances; using substances as a bargaining tool to coerce sex; expecting victims to provide them with money for drugs and taking a disproportionate share of drugs; using victims' drug and alcohol use to demean them through emotional abuse; forcing victims to trade sex for money or drugs; and attempting to undermine victims' sobriety and recovery by controlling their medication, treatment, and access to resources and support.[26]

The evidence base around drug and alcohol treatment for women

Barriers to accessing treatment

Men outnumber women in treatment services in England and Wales: in 2020/21, 28.6%[27] of people in drug treatment and 42.3%[28] of people in alcohol treatment were women. This disproportion may reflect gender inequalities in the use of substances; however, there is significant evidence to suggest that women face distinctive barriers in accessing treatment. Barriers include:

- **Stigma:** Fear of judgement from others can inhibit disclosure of drug and alcohol use issues by women.[29] Drug and alcohol use is more stigmatised for women than men; women who use substances are typically portrayed as 'bad', 'deviant' and 'unfit mothers'.[30] Women who are using substances to cope with mental health issues or trauma can be resistant to seeking treatment as they may want to avoid being confronted with traumatic memories.[31]

- **Safety concerns:** Emerging evidence also suggests women may choose not to access mixed services due to fearing for their safety, especially if they have already experienced interpersonal abuse, are experiencing domestic abuse or have engaged in sex work.[32] Women may feel unsafe disclosing their experiences in front of men in mixed groups or feel uncomfortable staying in mixed-gender residential facilities.[33]

- **Caring responsibilities:** Research in the UK has found that parenting responsibilities may act as a disincentive to accessing treatment for women due to perceived risks of having children removed due to disclosing drug and alcohol use and/or domestic abuse.[34] The difficulty of accessing treatment alongside continuing work and family commitments creates an additional barrier for women with children.[35]

Additional barriers facing specific groups of women

Marginalised and minoritised women may face additional barriers to accessing and engaging with treatment. Although there is limited evidence exploring how intersectionality impacts women's drug and alcohol use during treatment, one qualitative study by treatment provider We Are With You found that Black and Minoritised women experience additional cultural barriers to accessing treatment such as experiencing shame around their use and fearing that accessing treatment may lead to family or community ostracism.[36] The report also found that Black and Minoritised women did not feel treatment services were delivered in a culturally sensitive way.[37]

Women who engage in sex work have been documented to face unique barriers to accessing and engaging in treatment due to the stigma and the often demanding lifestyle they face. Research has found that sex workers use drugs to cope with unmet mental health needs and experiences of abuse, as well as to overcome the tiredness associated with the work. This is referred to as the 'work-score-use cycle'.[38]

Women's engagement with treatment

Women may engage with treatment differently to men. Different psychosocial mechanisms have been evidenced to underpin positive treatment outcomes. Qualitative research has explored 'pivotal moments or tipping points' in the recovery journeys of women, finding that women often attribute positive treatment outcomes to forming female friendships during the recovery process,[39] as well as receiving support and forming bonds with peer mentors who can understand their experiences.[40] The process of negotiating the stigma of using substances and redefining their identities as women and mothers was also identified as a key part of the successful recovery journey.[41] Finding employment and career advancement has been evidenced as being more likely to motivate men to engage in treatment, whereas women's engagement was more likely to be motivated by wanting to be a better parent.[42]

However, intimate and familial relationships can both facilitate and impede recovery for women. While positive relationships with children or a partner can be a motivating factor during the recovery process,[43] the presence of a partner that uses substances can sustain use, especially if domestic abuse is also present.[44] Having family commitments and caring responsibilities have been evidenced to constrain the capacity of women to meaningfully engage with treatment and increase the likelihood of withdrawal.[45] However, a UK study found that regaining custody of children can both motivate and sustain recovery.[46]

Women's outcomes in treatment

There is limited evidence on women's experiences once in treatment. Some studies have detected no differences between treatment outcomes for men and women.[47] However, other evidence suggests that women who do manage to access treatment achieve the same or potentially better outcomes. In a recent large scale outcomes study, women were less likely than men to report illicit use a year after receiving treatment.[48]

The evidence base around gender-responsive support for women

Given that different factors have been evidenced to underpin women's substance use and their treatment pathways and outcomes, the evidence base points to the value of gender-specific treatment approaches that are specifically designed to respond women's needs.[49] Our review of the literature has identified four key elements which are identified as particularly relevant.

Trauma-informed practice

Researchers have stressed the importance of adopting trauma-informed practice in support services for women, given the high prevalence of trauma among their client group[50]. Cumulative adversity and trauma can lead to complex post-traumatic stress symptoms which include profound difficulties with regulating emotions and forming relationships. Trauma-informed care has evolved through a recognition that current models of service provision do not serve those with complex trauma well[51]. Rather than attributing people's trauma-presenting issues as to a defect or disease, a trauma informed approach understands them through the lens of past experience.[52]

A trauma-informed framework aims to be responsive to trauma survivors by fostering an atmosphere of safety, trust, and genuinely mutual collaboration.[53] While recognising the impact of trauma, the overarching aim is to work with survivors to build upon their strength and resilience. It represents a whole service ethos in which all practitioners aim to provide healing interactions and holistic restorative support, and where attention is paid to potentially harmful or triggering aspects of the service delivery.[54] This approach helps to foster engagement, build relational trust, and develop capacities like emotional regulation.

A recent UK qualitative evaluation of a trauma-informed treatment programme reported that the model was perceived as highly valuable by practitioners, however, practitioners that were interviewed reported challenges and concerns relating to services adequately resourcing trauma-informed approaches.[55]

In addition to trauma-informed frameworks which can guide delivery of any service being delivered to people with trauma, research has also highlighted the value of trauma-focused treatments such as Eye Movement Desensitization and Reprocessing (EMDR) Therapy[56] in directly addressing the psychological and physical symptoms of trauma.

Women-only treatment services

Although a number of studies have recommended the implementation of women-only services, the evidence of their impact on outcomes is somewhat limited. Several studies have evidenced that women-only treatment is as effective or more effective than mixed-gender treatment at reducing drug and alcohol use[57] and that women-only residential treatment is associated with longer stays, higher

completion rates[58] and increased out-patient aftercare following treatment.[59] However, other studies have reported no significant differences in outcomes between women-only and mixed treatment[60], or found that the improvements in outcomes from women-only treatment are not sustained over time[61].

There is also emerging evidence which indicates that the provision of women-only services may attract women to treatment who would not typically access mixed-gender mainstream services. An Australian study found that providing gender specific programmes attracted more women with caring responsibilities, LGBTQ+ women and women with a history of sexual abuse.[62]

Integrated support

Evidence indicates that women do better in drug and alcohol treatment when co-occurring mental health issues are addressed.[63] Different treatment models can be integrated through co-locating practitioners with different specialisms (substance use, mental health etc.) in the same facility or through strong partnership working between different services. Women's centres (described in more detail below) are a key example of an integrated approach to supporting women.

The evidence base suggests that integrated treatment may be more effective when it is appropriately sequenced. For example, it is important to 'stabilise' substance use and ensuring physical safety if experiencing domestic abuse before asking women to undertaking trauma focused work and working with them to establish new emotional regulation strategies.[64]

The policy landscape

Gender awareness in the commissioning of drug and alcohol treatment

Commissioning of drug and alcohol treatment is the responsibility of local authorities and is governed by standards developed by the Department for Health and Social Care's Office for Health Improvement and Disparities. The Care Quality Standards require that "*treatment services are contracted to offer tailored responses to under-represented groups identified in the partnership's needs assessment, for example, women.*"[65] The standards also include a number of criteria which might be appropriately met through a gendered approach. For example, they require that treatment providers undertake *triage, risk assessments and comprehensive assessments, including health assessment and assessment of recovery capital* and that *co-ordinated packages of treatment and care identify support needs to improve personal safety, health, and wellbeing*.

Although the research base on the gendered dimensions of recovery is limited,[66] there is a clear consensus in policy that a gender-responsive approach is vital to maximise women's access to and successful participation in drug and alcohol treatment. The European Monitoring Centre for Drugs and Drug Addiction identifies five key components of a women-friendly drug and alcohol treatment service:

1. Be gender responsive, incorporating women's needs in all aspects of their design and delivery
2. Be delivered in environments that are welcoming, non-judgmental, supporting and physically and emotionally safe
3. Be holistic and comprehensive in order to address the multiple issues that women face
4. Promote healthy connections to children, family members, significant others, and the community
5. Address socioeconomic conditions.

Gender-responsive services in the criminal justice system

Looking beyond the drug and alcohol treatment sector, it is worth considering the development of the women's centre model which is now a well-established way of support for women engaged in the criminal justice system (as well as other women with complex needs).

The 2006 Corston Report which investigated what it described as "*vulnerable women in the criminal justice system*" laid the foundations for a broad-based consensus on the right way to work with women in the justice system (though not one which is always achieved in practice). Baroness Jean Corston called for a "*distinct, radically different, visibly-led, strategic, proportionate, holistic, woman-centred, integrated approach*". The report made a number of key points about women in the criminal justice system:

- Women with histories of violence and abuse are over-represented as 'offenders' in the criminal justice system; they can equally be understood and responded to as victims
- Coercion by men can form a route into criminal activity for some women
- Drug use plays a significant role in women's offending
- Mental health problems are far more prevalent among women in prison than in the male prison population or in the general population
- Women and men are different. Equal treatment of men and women does not result in equal outcomes.[67]

The report recommended that every agency within the criminal justice system *"radically transform the way they deliver services for women".* In particular, it recommended a significant expansion of the women's centre model to respond to the needs of women in the criminal justice system.

The women's centre model

The model of services proposed by the Corston Report drew heavily on examples of women's centres such as Anawim – Birmingham's Centre for Women, and the 218 Centre in Glasgow which provide integrated, whole-person support for women with complex needs (often including criminal justice system involvement).

Women's centres, which can operate as community or residential services, provide a 'one-stop-shop' for accessing individually tailored support in a women-only environment. The support available varies between different centres but will usually include a core of advice and guidance with additional support offered around a range of issues such as drug and alcohol use, domestic abuse, family and parenting support, debt and benefits, and housing.[68]

The women's centre model responds to an understanding of women's difficulties as stemming from the cumulative impact of multiple interlinked adverse and traumatic experiences such as abuse, poverty, losing a child to care or imprisonment. The model responds by emphasising support which addresses women's whole lives and the changes they are seeking to achieve for themselves through an integrated package of support or help, rather than responding to issues like drug and alcohol use, trauma or offending in distinct, siloed services. They also work on enabling women to build on their capabilities and strengths, including belief in their own ability to make positive change, and addressing perceived needs or deficiencies.

Although there is a shortage of robust evaluations on the outcomes of the women's centre model, a number of promising studies have shown evidence of a positive impact,[69] including a reoffending analysis by the Ministry of Justice's Justice Data Lab[70] which found that the one year proven reoffending rate for 597 women who received support provided by women's centres throughout England was 30%, compared with 35% for a matched control group. Another study of the Manchester Whole Systems Approach, which provided support to women at all stages of the justice system via a women's centre model, found that 17% of supported women reoffended, compared to 46% of women in a similar cohort from the period before the approach was introduced.[71]

Statutory support for women's centres

After the publication of The Corston Report, The Ministry of Justice (MoJ) worked with a coalition of independent funders to make women's centre support available to women on community sentences via the Specified Activity Requirement. However, statutory funding for women's centres was significantly disrupted by the restructuring associated with the privatisation and subsequent nationalisation of the probation service that resulted from the abortive Transforming Rehabilitation agenda. There remains a need for a sustainable, long-term funding solution for these services: a 2020 report by the Women's Budget Group identified a £10m a year gap in core funding for these services[72].

More broadly, despite the range of support which the Corston Report recommendations attracted, progress has been painfully slow. In 2017 an assessment by the charity Women in Prison to mark the ten-year anniversary of The Corston Report[73] concluded that just two of the report's 43 recommendations had been fully implemented.

The following year, MoJ published its long-awaited Female Offender Strategy which explicitly endorsed the Corston principles and approach and set out a clear vision *of "seeing fewer women in the CJS"* [criminal justice system], *fewer women in custody and more women being successfully managed in the community*". The headline action points were:

- Piloting residential women's centres across England and Wales
- Greater focus on innovative community provisions to keep women away from prison
- The scrapping of plans to build community prisons for women.

However, implementation of the strategy remains slow with the first residential women's centre due to open in Swansea in 2024 (subject to planning permission) while resources are invested in expanding the number of prison places for women.

2. Methodology

This research set out to expand the evidence base on women's drug and alcohol use and the provision of drug and alcohol treatment for women through a qualitative research project, engaging with practitioners and service users in the West Midlands. The methodology and research tools of the project in its entirety were approved by Staffordshire University ethics board prior to data collection. The British Society of Criminology (2015) ethical guidance was adhered to in regard to informed consent, rights to withdraw and/or not to answer a question, rights to anonymity and associated debriefing practices.[74]

Our research explored the following questions:

- What are the needs of women experiencing drug and alcohol use issues?
- What are women's experiences in seeking to access drug and alcohol treatment?
- What are women's experiences in undergoing drug and alcohol treatment?
- How do current drug and alcohol treatment services respond to the specific needs of women?
- What would be the characteristics of effective drug and alcohol treatment for women?

Practitioner interviews

The Centre for Justice Innovation conducted three focus groups with practitioners in drug and alcohol treatment services in the West Midlands, as well as six further interviews with practitioners in specialist services working with women. A total of 17 practitioners took part in this phase of the data collection.

Focus groups with drug and alcohol treatment practitioners

Our three focus groups included a total of 12 drug and alcohol treatment practitioners working within commissioned treatment services in three different local authorities. All three services had multiple sites across the local authority area. They only offered mixed-gender provision, with the exception of one service which had one dedicated site offering distinct treatment to women with high levels of need, with a particular focus on domestic abuse. Practitioners worked in a variety of roles, including as peer mentors, group facilitators, key workers, and service managers. Eleven interviewees were female and one was male. Two drug and alcohol treatment practitioners who participated in the focus groups had lived experiences of drug and alcohol use and recovery.

Interviews with specialist women's support practitioners

We also undertook five in-depth interviews with practitioners in specialist services working with a range of women with complex needs. Five practitioners worked within specialist women's services in the West Midlands, including: a rape crisis centre; a women's centre; a specialist domestic abuse organisation; a specialist 'by and for' refuge for Black and Minoritised women; and an organisation specialising in supporting sex workers. Additionally, we interviewed practitioners who worked with a majority-female caseload at an integrated service that supported parents subject to care proceedings. All the specialist women's practitioners who took part in our six additional in-depth interviews were female; they worked in a range of roles including as chief executives, service managers, drug and alcohol use specialists, and key workers.

Recruitment and analysis

The majority of practitioners were recruited with the assistance of the Office of the West Midlands Police and Crime Commissioner and The JABBS Foundation, who facilitated the Centre for Justice Innovation's contact with local services. The remaining participants were recruited through reaching out to services directly via their websites or via referrals from other interviewees.

A coding scheme was devised based on the findings of previous literature and the emerging themes; the interviews and focus groups were analysed using a deductive themed analysis.

Interviews with women with lived experience

Staffordshire University worked in partnership with Expert Citizens CIC to co-design research questions with women with lived experience of drug and alcohol usage and community drug and alcohol treatment services. Utilising existing professional networks of the Office of the West Midlands Police and Crime Commissioner and The JABBS Foundation, a presentation was delivered to drug and alcohol services across the West Midlands about the research and organisations self-selected to further engage with the research. Those who self-selected agreed to recruit women to the research project and to provide additional support immediately after interviews and focus groups. There was remuneration through gift vouchers to organisations for providing this additional support. Data collection took part on their premises. One participant needed to leave before the focus group started and asked if we could undertake a follow-up telephone interview, which we accommodated.

A total of 28 women with lived experience took part in one-to-one interviews and focus groups. All the women were currently receiving community-based drug and alcohol treatment in the West Midlands. Women had the choice of an interview if they preferred this to a focus group. All women were given a £20 gift voucher to remunerate them for their time and contribution to the study. During the interviews and focus groups refreshments were provided by the research team. An academic worked with a lived experience expert for each of the interviews and focus groups. For one focus group there were two academics and two lived experience experts in case anyone wanted to be interviewed. For three focus groups, one or two practitioners were present to support the women and for one of these sessions, there were two practitioners, and both were also lived experience experts. In total five professionals engaged in the focus group activities and contributed their knowledge and experience to the discussions.

Interviews and focus groups were transcribed verbatim and six phases of themed analysis outlined by Braun and Clark (2006) were utilised to process the data.[75] The research team debriefed after data collection events and at team meetings to discuss the data and key themes as a further data check to the analysis work undertaken by the principal investigator from Staffordshire University. Data checking with lived experience experts is an important feature within participatory practice and analysis.[76] A further cross-check of the data occurred with practitioners at a follow-up online world café event.[77]

In order to triangulate findings and cross-check data from the women's lived experience findings, an online world café was conducted with nine professionals across the West Midlands working with women who are using drugs and alcohol. Page's online adapted world café model was used, where group discussion facilitators were pre-selected and pre-trained to collect data in the break-out rooms following a presentation.[78] The research team innovated from this approach by using Microsoft Teams as the host space for this event. Group discussions were audio recorded and transcribed verbatim. Participatory themed analysis occurred as described by Page (2023), whereby, participants highlighted the main themes that emerged from the group discussions for the facilitators to share back with the wider group.[79] Practitioners were invited to verify the findings from the women and to share further information and suggestions for improvements to drug and alcohol community services.

Case study

Our case study of the Nelson Trust's women-only drug and alcohol treatment is drawn from a site visit where we spoke informally with both staff and service users. This was supported by a review of documentation provided by The Nelson Trust.

3. The lives of women who use drugs and alcohol

Using drugs and alcohol to cope with abuse, exploitation and traumatic experiences

Women with lived experience disclosed how their drug and alcohol use commonly stemmed from adverse childhood and other traumatic experiences including domestic abuse and victimisation. Women described starting to use drugs and alcohol in their childhood and use becoming a coping mechanism to supress trauma. In corroboration, interviewed practitioners consistently reported that women were more likely to use substances to cope with mental health issues than men, and that their use often stemmed from historic and current experiences of abuse and trauma. Practitioners felt that women's drug and alcohol use was often related to the presence of an intimate partner who used substances or being part of a social group where use was 'normal'.

> *... I've got childhood traumas, I've got all sorts of, all sorts of you know, throughout my life, I've had a hell of a lot of, erm, physical and, erm, and mental abuse ...*
>
> Woman with lived experience

> *... I was fifteen when I met him* [referring to ex-partner], *erm, he used to beat the shit outta me ..."*
>
> Woman with lived experience

> *Probably 99% of the women in our group have all got childhood trauma. So, they're self-medicating and so their using is a symptom of something else.*
>
> Drug and alcohol treatment practitioner

Practitioners highlighted that these experiences were perceived to have had highly negative impacts on women's self-esteem, self-worth and mental health. Using substances helped to temporarily alleviate these impacts through offering 'numbing', 'disinhibition' and 'escape'. This aligned with what women with lived experience described.

Women's adverse experiences were often described by practitioners as being prolonged, taking place over several years, and 'layered', meaning that many women were coping with several different traumatic experiences that had cumulative impacts. These experiences were often 'interpersonal' and perpetrated by partners and family members. They could affect women across their lifespan – from abuse in early childhood to sexual and domestic abuse experienced as adults.

In some instances, drug and alcohol use was a coping mechanism that had developed to help women survive ongoing traumatic and distressing experiences by offering an escape. This point was made in relation to women who were involved in pervasively stressful and unsafe environments, such as those experiencing current domestic abuse, homelessness, severe financial difficulties, and those involved in sex work. Practitioners referred to several other specific situations in which women used substances to attempt to alleviate distress. These included coping with eating disorders, bereavement, and the removal of children by social services. Women with lived experience confirmed these observations.

> *A lot of our women are in exploitative relationships, coercive relationships, relationships where they are the victims of domestic abuse. Often that can lead to drug and alcohol use coerced by their partners, forced into street-based prostitution and then using substances as coping mechanisms to the situations that they're in*
>
> Specialist women's practitioner

> *… even after I did lose them* [referring to her children being taken into care of the local authority]*, well then it was just free reign to drink after that… at the time I needed help… I didn't feel safe to ask for it because of the social …"*
>
> Woman with lived experience

Specialist practitioners also noted that modern slavery trauma was also an issue for many of the women they worked with. Professionals in the modern slavery field highlighted that women use substances to cope with abuse associated with modern slavery. They also noted that drug and alcohol use could make those who had escaped from slavery more vulnerable to being re-exploited. As such, they suggested that there was a crucial time after exiting modern slavery where a co-ordinated package of trauma-informed support and drug and alcohol recovery was needed

Many practitioners who were interviewed suggested that men's drug and alcohol use was also often underpinned by experiences of trauma and abuse. They also reported a perception that men presented differently than women, being less likely to display 'emotional' or 'relational' impacts from adverse experiences – although it's important to be clear that professionals' perceptions should not be presumed to be an accurate account of the impact of traumatic experiences on men without further research.

Women's drug and alcohol use and their social context

Interviewed practitioners generally saw women's substance use to be more influenced by their social context than that of men. Several practitioners described a pattern in which women started to use substances due to the influence of their wider social circle. Women's use was sometimes perceived to start as a 'recreational habit', with women initially using substances in social contexts with their peer group or intimate partner. From this point, women's use was seen to gradually escalate to dependency, shifting away from recreational use, towards becoming a coping response. Practitioners observed that some women had grown up in home environments where drug and alcohol use was seen as 'commonplace' and had witnessed others using substances to cope with the impacts of adverse circumstances; being exposed to this home environment was perceived to increase the likelihood of future use.

> *So, some women will have got into the wrong crowd as they describe it and will have used something once and then liked the way that it felt. I think a lot of the substance misuse is related to feelings, whether that enhances something or blocks something out.*
>
> Specialist women's practitioner

> *That behaviour may have been normalised by their own lived experiences growing up with their parents using cannabis, drinking alcohol, or using cocaine or crack or whatever the drug of choice has been within that family.*
>
> Drug and alcohol treatment practitioner

Generally, women agreed with this, although there were also some contrasting comments. Some women spoke about how observing family members experiencing related harms to drug and/or alcohol usage was an initial driver to abstain. Others talked about how peers or romantic partners influenced them to use drugs or alcohol rather than family members. Women with lived experience described the interconnectedness of two or more of the following: adverse childhood experiences; parents using drugs; peers or partners using drugs; and domestic abuse; as creating a combined influence on them starting to use drugs at a young age:

> *… I think it was more to do with my social circle more than anything, erm, because I was so against,* [having] *being brought up around it through family members being users and stuff like that. So, I was just like 'no, I would never do that' and then, I think it was more like to do with my childhood as well like because there was a lot of domestic violence at home between my mum and my dad and then, also, I kinda, it was more of a distraction, I think … the people that I hanged around with was older than me and then it was kinda like, it become a habit then and then I ended up getting addicted. Got stuck in that cycle…*
>
> Woman with lived experience

While adverse childhood experiences did play a part in men's drug and alcohol use, professionals perceived men's use to be more driven by coping with changes in material circumstances, such as experiencing homelessness or unemployment, and potentially the associated mental health impacts of these issues.

> *A lot of the men I worked with started using as well through loss of employment. So, they'd either been around those types of negative associates and whatnot through friends and people have introduced them and things, or through a loss of employment. So, things like losing your house, losing your job, not being able to feed your kids and whatnot. It was very almost traditional in that sense.*
>
> Specialist women's practitioner

This professional perception would need further scrutiny with men with lived experience.

The influence of intimate partners

According to practitioners, the presence of intimate partners using substances was observed to provide women with easy access to substances in their immediate environment, which could contribute to them starting to use substances and make it more difficult for them to become abstinent or to remain abstinent. This view was corroborated in what women with lived experience disclosed. Furthermore, women talked about how male partners may behave in ways that created barriers to them accessing treatment or achieving their treatment objectives.

Practitioners noted that women with drug and alcohol use issues were often in abusive intimate relationships and noted that there were a range of ways in which abuse could interact with drug and alcohol use. For example, use could be a mechanism of control: partners could use control over access to substances as a way to exert power. Practitioners also thought that abusive partners would sometimes coerce women into sex work or criminal activity in order to fund both partners' drug and alcohol use. This was also mentioned by women in the lived experience interviews and focus groups. Women also indicated that disclosure to an intimate partner about past abuse and present processing of trauma might be used against them, and such relational tensions impacted their emotional well-being and recovery journey.

> *It can be that the partner might be sending them out to work, whether that be sex work or shoplifting or whatever they do to get by. The man or woman will send them out to do that to fund both of their drug habits. Then the partner won't allow the woman to then get help and get clean, because if she does that she no longer wants to go out and earn that money to buy the drugs for both of them.*
>
> Drug and alcohol treatment practitioner

> *I've had partners where I've told 'em certain things that've gone on in my life and they've thrown it in my face.*
>
> Woman with lived experience

Criminal exploitation of women who use drug and alcohol

Practitioners from one drug and alcohol use service observed that some women they worked with were connected with local gangs who often facilitated their access to substances and could be exploitative and coercive. One practitioner described a pattern of homeless women engaging in 'survival sex' to gain access to substances and accommodation.

> *I saw changes in her when she joined the gang. She had been stabbed twice by the girls in the gang, and she was robbed. She was given different kinds of drugs, without knowing what these drugs were.*
>
> Drug and alcohol treatment practitioner

None of the women with lived experience reported being part of a 'gang', but several commented on having associations with males who coerced them into criminal activity and being exploited through sex. Lived experience interviews did not specifically ask about engagement in organised crime, so more research would be needed to ascertain a nuanced picture of women's engagement with gang activity.

Perceptions of impacts associated with different substances

Some practitioners observed that women who used what they referred to as 'harder substances', such as opiates and cocaine, presented with different needs to women using other substances, including alcohol. Some practitioners perceived that women using 'harder substances' were perceived to have already 'hit crisis point' and were seen as more likely to experience homelessness, unemployment, be involved in sex work or criminal activity, and to have children removed from their care. In contrast, practitioners noted that women using 'softer substances' often still had custody of their children, were in work, and were less likely to believe that their drug and alcohol use was harmful and warranted treatment.

> *Opiate users usually have lives that are very chaotic. They feel they've got nowhere else to turn, or when they feel that it's out of control, or, as you've said, when they have turned to crime to fund their drug use.*
>
> Drug and alcohol treatment practitioner

> *We've got ladies who are being referred or referring themselves when it's alcohol use, it's usually those ladies are still within the family. They're employed. They're trying to keep their … They're trying to juggle so many different balls and trying to maintain the family and the relationships that they have.*
>
> Drug and alcohol treatment practitioner

Despite Public Health England evidence confirming the significant harms of alcohol and the women with lived experience confirming severity of alcohol-related harms in their personal accounts, worryingly some practitioners perceived alcohol as a 'softer drug'. This misconception about alcohol harms could negatively impact women in treatment. Women told us that practitioners tended to regard harms from binge drinking as less severe and were less likely to offer referrals or support in response. Such perceptions are indicative of a professional knowledge and understanding gap. Some women felt like they were not drinking enough to be able to get the help they wanted. This suggests that the criteria for alcohol treatment may need adjusting as thresholds on quantity of alcohol and frequency of alcohol consumption seem to be exacerbating access issues and recovery capacity and missing opportunities to provide support when issues are less entrenched.

> *… because I was binge drinking and, erm, functioning no services will touch ya, cause as far as they're concerned, you're not addicted. But it's dead frickin' hard cos I still feel like hiding in the bottom of a bottle sometimes, but you know.*
>
> Peer researcher with lived experience

The health harms from alcohol and drug usage were evident in the accounts shared by women with lived experience, including accident and emergency treatment, which is a significant cost to the NHS. A further harm is involvement in the criminal justice system itself. Women with lived experience talked about engaging in crime and losing paid employment. Alcohol, heroin and cocaine were the addictive substances where women described experiencing multiple disadvantages and reaching crisis point. Harms went were felt not only by the women, but also by their families and had particular impact on the welfare and safeguarding of their children.

Women who were mothers had a range of experiences with the child protection system. For many, threats of child removal were an important factor in women wanting to access treatment. Some women told us that they had had children permanently removed from their care. Others described being able to keep children in their care once they were engaged in treatment and making recovery progress. However, women who had had earlier children removed described how pregnancy, childbirth and child-rearing were more heavily monitored. Some women whose children were in looked after care settings were hopeful that they would be able to regain contact in the future if their recovery went well.

4. Factors shaping women's experiences in drug and alcohol treatment

Routes into treatment

Mandatory referrals

Drug and alcohol treatment practitioners observed that a significant proportion of women in their caseload had been mandated to access and engage with services as part of either a community sentence or their child protection plan.

> *We do get the women who are ordered to go to drug services. In one way it's good because it almost forces them to reach out and get that support, whereas before they wouldn't have done that. But at the same time, if they're not doing it for the right reasons.*
>
> Drug and alcohol treatment practitioner

Practitioners reported that in these instances women often felt 'coerced' into treatment as a requirement of their plan or sentence. They also noted that practitioners within women's services and drug and alcohol use services may be obligated to share emerging information and progress with children's services and/or probation, and that this could be difficult to manage and could undermine women's trust in their service. Several practitioners talked about the importance of trust and collaboration when working with women who had been mandated to attend treatment. They described advocating for women with other services, co-ordination between services and being transparent about what information is being shared.

> *So, if they've missed a couple of probation appointments but they're still engaging with me, I would say, 'Right, okay, come into the office because probation is going to see you as well.' It just works better because I think sometimes, if you've got a woman who is overloaded.*
>
> Specialist women's practitioner

Self-referral at a point of crisis

Practitioners also described a pattern where women would self-refer by initiating access to services following reaching 'crisis point'. Examples of crisis points included suffering a severe deterioration in mental health or losing a child, a home, a job or a family member. These experiences acted as a 'call to action', prompting women to recognise that they should access treatment. Women who reached these crisis points could also be less fearful of the consequences of disclosure as these risks may already have occurred.

Women with lived experience talked about feeling frustrated when seeking to self-refer via helpline numbers that they had been given to access support. Experience varied from describing how no-one picked up their calls, through to getting through to someone and receiving only a brief intervention by phone rather than a referral.

Barriers and facilitators to accessing and engaging with treatment

The practitioners that we spoke to all shared the view that women faced different and greater barriers to accessing drug and alcohol treatment services than men. Barriers cited included the stigma around women's drug and alcohol use, parenting commitments and fears over social service intervention, safety concerns and the high incidence of historic or ongoing abuse.

Childcare responsibilities

Childcare responsibilities were frequently named by practitioners as a key barrier to women being able to access drug and alcohol treatment services. The burdens of childcare were seen as leaving women with little free time or energy to attend appointments or to implement the changes needed for sustained recovery. Many practitioners talked about how women would put themselves last, prioritising the needs of other members of their households (including sometimes the needs of their partners to engage with treatment) over their own health and well-being.

> *They're the main caregiver of the family and they want to keep everything going. They're not the priority. Your kids, your house, your bills, everything else, are the priority, and I think that's a massive barrier.*
>
> Drug and alcohol treatment practitioner

Practitioners highlighted that mothers and pregnant women also faced particularly high levels of stigma around drug and alcohol use:

> *I think there's lots of difficulties for women in terms of there are those societal expectations, isn't there, on women to be the carer, to bring up children.*
>
> Drug and alcohol treatment practitioner

Childcare responsibilities also created significant practical barriers to access. For women who had custody of their children, attending group sessions became a challenge for them in the school holidays when they were engaged in additional child-care responsibility. They recognised the school holidays as a trigger point for increased stress, when they needed peer support all the more, but were unable to access it. According to the women, childcare needs were not always attended to by services.

Fear of intervention by children's services

One of the most acute barriers to engaging in treatment for women with caring responsibilities was the fear of triggering an intervention by children's services that would result in their children being permanently removed which they agreed was a potential outcome.

> *There's the fear of their children being taken into care. And then sometimes that does happen. That is always really, really difficult.*
>
> Specialist women's practitioner

Women with lived experience also talked about not having trust in social workers and some drug and alcohol services and/or workers. One woman reported that a practitioner in a drug and alcohol service had shared inaccurate information with social services, implicating her as still using drugs, when she had been drug-free for some time and in mandatory relapse management as a measure of child protection. This inaccuracy could have led to her baby being removed and placed in looked after care, like her previous children had been.

> *...they* [drug worker] *try and help but they're not in my good books... I was in a conference* [referring to a child protection meeting] *... The first time I've had my daughter and they was on table and they was like 'I've used, I haven't got my script, I haven't done this ...' and I said 'no, that's not correct'... They just said 'it was our mistake' but that's not good enough. Sorry but not good enough."*
>
> Woman with lived experience

Some practitioners suggested that social workers were poorly trained in understanding drug and alcohol use, leading to them making inaccurate assessments of the risk of harm to children. Practitioners noted that the trauma of children being taken into care could often jeopardise a women's recovery and trigger a relapse or increase using in a woman who had been seeking to engage in treatment.

> *If maybe something goes wrong with their children and, you know, their children go from being in a foster placement up for adoption, that can often be very triggering – there's so many complex unmet needs that are so interrelated that any one of those factors can be re-traumatising and could lead to women relapsing.*
>
> Specialist women's practitioner

Women with lived experience talked about how having a child removed typically initiated an increase in their substance or alcohol usage. However, some practitioners did suggest that for some women, the removal of children could act as a 'wake-up call' and motivate change as well as provide them with the 'space' in their lives to attend services. This view was also evident in a few accounts shared by the women with lived experience.

Gaining care of a child, whether by giving birth or having children returned to their care was seen as a complex point in women's recovery. For many women this could be a key motivator to engage with treatment. However, one practitioner also noted that the return of children could make engagement in treatment more difficult due to women suddenly having additional responsibilities to assimilate into their lives; the stress of this could trigger lapse or relapse.

> *She was using heroin daily among the wealth of other drugs and was sex working. She found out she was pregnant and has just, kind of, changed her life around and has just gone on to – and kept her baby, got her own accommodation, has been stable on a script.*
>
> Specialist women's practitioner

Fear of stigma and judgment

Many practitioners voiced that women who used substances feared facing stigma and being judged by professionals, family members and community members which could make them hesitant to access treatment. There was widespread agreement among practitioners that women who use face a greater stigma than their male counterparts as using substances was perceived to conflict with societal expectations of what it was to be a 'good woman' or 'good mother'. Women often resisted disclosure of drug and alcohol use due to fear of being subjected to judgement or discrimination.

> *I think the minute people hear you are a user you are automatically labelled, aren't you?*
>
> Drug and alcohol treatment practitioner

Women with lived experience talked about facing stigma as a result of an expectation from professionals that drug or alcohol users would present as intoxicated and engage in anti-social behaviour. These expectations could drive negative interactions with professionals in the criminal justice system and healthcare systems.

> *...you know what I think it might be with the stigma cause... some people when they're drink, they're disruptive aren't they* [group agree] *so the police and the hospital staff see that side of it so, you know, they are gonna be labelled..."*
>
> Woman with lived experience

> *It's across the board, isn't it? In hospitals as well, so I've been in hospitals before, and the hospital staff have just been not very nice. You're a heroin addict, then they kinda like, when they are doing the medication, they'll leave you til last... you're nearly ready to walk out the door to go and score ...*
>
> Woman with lived experience

Professionals accompanying the women in the focus groups concurred that they had observed stigmatising treatment from partner agencies towards the women that they support.

Practitioners in interview talked about how many women choose not to access treatment due to not wanting to risk being seen to enter a service; this would effectively 'out' their drug and alcohol use issue and in some instances could fuel rumours and gossip.

> *If you've got 'Welcome to the Drug and Alcohol Service,' over the door rather than a discreet building. You don't want to be seen.*
>
> Specialist women's practitioner

Buildings and signage were also talked about by women with lived experience. Having 'addictions', 'drugs or 'alcohol' in the title of the building increased the feelings of stigmatisation.

Higher levels of stigma for minority groups

Practitioners from drug and alcohol use services reported rarely seeing Black and Minoritised women within their caseloads, despite there being substantial numbers of people from South Asian backgrounds within the geographical locations they served. Some practitioners felt that drug and alcohol use was less prevalent among South Asian groups. However, others were of the view that drug and alcohol use was more prevalent than presumed, but that South Asian women did not typically present at treatment services due to cultural barriers, most notably a higher level of stigma attached to drug and alcohol use by women than would be seen in the White British community. It was widely agreed by practitioners that women from South Asian backgrounds faced an even greater stigma to accessing drug and alcohol treatment services. Practitioners felt that, often due to widespread religious beliefs and practices relating to substances, drug and alcohol use could be viewed as 'taboo' within the South Asian communities; consequently, drug and alcohol use issues were rarely or never spoken about and viewed as deeply shameful.

> *Men and women from Asian communities won't access services because it brings shame on the family and it's pushed under the carpet, so that comes into it.*
>
> Drug and alcohol treatment practitioner

> *In the Asian community, I think, a lot of the women are petrified to come into service, because it's shame on the family. They are ashamed because they're going to put their whole family down if they're seen.*
>
> Drug and alcohol treatment practitioner

Women from Eastern European groups were also mentioned by several practitioners; they perceived there to be high levels of alcohol use within this group but also that Eastern European women rarely presented in treatment.

One woman with lived experience had a Traveller background and felt that this community was less accepting of drug use. As a result, she was discouraged by her ex-partner from disclosing her situation to his family (who were also Travellers).

Abusive relationships

Women with lived experience talked about intimate partners being enablers to alcohol and drugs and creating a barrier to accessing services. Practitioners voiced that abusive partners acted as a barrier to some women accessing treatment. Partners could seek to discourage women from accessing treatment at all or seek to accompany them on visits to treatment spaces or even into appointments in order to prevent women from disclosing abuse.

> *If you're being controlled and manipulated at home and you feel unsafe, are you going to feel safe enough to go into a service? Have you got autonomy in terms of making that decision, to know that this is what you want for yourself. You haven't got the foundation there, have you, to make your own choice.*
>
> Drug and alcohol treatment practitioner

The presence of an abusive or using partner was perceived to prevent women from engaging due to them being in close proximity to substances and needing to use to cope with abuse they were currently experiencing. Several practitioners noted that leaving an abusive partner or an abusive partner spending time in custody was often a 'key juncture' in a woman's recovery journey as they were free from their partner's influence to engage with treatment services.

> *Sometimes the abusive partner being in prison can be a 'window of opportunity' for women to stop using. However, it could all change when the partner comes out of prison, or, even still, the women may still be vulnerable to the same type of abusive relationship.*
>
> Drug and alcohol treatment practitioner

Additional barriers for women who were sex workers or who had been incarcerated

Sex workers using substances were perceived by professionals to face a 'double-edged stigma' when disclosing their circumstances, arising from judgements about both their drug and alcohol use and their involvement in sex work.

> *It's really difficult to go to somebody who doesn't understand where you've come from and tell them that, 'I'm a sex worker. I've done x, y, and z to get my money'.*
>
> Drug and alcohol treatment practitioner

Sex workers were also seen as facing particular practical barriers to accessing treatment, most notably an often nocturnal working pattern.

> *If you've got a woman who is sex working from the hours of nine o'clock at night until five o'clock in the morning and then you ring her at nine thirty and book an appointment for an early morning appointment, she's going to be rattling. She's going to not feel like even engaging or getting up and having a shower, let alone coming to an appointment.*
>
> Specialist women's practitioner

Women with lived experience talked about engaging in sex work as a result of coercion from male drug using partners. They also talked about how women were targeted in mixed services by males who would groom women into sex work activity.

Practitioners noted that women engaged in sex work often disengaged early from treatment due to drug and alcohol use services operating 'rigid' policies around required levels of engagement. These policies often led to women being 'struck off' from services or having to return to the start of their engagement for missing an appointment, sometimes ending or 'resetting' the substitute prescription. This could prove deeply demotivating for women who might elect to disengage from the service completely instead of going 'back to square one'. This highlighted the additional stigma from services towards service users who did not attend appointments and, while resource constraints may be contributing to policy decisions, a more realistic understanding of the multitude of reasons why people cannot make an appointment is needed. Furthermore, daytime only provision may not be the most accessible for those engaged in the night-time economy or daytime work and/or childcare activities.

A further stigmatising feature identified by professionals supporting lived experience women in the focus groups was that having a criminal record and having been incarcerated also had led to stigmatisation which created a barrier for engagement in services. Women might ask the support worker if the women's group included others who had been incarcerated before they would be willing to commit to joining the group. Women with lived experience talked about how criminal justice professionals treated them as criminals and were not trauma-informed in their approach. They felt labelled and mistreated. As a result, they might feel unable to contact the police if they were a victim of crime. This barrier to asking for criminal justice help was felt more acutely by some Black women, who felt that there was an additional racial discrimination to the stigmatisation.

> *... in my community (a) there is a justified mistrust of the police and (b) you're treated differently as a Black person. So, I don't care what someone done to me, I wouldn't call the police for no Black person, so I think that makes a difference.*
>
> Woman with lived experience

> *… criminals of any colour are treated differently, do you know what I mean? Just as a criminal automatic, obviously I get what you're saying, Black you are definitely treated differently, but as a criminal or anyone who has got a history of anything, you could have changed ten years ago and every time they come and see you and it's on your history, you're treated a certain way.*
>
> Woman with lived experience

Even when women had successfully changed the trajectory of their lives, they felt professionals continued to label them based on their past. This could include interactions with previous drug support workers who knew them when they were using and challenged their present recovery status.

5. How is support for women with drug and alcohol issues being delivered in the West Midlands?

Treatment locations

Mixed-gender treatment spaces

Across the three treatment providers we engaged with, almost all women were accessing treatment in mixed gender spaces. Practitioners were in broad agreement that mainstream mixed-gender treatment service locations could be difficult for women. They noted that spaces could be noisy, chaotic or intimidating.

> *people might be walking in there that aren't even registered for treatment but they might be gouching, sedated, sat there smelling of alcohol. You might have one or two people sat there in the waiting room like that, slumped, under the influence. Then you might have someone coming in actually in withdrawal, highly agitated, sweating, asking for the needle exchange.*
>
> Drug and alcohol treatment practitioner

> *I've worked with women that have struggled to go in there because they didn't want to go on a mixed floor.*
>
> Drug and alcohol treatment practitioner

Practitioners also noted that women who'd experienced trauma could face safety issues in mixed gender treatment spaces.

> *My experience again of women coming in to services, that you do tend to get a lot of predatory males attending services as well. I know over the years it was sort of like a hunting ground.*
>
> Drug and alcohol treatment practitioner

> *Even if someone has been able to escape a domestically violent relationship in those situations if they are still accessing the same service they can just meet each other in the lift or something. That could cause then a bit of trauma for those women*
>
> Drug and alcohol treatment practitioner

Women-only treatment spaces

All the practitioners we spoke to felt that having access to treatment in women-only spaces could encourage more women to access treatment and help them to engage with treatment and achieve recovery. However, only one of the three services we worked with had any provision in single-sex spaces and this was only available to a limited number of women facing complex and multiple needs.

Practitioners with experience of women-only spaces perceived them as crucial for women who had previously experienced trauma due to domestic or sexual abuse.

> *We do have a site specifically for women, which is brilliant because a lot of our women are very uncomfortable around men, for whatever reason. They have some historic sexual abuse, maybe it's recent sex work or abuse, so that's really good, and they do very female specific work.*
>
> Drug and alcohol treatment practitioner

Women with lived experience agreed, describing that women's only spaces very valuable because of the risk of being targeted for abuse in mixed-gender services.

> *For me, I think you're able to be vulnerable, and without the risk of, erm, predatory males seeking out your vulnerability to, you know, because you can become a target, in any service but especially around drugs and there is a lot of predatory males.*
>
> Woman with lived experience

Those women who had received treatment support in women only-spaces also reported that it had contributed to positive treatment outcomes. One woman from a Gypsy, Roma, Traveller background described how a women-only treatment service had enabled her to explore family challenges and gender health needs and helped her overcome the stigma around drug and alcohol use that she experienced in her birth community.

> *... if I had a geezer for a worker* [drugs worker] *... there are certain things I wouldn't be able to tell him. Do you know what I mean? ... When I was offered the opportunity to move over to a woman's only service, this felt best ... no matter what you say, they* [referring to the women's service workers] *would go to the end of the world for you. Trust me they would ... they give you more like family support ..."*
>
> Woman with lived experience

Community and home-based treatment

Practitioners also spoke positively about the value of using community spaces as a venue for treatment. This was seen to have a number of advantages, providing an alternative for women who would find treatment services to be unsafe or worry about the stigma or attending those sites, but also facilitating co-ordination between treatment services and other agencies.

> *The hubs that we're doing now - I think that has made it much easier because that isn't just a drug service. You could be going there for yoga. You could be going there for any other classes or Citizens Advice.*
>
> Drug and alcohol treatment practitioner

We also identified services which were offering treatment support to women at home either through home visits or online. This was seen as particularly helpful for women with childcare responsibilities or for women who were sensitive to the risk of disclosure.

One-to-one key working

Relationship-building

Practitioners broadly agreed that developing a trusting relationship between client and key worker was an important building facilitator of successful treatment.

> *If the woman hasn't felt that she's been supported, she might be leaving before treatment is completed or even before she started treatment. Whereas some, you know, will see it all the way through. And again, that might be because of the nature of the relationship they've got with their worker*
>
> Specialist women's practitioner

Practitioners also commonly believed that it could be particularly complex for women who use substances to build these trusting relationships, owing to their history of trauma, or past negative experiences of public services.

> *It takes time, more so with females than with our male service users, to build that therapeutic relationship, for them to actually divulge the information that is sometimes key to making the changes within their addiction.*
>
> Drug and alcohol treatment practitioner

> *A lot of our women feel let down by other professionals. So, it's kind of like a, 'Well, why would I engage with you when so-and-so let me down three years ago'?*
>
> Specialist women's practitioner

Specialist women's practitioners described working within trauma-informed frameworks which allowed time for relationship-building to be driven by the client's timescale. For example, they talked about inviting women to attend services for informal support or even just a cup of tea before they formally began working with the service.

In contrast to this, key working treatment services were described by some practitioners as following a relatively rigid and inflexible timeline which would not always allow space for the development of a trusting relationship.

Women with lived experience also reported that they found it easier to build rapport with a female key worker. Having a female key worker helped women to be more open about trauma they were currently and have historically experienced, especially pertaining to domestic and sexual violence. However, only two of the three services we worked with guaranteed women the offer of a same gender key-worker.

Frequency of appointments

All practitioners agreed that, for women with more complex needs, regular appointments were necessary in terms of building of trust and ensuring they felt supported by professionals, However, drug and alcohol treatment practitioners suggested that typically women only met with key workers once a month, which was not sufficient to sustain and build rapport and trust.

> *Typically, you will not be seen by your key worker there weekly. You won't be seen fortnightly or every three weeks. You'll be seen once a month and you'll be drug tested possibly every three months.*
>
> Drug and alcohol treatment practitioner

In contrast, one drug and alcohol treatment provider which was offering a dedicated service for women with complex needs reported offering much more frequent appointments than other services:

> *Because we have got lower caseloads in our team with the clients that we have, we try to contact our clients every week, sometimes more than once a week.*
>
> Drug and alcohol treatment practitioner

Key workers with lived experience

Some practitioners identified the value offered by key workers who had visibly recovered from drug and alcohol use; this supported motivation by showing women that recovery was possible.

> *We come in with our lived experience that helps them to know that somebody's been there through the same kind of things, experienced the same things that they're going through and that there's another way. But I think it's really scary for people that first step.*
>
> Drug and alcohol treatment practitioner

Women with lived experience welcomed experts by lived experience working as drug and alcohol support workers and felt this added an additional layer of empathy and they experienced enhanced non-judgemental support. However, people without lived experience who were empathic and went above and beyond, were also highly regarded:

> *... I don't believe that you can only help people if you've got lived experience, I think you can help people if you don't, but I think that you have to come from a real place of compassion and empathy.*
>
> Woman with lived experience

Group work and peer support

Mixed gender group work

One of the three services that we engaged with offered women group work support in a mixed gender group. Some practitioners were critical of mixed-gender group work, suggesting that attending a mixed-gender group could inhibit women's ability to openly discuss their experiences.

> *if you've got one woman sat with a group of men, she's not going to disclose that she has been sexually exploited and that's why she started using drugs because she might not feel comfortable to do so … if you've got a woman who has been sexually assaulted by a man, you're not then going to feel confident to disclose how that's linked with your substance misuse in front of a group of men.*
>
> Specialist women's practitioner

Women-only group work

Two of the three services we spoke to offered women-only group work sessions. These differed to men's groups and were typically holistic in nature, offering an opportunity for women to share their experiences of drug and alcohol use and trauma. They offered psycho-educational work in areas such as parenting skills, awareness of healthy relationships, as well as arts and body-based activities designed to help women discover new ways to cope with the impacts of trauma.

Practitioners and women with lived experience praised these groups, suggesting that they provided a space for women to discuss gender-sensitive issues with peers who had similar experiences.

> *I facilitate the women's group, work with the women, and I put together the programme that we follow. It looks at things related to addiction, and a lot of it is to do about past trauma, how to have healthy relationships etc., those type of things.*
>
> Drug and alcohol treatment practitioner

Some evidence from women with lived experience suggests that women-only group working can be a helpful facilitator for identifying and responding to domestic abuse. Women who had had access to women-only treatment groups reported that they provided space for them to identify abuse in their relationships and to get associated help such as referrals to training courses. Some women disclosed that because they also physically assaulted their partners, they had not realised they were a victim of domestic abuse or did not feel they had the right to report domestic abuse to the police. Policing response to domestic abuse were perceived by the women as problematic and, leaving women feeling further stigmatised, rather than supported.

> *… it's a really safe space when we're with women and like to talk about all different topics that kinda, you know like rape… we can relate to each other. Whereas, a man, if you was to talk about sexual rape and violence and stuff like that, I just wouldn't feel comfortable in kind of getting vulnerable in a group, a mixed group, and talk about that stuff. I struggle anyway to talk about that stuff.*
>
> Woman with lived experience

Practitioners also talked about the value of peer support in groups, and the value of support from peer mentors or key workers with lived experience. Such support was viewed as helping women to feel more comfortable opening up in group and one-to-one settings.

> *We're really trying to ensure that we've got women with lived experience supporting women who are in those situations themselves.*
>
> Specialist women's practitioner

Accommodating caring responsibilities

Given that caring responsibilities often posed a barrier to women engaging with treatment services, practitioners identified accommodating childcare responsibilities as an important facilitator of women's access to treatment. However, in practice, there could be significant barriers.

Suitability of treatment spaces for children

In addition to the concerns about safety in mixed-gender services described above, the physical design of some treatment spaces could present additional barriers like limited pram access or baby changing facilities. Buildings with multiple levels, without a lift, created access and safeguarding challenges for the women who were already experiencing pressure from juggling mandatory service expectations with childcare demands.

> *Researcher: Even in this building* [referring to a community drug and alcohol service building]*, do you find it easy moving the baby up and down the stairs?"*
>
> *Participant: Not really, not really. I find it awkward and very dangerous if I'm honest.*
>
> Woman with lived experience

This lack of building design consideration can in itself reinforce stigma and create a barrier to recovery. A mother concerned about the safety of her baby is less likely to be fully engaged for the duration of a treatment session.

Practitioners expressed significant enthusiasm for making it easier for women to attend treatment with their children. Practitioners from one treatment service aspired to have a crèche available at their site and to provide some therapeutic or support groups that women could attend with their children. Practitioners from another treatment service hoped that in the future their service would operate from a community centre where older children would be able to safely wait for their parents to finish appointments.

Flexible options for accessing treatment

One area where some progress was already being made was around offering more flexible options for accessing treatment. Practitioners from one site worked to ensure that women's appointments did not coincide with school pick up or drop off. Another site reported operating a drop-in service for women during the school holidays to try to reduce the likelihood that caring commitments would prevent them from attending appointments. Other services gave women with caring responsibilities the opportunity to join groups and appointments remotely so their childcare would not be disrupted.

> *The ones that have got children we have to give them clinic spots that tallow them to do the school run either side. Then there are groups. If they have got the children still at home with them, they can't really come in and do groups. It's actually been quite beneficial that we've gone over to Zoom, and we have got that hybrid option because they can still access stuff and have the little baby asleep or cuddling them or something as long as they are not disturbing the group.*
>
> Drug and alcohol treatment practitioner

Support for pregnant women

Some drug and alcohol use services and women's organisations had already developed specialist provision for pregnant women. This provision included groups that were only open to pregnant women and co-located midwives within treatment services.

> *We developed a Healthy Pregnancy workshop, so the first week, which we run once a quarter, so the first session the midwives run, and it tries to give the clients some kind of empowerment about what to expect when they go into hospital, what will be happening to baby.*
>
> Specialist women's practitioner

The impact of resource constraints upon access to services

A number of practitioners identified how capacity and resource issues had contributed to services which did not offer the intensiveness, flexibility or patience which would best support women's outcomes.

Waiting times

Many practitioners were highly critical of the impact of long waiting times for treatment. It was observed that women in many parts of the West Midlands might typically wait months for their first appointment. Often women disengaged from support during this waiting period, particularly if they weren't receiving any support for their needs in the interim. Women with lived experience concurred with the concerns about waiting lists for trauma-informed counselling, mental health support and therapy.

> *It's such a long, drawn-out process for them to get the appropriate services and treatment that they really need, that they almost think, I'm just not going to bother. There's no point in doing that because it's just too much'.*
>
> Drug and alcohol treatment practitioner

One specialist women's service provider stressed the importance of being able to provide women with timely support at the point they felt ready to access services.

> *One of the things that we find really, really successful is that when a woman says, Okay, I'm ready to change now. I want to leave this, you know, I want to leave my perpetrator, I want to get help with my substance use, or, you know, I don't want to be involved in sex work anymore.*
>
> Specialist women's practitioner

Responding to missed appointments

Specialist women's practitioners in particular, were highly critical of what they saw as a readiness by treatment services to remove women from treatment on the basis of mixed appointments or slow responses. They saw this as particularly harmful to women who faced additional barriers to accessing services.

> *I get frustrated that they can't see the barriers for females entering a service. They're offered an appointment. They don't engage with it. They might be offered another appointment if they're lucky. Their case is just closed. For somebody who's already feeling quite low self-worth, I get frustrated ... that they don't see the negative impact that has on somebody's life journey.*
>
> Specialist women's practitioner

> *I think we need to get rid of really strict, you know, three calls, or miss your first appointment and you're taken off the waiting list, approaches. I mean, there needs to be more funding into all services, doesn't there, including statutory services.*
>
> Specialist women's practitioner

Short timeframes for delivery

Practitioners working within women's services also reported that timeframes for the delivery of services failed to meet some women's needs. They felt that there was not sufficient time to build women's trust in services and that, in some cases, women's treatment would end at a point where they would still benefit from further support.

Some women with lived experience described how, once they had engaged with treatment, it could be withdrawn when they had completed the 'programme', rather than working to the woman's expressed needs. For example, one recovery group was only accessible to women while on a probation licence. This led to women experiencing anxiety about the withdrawal of services and was considered detrimental to recovery.

Slipping through the gaps between different providers

Practitioners noted that a discontinuity of support across partner services could result in women disengaging from treatment. Practitioners mentioned examples of women transitioning between custody or residential to community treatment and not being able to access the same prescription and social support that they had previously accessed. Similarly, a stay in hospital could prove disruptive to women's treatment and they may not be able to access a substitute prescription with the same dosage that they were accessing from community treatment services. These instances could result in women discharging themselves to procure substances to alleviate the withdrawal they are experiencing.

Domestic abuse awareness

As noted above, women's drug and alcohol use is often associated with abusive relationships, and ongoing abuse can present a significant barrier to women achieving success in treatment. Many practitioners, therefore, stressed the importance of treatment workers being able to identify and respond appropriately to clients experiencing abuse. However, some practitioners reported that time pressure and resourcing limited the capacity of many treatment practitioners to identity and apply knowledge of domestic abuse when working with service users with any but the most obvious signs of domestic abuse.

> *I don't think treatment agency workers work from, let's say, a domestic abuse informed approach. If someone came in with a bruised eye or a cut lip and there were things that they were noticing that were obvious in terms of risk, then they would ask about that.*
>
> Drug and alcohol treatment practitioner

Models of good practice in responding to domestic abuse in treatment were identified by some specialist women's practitioners in their own work. One specialist women's practitioner described helping women to safety plan around their treatment. These plans often assisted women to attend treatment appointments safely and worked to ensure that the perpetrator did not attend appointments with the woman.

> *We would ask 'are they safe? What's their plan for that? What's their safety plan? What do they want to do?' So, giving them some control and power back and enabling them to access support services. 'Do they need refuge? What do they need right there and right then'?*
>
> Specialist women's practitioner

Trauma-responsive practice

It was widely agreed that a significant number of women in treatment had experienced trauma that contributed to their drug and alcohol use. Consequently, awareness of how to respond to trauma was perceived to be vital to supporting women to engage in recovery.

> *What we've found is there's a lot of trauma in these women's lives. So, whether that's from generational trauma or whether that's from domestic violence situations, from ongoing sexual violence or drug or alcohol misuse, it tends to be, like I said, almost ingrained. It's their normal, yes.*
>
> Specialist women's practitioner

> *I also think that there needs to be a trauma-informed space as well. Again, you know, there's often a lack of understanding from professionals about the complexity of the women's lives and why they might be using substances or what those barriers are.*
>
> Specialist women's practitioner

One practitioner emphasised that women can often have experienced traumatic experiences while engaging with statutory agencies, and that this might have a particular impact on their capacity to engage with services.

I think a lot of them, they've grown up through the system, and that may be, from a very young age, they may have been taken into care. They may have had a negative experience with social workers and care professionals, foster parents, children's homes... They may have been physically or sexually abused in those places

> [...] *they automatically bunch every professional in together and think, 'Well, you're a professional, so you're bound to be out to get me'."*
>
> Specialist women's practitioner

However, while individual practitioners did show an awareness of trauma, many of the practices described above run counter to the principles of trauma-informed care. Asking women (or men) to engage with support in spaces that feel unsafe or expecting them to quickly form trusting relationships with key workers are examples of practices which have the potential to inhibit engagement or actively cause harm to users with experience of trauma.

Work to improve access to treatment services for women from South Asian backgrounds

As noted above, a number of the practitioners we spoke to expressed concerns about the low numbers of South Asian women accessing treatment, suggesting that there was unmet need among this group. Some treatment services were seeking to address this, raising the profile of the service among south Asian communities, and exploring the option of delivering services from community-based venues.

However, one practitioner who specialised in working with women from South Asian backgrounds experiencing harmful practices felt that South Asian women would have a preference for working one-to-one with practitioners in drug and alcohol use services with disclosure in a group setting inhibited. Moreover, the practitioner felt that women from South Asian backgrounds might have a preference for working with a practitioner from a different cultural background from themselves; reporting that women may worry about confidentiality being breached by a practitioner from the same cultural background and their wider community finding out they had accessed treatment.

> *It would be very, very, private in my community, they'd probably see someone one-to-one. I don't think they'd sit in a group with anyone to get group therapy or talk about their issues. It would have to be more of a one-to-one thing, I would imagine, individually. I don't think they'd like to be identified, who they are as well, by other people.*
>
> Specialist women's practitioner

Access to other forms of support for women with drug and alcohol issues

Beyond drug and alcohol treatment, women's recovery relies on access to a range of other forms of support. However, our participants identified a number of barriers to women's access to this service.

Women's access to mental health support

As noted above, practitioners identified that women in treatment commonly also experienced mental health difficulties, often as a result of trauma. However, women with lived experience commonly reported experiencing delay around accessing mental health treatment and trauma support.

> *I was waiting on the NHS list for about three or four years ... finally I've been assessed, now I've got to wait again to be put on the waiting list and I've got to wait for a doctor to be available now. So, I don't know how long that's gonna take. I will be starting some therapy, err, hopefully soon.*
>
> Woman with lived experience

This was also singled out as an issue by practitioners. Many of the practitioners that we spoke to highlighted that women in drug and alcohol treatment faced significant barriers to access mental health treatment. Mental health services were seen as unwilling to take on clients who were still using substances, leaving women whose mental health issues were acting as a barrier to recovery in a catch-22 situation.

> *We do get it at times especially around mental health services, they will say, 'Sort your addiction out first'.*
>
> Drug and alcohol treatment practitioner

Many women talked about having to travel to another provider agency for additional therapeutic support or lengthy waiting lists before they were seen. Travelling to multiple services has a significant cost implication for women, who may be on low income or benefits.

Some women also described poor experiences of talking therapy provided through mental health services:

> *the only thing that was available was telephone counselling, so it was once a week and he'd spend twenty minutes asking me a load of questions like 'on a scale of one to ten how much do you wanna kill yourself?' … Literally he'd do that for twenty minutes and then it was ten minutes to talk then that was it and then the next week he would ask the same set of questions for twenty minutes to see how it differs and then you're left with ten minutes to talk. So, on the third week I said this is not doing me any good, it's just more about you and your paperwork than any counselling.*
>
> Woman with lived experience

This is particularly problematic as mental health support can play an important role in women's recovery. Studies have evidenced improved treatment outcomes for women when they are able to access concurrent support for mental health issues.[80] Given the reported high prevalence of trauma among women who use substances, trauma-specific interventions such as Eye Movement Desensitisation and Reprocessing (EMDR) Therapy[81] may be particularly relevant.

Women's access to appropriate housing

Practitioners commented upon how the region's poor housing stock made it difficult for women to get suitable accommodation. Women with lived experience echoed these concerns. Women talked about living in neighbourhoods where drugs were prevalent and not being able to escape from a climate of dealing and drug and alcohol usage. Those placed out of area, welcomed the opportunity for a 'fresh start'.

> *… I moved away from the area I lived to move away from the, the crowd I was with, which was very difficult, but when I came over to [place in West Midlands], I had more of a support network than I did … There was nothing over there [previous West Midlands location], there was but it was very, it was just ticking boxes and stuff like that."*
>
> Woman with lived experience

Some practitioners identified that women's drug and alcohol use could create particular barriers to safe and appropriate housing as housing associations and domestic abuse refuges were commonly unwilling to house women whose use was ongoing.

Women also talked about being offered accommodation that was not suitable for their childcare needs. For example, one woman who had a baby and used a pram was placed in accommodation that was only accessible by several flights of stairs and had no secure pram storage at ground level.

6. How can we improve co-ordination between drug and alcohol treatment services and other agencies?

As described above, our research findings and the evidence we reviewed set out a number of options for tailoring the delivery of drug and alcohol treatment to the specific needs of women. However, both the people that we spoke to, and the research literature stress that for many women, their substance use is only part of a picture of a complex set of challenges which can also include abuse, mental illness, poverty, criminal justice system involvement and parenting challenges, often all underpinned by historic trauma. Addressing these challenges alongside substance use is important to supporting women's recovery.[82]

However, many of the practitioners that we spoke to highlighted that treatment services often exist in silos with only limited co-ordination with other services. We have identified two groups of strategies which can improve the integration between treatment services and other agencies which might support the same women: co-location and streamlining referrals. But looking more broadly it is important to consider how a broader reimagining of the role of treatment services could form part of the development of a whole systems approach for women who use substances.

Co-location

A number of practitioners highlighted the potential benefits of co-locating drug and alcohol treatment with other services, either by hosting other professionals in treatment services or by delivering treatment services in other venues. reported working closely with sexual health practitioners, while, as mentioned above, another had offered midwife services on site.

> *I think one of the one things we do offer is the pregnancy wraparound service for pregnant service users. We have a specialist midwife attend the service and has medical reviews. They can check the female service user and the unborn's health and well-being.*
>
> Drug and alcohol treatment practitioner

Some treatment organisations offered treatment appointments at local specialist women's services. Specialist practitioners valued this practice, noting that women attending these appointments tended to have already built rapport with women's service practitioners and felt safe in their facilities owing to their adoption of trauma-informed practices. This "outreach" model was also perceived to afford more flexibility to practitioners in terms of when and where appointments were conducted, making it easier to conduct joint appointments with other professionals if relevant.

> *So, there's a drug and alcohol use service that are more hands-on because they're outreach. So that period of waiting to be scripted or whatnot, there'd be more support with that service in particular because they're outreach and they're able to go out.*
>
> Specialist women's practitioner

Improving inter-agency links in order to streamline referrals into other support

Many practitioners identified the importance of drug and alcohol use services having strong links to an array of local services to make onwards referrals where necessary.

> *So, we have different services that we can obviously signpost like Women's Aid or other organisations. Some of those services have actually come into the service and done talks, so then the women can be referred to those other agencies and access extra support around DV* [domestic violence] *or gaining ... qualifications, confidence building courses, assertiveness, all different kinds of thing."*
>
> Drug and alcohol treatment practitioner

However, as noted above, practitioners also noted that it could be difficult to make referrals into some services, with mental health treatment being identified as particularly problematic. In response to these barriers, some practitioners told us that they would saw it as important to improve their relationship to mental health treatment providers.

> *I think another one of our gaps, or certainly one of my things that I would like to see improved, is ... to have better links with the mental health service and trauma-based care within the mental health service.*
>
> Drug and alcohol treatment practitioner

Other services who had sought to improve these links reported finding it challenging.

> *We try to work closely with mental health services as well. We have some liaison with those. They are a bit trickier to get into meetings and stuff like that.*
>
> Specialist women's practitioner

This highlights how a multi-agency working that can facilitate streamlined referrals faces a range of challenges including siloed commissioning approaches, resource constraints and tensions in organisational or professional cultures.

A whole-systems approach for women

A whole systems approach for women (WSA) refers to a system-level redesign which reorients the work of all the agencies in a system to ensure that women can access gender-responsive support at every point in their journey. In seeking to change practice across a whole system, WSAs go beyond inter-agency partnership models like co-ordination or co-location. WSAs tend to have at their centre an integrated, whole-person support service such as a women's centre which offers a package of support informed by an understanding of the inter-relationship between the targeted problem and other issues such as domestic abuse, drug and alcohol use, mental health, poverty and trauma.

In the case of women who use substances, a WSA might mean tracking the range of points where women with drug and alcohol issues might come into contact with statutory agencies including children's services, criminal justice and primary healthcare and exploring how all of these agencies could form part of a network which facilitates access to and contributes to appropriate support.

In the UK, WSAs have been implemented in a number of areas to provide gender-responsive support to women at every stage of the criminal justice system. One of the most influential examples of comes from Greater Manchester where, beginning in September 2014, systems were put in place at key stages of the criminal justice system in Manchester with three main goals: diverting women away from the criminal justice system; supporting women in ways which reduce their repeat criminalisation; and ensuring access to safe women-only spaces.

At the heart of the approach was a network of women's centres in each of Manchester's boroughs which acted as hubs for a holistic, person-centred approach which sought to address the full range of women's needs while also acknowledging and developing their strengths. This holistic approach was delivered by a multi-agency partnership with a wide range of interventions including counselling, interventions around issues like drug and alcohol use and mental health, and practical help with debt and benefits. Beyond the activities on offer, women also valued access to a safe and supportive space which encouraged them to form relationships with practitioners and other service users, helping them to open and feel valued. Evaluations of the Greater Manchester WSA point to its impact in reducing women's contact with the justice system and supporting them in addressing their needs. There was also some promising evidence of reduced reoffending.

The integrated approach to providing different forms of support embedded within WSAs is supported by a range of literature which highlights the importance of appropriate sequencing in the delivery of complex interventions. Initially, treatment should support people towards stabilising – this is both important in relation to their use of substances but also in relation to other issues such as stability through ensuring the physical safety where women are experiencing abuse. This provides an important foundation to undertaking trauma-focused work and helping women to establish new emotional regulation strategies.[83]

One example of a trauma-informed whole system approach is the Women's Integrated Treatment (WIT) Model, which is in use in some parts of America.[84] The model recognises the association between PTSD and drug and alcohol use and employs therapeutic interventions to address both issues concurrently. Women being treated by WIT progress through two distinct phases: stage one entails building relationships with women to help them feel safe and manage their PTSD symptoms while drawing on psycho-educational models to increase women's awareness of their drug and alcohol use and trauma. Stage two focuses on revisiting and addressing traumatic experiences.[85]

Fully exploring what a whole systems approach might look like for women with drug and alcohol treatment is beyond the scope of this paper, but drawing on the lessons of earlier approaches it might incorporate the following features:

- Development of clear referral pathways into the whole systems approach. These might include identification of drug and alcohol use issues at the point of contact with the criminal justice system, GP referrals or child protection interventions.

- Resourcing women's centres to provide a whole-person support offer which is informed by an understanding of the inter-linked nature of women's needs and, in particular, the relationship between trauma and women's drug and alcohol use as well as the importance of building women's strengths.

- Co-ordination with other agencies including mental health services, children's service, probation, housing advice and debt advice to supplement the women's services offer in an integrated approach.

Work exploring the potential of a WSA for women in the criminal justice system in the West Midlands has been ongoing for a number of year, with initial scoping work undertaken by Crest Advisory in 2019. Currently work is being led by the Police and Crime Commissioner and the Combined Authority under the Trailblazer Deeper Devolution deal. Given the broad nature of support which would be offered under such a model, it would likely offer an important foundation for the development of a similar offer for women with drug and alcohol issues.

Case study: The Nelson Trust's women only residential treatment houses

In 2004, the Nelson Trust established a specialist residential treatment service for women in Stroud, Gloucestershire. The service, which focuses on addressing the traumatic experiences and related mental health needs that underlie women's drug and alcohol use, has long been recognised as a centre of excellence in providing gender-responsive treatment. Although not all of the elements are translatable to community-based treatment, the model is a helpful example of drug and alcohol treatment for women which incorporates a range of elements identified as important.

Women come to the service from all over the UK and typically reside there for 12 to 24 weeks. To enter the service women must have already detoxed from drug and alcohol use; be in a stable enough place to engage with treatment; and express motivation to engage with residential treatment.

The service has four residential houses which are designed to feel warm and homely; three of them are women-only and one is mixed gender. Women are encouraged to access some services in spaces shared with male clients to support the transition back into their communities.

Underpinning principles

The service is informed by four principles which are aligned with evidence about what works for women:

- Trauma-informed approach: Drug and alcohol use often develops as a way to cope with unresolved traumatic experiences. Service groups and facilities allow women who have experienced trauma to feel safe, allowing them to engage fully with support.
- Gender responsive: The service recognises the common link between women developing drug and alcohol use and gender-based violence such as domestic and sexual abuse. As a consequence of this, women reside in and receive support in women-only facilities.
- Enhancing recovery capital: The service helps women to recognise and enhance their existing strengths during treatment. Towards the end of their stay, they will be enrolled with the nearby Stroud College and can access a range of college courses within the residential site.
- Relational approach: The service acknowledges that women's wellbeing is often highly influenced by peer, family and intimate relationships. The Trust harnesses this by encouraging and facilitating friendships between women going through treatment.

Phased treatment

Women accessing the service typically move through three stages:

1. Building safety and rapport, understanding drug and alcohol use: Women settle into residential treatment and build connections with their recovery workers, therapists, and peers, helping to establish a sense of safety. This foundational work seeks to build an understanding of the role of drug and alcohol use in the woman's life.
2. Understanding trauma and its impact: Once a sense of safety and an understanding of drug and alcohol use has been established, women move into trauma-focused work. This work principally focuses on understanding and addressing traumatic experiences in depth.
3. Harnessing strengths and building recovery capital: Once women are displaying progress in trauma-focused work, treatment moves towards building women's inherent strengths and establishing new ways to cope with trauma. As part of this, women engage in classes or courses, volunteering work and the Trust actively works with women to plan for their life once they leave treatment.

Interventions

Women are offered a range of forms of support including key working, group work and a range of models of one-to-one counselling, including person centred approaches, cognitive behavioural therapy, and eye movement desensitisation and reprocessing (EMDR).

The Trust runs separate group programmes for women who have been involved in sex work where they can discuss their experiences in a setting with others who can relate and understand. The groups were developed in response to women who had engaged in sex work who reported that they felt judged by other women and often felt unable to share their experiences in open groups.

Recognising the important role of families in women's recovery, the Trust also works with clients' families. They are offered online support and counselling to help them understand their family member's drug and alcohol use and a dedicated flat is available for them to stay in while visiting.

7. Conclusions

This research aimed to explore the specific experiences of women in drug and alcohol treatment in the West Midlands. By interviewing women in treatment, as well as professionals in both treatment services and specialist services working with women, we sought to explore women's gender-specific treatment needs, the way services were meeting these needs at present and what effective practice might look like.

We found that women had a range of distinctive needs including facing greater stigma than men for their drug and alcohol use, a much higher prevalence of historic and ongoing sexual or domestic abuse and a higher burden of childcare responsibilities. Barriers to accessing treatment were seen as particularly pronounced for members of some minority communities including women of South Asian or Eastern European backgrounds.

While we found many motivated and skilled practitioners, our research did suggest a number of important ways in which women's needs weren't being met within the treatment system. Long waiting times and strict policies around missed appointments created significant barriers to accessing treatment for women struggling with trauma in particular. High caseloads meant that key workers did not have time to build trusting. relationships with women. Furthermore, while women spoke highly of the value of gender-specific group work this was not available to all women. Beyond treatment services, we also found that women who were using substances could be excluded from some of the services that were important to their recovery including domestic abuse refuges, social housing and, crucially, mental health treatment services.

We identified a number of evidence-backed options for improving the way treatment is provided for women. These included delivering services in community-based and/or dedicated women-only spaces, redesigning services to accommodate women's caring responsibilities, building staff capacity to respond effectively to trauma and domestic abuse, and specific work to support women from ethnic minorities.

However, we also identified that effectively meeting the needs of women who use substances requires reform that goes beyond improvements to treatment provision. Our research highlighted that women who use substances often experience a range of overlapping needs including mental health, housing, poverty, debt, trauma and interpersonal abuse. The most effective models of support will encompass all of these needs, as well as women's strengths in a joined upwhole-person approach like that used by women's centres. While there are a number of ways to move towards this , whole person model, including improved inter-agency collaboration, co-location and ensuring that women's drug and alcohol use does not bar them from support, there is potential for a more fundamental challenge to existing models of provision to have a greater impact.

Commissioners of drug and alcohol treatment and other relevant services could consider the example of whole system approaches to supporting women, which have been explored for women in the criminal justice system in areas such as Manchester. These whole system redesigns aim to ensure women in any part of the system have access to timely, appropriate whole-person support centred around the work of local women's centres.

Our research has taken place in one region of England – the West Midlands. But our findings are consistent with a range of previous research. We believe the lessons of this work, and our recommendations, can improve the lives of women who use substances across England and Wales – and beyond.

Recommendations

1. All treatment services must ensure that their offer to women meets four basic standards:

    a. Treatment is provided in a safe, accessible, appropriate and non-stigmatising space that is accessible to disabled users and women with children.

    b. All women have the choice of attending women-only group work sessions instead of mixed-gender sessions.

    c. All women have the option of a same-gender key worker.

    d. All women have access to appointments where the timing and delivery makes it possible for them to attend alongside their other commitments (e.g. childcare and work).

2. Treatment services should expand their capacity to meet women's gender-driven needs by:

    a. Incorporating key principles of trauma-informed care into their work with women.

    b. Training all key workers working with women to recognise and respond appropriately to signs of domestic abuse and sexual violence.

    c. Working with services that specialise in supporting under-represented ethnic groups in order to develop effective strategies for promoting access to treatment among these women.

3. Treatment services should explore the potential to facilitate women's access to other relevant services such as women's centres by hosting these services in their own treatment locations, or delivering treatment from the location of other services, such as women's centres.

4. Providers of services which are vital to women's recovery from drug and alcohol use, including mental health treatment, domestic abuse refuges and social housing, must ensure that use of substances does not prevent women from accessing the support they need. Providers of mental health treatment should ensure that their service offers women timely access to trauma-focussed interventions such as EMDR.

5. Local combating drug partnerships should seek to implement whole systems approaches (or collaborate with existing approaches) in order to ensure all women who use substances are able to access timely, joined-up, gender responsive support.

Endnotes

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The Centre for Justice Innovation seeks to build a justice system which all of its citizens believe is fair and effective. We champion practice innovation and evidence-led policy reform in the UK's justice systems. We are a registered UK charity.

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