

A Question of Trust

How services fail women experiencing multiple disadvantage



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Recommendations for services

- 1 **Develop a person-centred approach within services**, with a greater emphasis on services understanding the meaning of this and making conscious decisions in the service to put this into practice, therefore avoiding using the term as a buzz word. Promoting agency and choices for women also includes working towards a gender and ethnically diverse work force, understanding a woman's barrier to engagement, and allowing individual recovery.
- 2 **Work towards a greater understanding of how SMD may affect women differently to men** and incorporate women's lived experience across different levels of organisation. If workers understand the gendered and intersectional notions in society and different forms of disadvantage, this creates a basis for meeting the needs of women with SMD that are using services.
- 3 **Work collaboratively with different agencies that have expertise relevant to each woman's individual situation.** This allows services to work together to meet all the needs women with SMD have, without having to repeat telling their story, and without having to be passed around services and repetitively start new relationships with different workers. It is also useful when working with women from minority ethnic backgrounds as mainstream services can be too standardised limiting their ability to meet cultural needs.
- 4 **Improve the provision and access of long-term counselling services** that can accommodate women with SMD and therapeutic aftercare for mothers who had their children removed. Women with SMD are often deemed too high risk to participate in statutory or general counselling services and/or mental health services. However, creating a space which is flexible and transparent for women with SMD helps perpetuate trust in services and facilitates better mental health and overall wellbeing.
- 5 **Promote advocacy for women with SMD and proactive services.** Services should be taken to vulnerable women. They should be included in each stage of the process and be helped to understand what is going to happen to them. If the beneficiary is a mother, services should provide advocacy and empower them to work towards keeping their children and/or re-establishing contact with children.
- 6 **Ensure that physical settings and interpersonal interactions promote a sense of safety and safe space for women** and develop measures to facilitate this. This includes the creation of women only and trauma-informed spaces, be that within an otherwise mixed-gender services or through the provision of a women-only service.
- 7 **Award more resources to culturally and gender-specific organisations.** Each woman's experience of SMD will be different dependant on their demographics, therefore, women should be able to access services that have an understanding of their experiences. Women from minority ethnic backgrounds are more likely to be able to communicate with their workers in their first language, for example, which helps to break down barriers and can be key in building trust. Currently, many culturally specific organisations in Nottingham have limited funding and need to carry out fundraising events in order to keep projects running.

Preface

The report was compiled on the basis of Katie Finnegan-Clarke's Changing Futures Bid Research: Women Experiencing Severe and Multiple Disadvantage (SMD) in Nottingham that investigated experiences and needs of women experiencing severe and multiple disadvantage (SMD) in the city of Nottingham and identified potential solutions and further areas of research. The report centred on stigma, lack of trust, lack of refuges, gender-insensitive definitions of SMD and being referred from service to service "pass the parcel" and their role in women's disengagement with services.

Our aim is to delve deeper into disadvantage and barriers women face due to preconceptions of what multiple disadvantage entails and focuses on the exacerbating mistrust in services women developed as a result of it. With recent research on women and SMD increasingly challenging previous conceptions of multiple disadvantages, the evaluation seeks to explore the gendered dimensions of disadvantage.

The report consists of three parts:

- First, a literature review that explores recent academic debates of gender and intersectionality and the evolving definition of SMD.
- Second, it explores the mistrust in services among women and lack of gender-specific safe spaces in Nottingham. The report further investigates the *experiences of different vulnerable groups among women. Namely, women who suffer from secondary disadvantages such as poverty, women with a history of gendered and domestic violence, women who have had their children removed, and women from minority ethnic groups.*
- Third, it ends with recommendations and good practice observed through observations and interviews with service providers. The final part provides suggestions on how to create more trustful and safe spaces for women and rendering (multiple needs) services more accessible.



What is severe and multiple disadvantage

The concept of Severe and Multiple Disadvantage (SMD) was first introduced in The Hard Edges Report, commissioned by Lankelly Chase in 2015. Their report provided a statistical profile of people facing SMD, meaning they faced homelessness, substance misuse, and offending. Defining SMD through these three dimensions, the report found that 58,000 people, 78% men, in the UK currently faced multiple disadvantage (Bramley, Fitzpatrick, and Sosenko 2020).

Due to the significant underrepresentation of women, a second report was commissioned by Lankelly Chase to explore SMD from a gendered perspective: The "Gender Matters report" was published in 2020 (Sosenko, Bramley, and Johnsen 2020). They found that the Hard Edges definition of SMD excluded a significant number of women who "face combinations of severe disadvantage at least as serious as those faced by men and on an equivalent scale". The revised definition incorporated access to mental health services, obtained from the Adults Psychiatric Morbidity Survey (APMS) and gendered violence to the previous indicators. As a result, a more balanced cohort of people became visible, with about the same number of women and men being affected by SMD at any one time. Replacing offending with interpersonal violence and abuse, it was revealed that more than 70% of the 17,000 people affected by a combination of homelessness, substance misuse, mental ill-health, and domestic abuse in the UK were women.

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The report also showed that SMD often comes with a range of secondary disadvantages, including (Sheffield Hallam University et al. 2020):

- income inequality
- being a lone parent
- being a migrant (particularly when compounded by poor English skills)
- being a Gypsy/Traveller
- being isolated, living in poor quality accommodation
- having a physical disability, having a learning disability
- being involved in sex work
- and having lost children to the care system.

As women occupy marginalised positions within society, they are disproportionately affected by secondary disadvantages implying higher vulnerability to violence, exploitation, and marginalisation and more significant barriers to escaping these vulnerabilities (Fitzpatrick et al. 2015). Being also disproportionately affected by poverty further undermines the capacity of women. Difficulties to break an abusive cycle and establish or sustain independent homes, contribute to a higher risk of female homelessness and the development of other needs as a result (Baptista 2010; Edgar and Doherty 2001). Thus, **alongside gender, a woman's ethnicity, legal status, sexual orientation, socio-economic status and disability all affect experiences of SMD and highlight the need for an intersectional understanding of SMD** (Armstrong et al. 2019).

Why gender matters

The Gender Matters report enhanced our understanding of the characteristics and circumstances of women who experience SMD differently and confirmed the importance of gender-specific



data collection of SMD. Yet, while there is increasing recognition of the importance of women's experience of SMD, and their interaction with services, gender-specific dimensions remain often neglected within homelessness practice and policy (Baptista 2010). In light of this, support for domestic violence, drug abuse, mental health, and offending remains poor (Bretherton and Mayock 2021). Accordingly:

- Women are three times **more likely than men to experience common mental health problems**, such as anxiety and depression and are more likely to experience psychological harm or clinical disorders such as self-harm, eating disorders or personality disorders as a result of this. 60-70% of women who access mental health services have experienced domestic violence in their lifetime (Trevillion et al. 2012).
- Women are five times **more likely than men to experience physical violence, gendered experiences of rape, sexual assault, domestic violence and childhood abuse** and female survivors suffer very high rates of mental ill-health, homelessness, poverty and addiction (The Royal College of Midwives 2020, Mayock, Sheridan, and Parker 2012, and Bretherton 2020).
- Women who live in poverty or who suffer any form of secondary disadvantage are more likely to experience violence and abuse and **poor mental health as a symptom of the abuse they have suffered** (Holly, Scalabrino, and Woodward 2012). An overwhelming percentage of individuals with multiple needs have been exposed to trauma resulting from abuse (physically, psychologically, and sexual) and neglect (Sheffield Hallam University et al. 2020). Trauma developed as a result of abuse has a severe impact of a person's coping skills, their sense of safety and self, perception of control and self-efficacy, and interpersonal relationships. Such experiences can lead to higher rates of anxiety, self-harm, suicide, depression, personality and eating disorders (Mayock, Parker, and Sheridan 2015). To cope with their trauma and mental health problems, people may start to "self-medicate", and use substance and are more likely to offend to afford their substance use. Over fifty percent of women in prison had experienced

domestic violence, twice as much as the male average (Stevens et al. 2007).

- Women are **more likely to be trafficked or involved in sex work and "survival sex"** (Allcock and Smith 2018; Duff et al. 2011).
- Broader structural disadvantage and **social stigma associated with women and motherhood in the context of homelessness** create rigid barriers to adequate support. Homeless women, mothers and mothers who have had their children removed are perceived as challenging gender stereotypes and subject to disapproval, criticism, and shame. Mothers, especially mothers who lost children to the care system, are also at a higher risk of addictions or becoming involved with the criminal justice system. They respond to the failure to meet the societal expectations of their gender role by perceiving themselves as "bad mothers" and "fallen woman" (Edgar and Doherty 2001). Perceived "un-cleanliness" affects women's self-esteem "leading to a collective experience of depersonalisation, devaluation and stigmatisation" (ibid.). Moreover, services don't always capture women who have had their children removed as mothers ("invisible mothers"), neglecting or not recognising the trauma that comes with having children taken away, and slowing down their process to recovery (The Royal College of Midwives 2020).
- Due to their negative experiences related to shame and stigma within services and in society, women are **more likely to engage in concealing strategies**, seek informal support or overcome struggles by themselves to prevent stigma and shame associated with their needs (Bretherton and Mayock 2021). Mothers with children particularly worry that they can lose their children to the health and social care system and avoid contact with the respective services. Lived experience of homelessness and trauma has also led to a reluctance to accept interventions (Sheffield Hallam University et al. 2020).
- Disengaging from services can represent a coping mechanism to retain a sense of agency "to disappear from one grid of visibility and reappear on their own terms" or to "maintain a sense of dignity and self-respect" (Hoffman and Coffey 2008). The history of traumatic violence and abuse and its consequences on women's identity, sense of self and wellbeing, contributes to **women's invisibility with service providers**, puts them at greater risk of harm, and presents significant barriers to access services and their recovery.
- Especially for women who flee domestic abuse and are made homeless as a result, the service is often inadequate. Movement can be restricted by a violent partner (The Royal College of Midwives 2020). Or they can face rejection from refuge services or domestic violence services due to tackling addiction and mental health problems (Netto, Pawson, and Sharp 2009), exhibiting anti-social behaviour (O'Sullivan et al. 2010), or due to a lack of gender-specific services. The only option often remains "low-threshold and largely male-dominated emergency settings that are ill-equipped to meet their needs" (ibid.). For example, Edgar and Doherty (2001) describe how **gender-unspecific housing and homelessness services** are catered for "rooflessness" and hence primarily affect and target men who comprise 86% of the rough sleepers. Given their history of gender-based violence, women, however, prefer to live in marginalised or unsafe living arrangements, sofa surf with families, friends or acquaintances, engage in survival sex, or enter relationship with accommodated partners, as opposed to rough sleeping or staying in emergency (mixed-gender) hostel accommodations and male-dominated spaces (Bretherton and Pleace 2018; Mayock, Sheridan, and Parker 2012; Casey, Goudie, and Reeve 2008).
- Owing to the mistrust of services and services who have failed to understand their needs, women often seek support when they have already exhausted all alternative options, such as temporary living options and sofa surfing with family & friends, or living within an abusive partnership (The Royal College of Midwives 2020), and consequently **seek support on average later than men** (Holly, Scalabrino, and Woodward 2012).

- Women are also more likely to have caring responsibilities than men, doing twice as much unpaid childcare and are more likely to define their lives in relation to their homes and children. With homelessness services being often separated from other support needs (e.g. social services, immigration services), **women might find it harder to attend appointments due to their caring responsibilities**, multi-agency, and inflexibility of services. Caring responsibility and poverty can also limit their time and movement.

Traditionally, policy decisions often neglect women and intersectional experiences and are unprepared to address gender-specific issues. As a result, women become “invisible” to the system. Previous research shows how women’s experiences with homelessness services have been negative and reinforced women’s sense of marginalisation. For instance, Bretherton and Mayock (2021) describe how many felt a lack of autonomy and control within services and support and that services undermined their capabilities to overcome their struggles.

“...policy decisions often neglect women and intersectional experiences and are unprepared to address gender-specific issues.”

They felt “treated like children” by staff and judged as “incapable or incompetent as women and as mothers”. Controlling behaviour of services, assigning male staff to observations or being labelled as “too complex”, “hard to reach”, or difficult to engage”, can re-traumatise. The rejection and undermining of service providers may lead to women internalising the stigma and blaming their behaviours rather than addressing their traumas and what happened to them.

Why intersectionality matters

Not only gender but also cultural and ethnic background can act as additional barriers to seeking help and a path out of abusive settings. As also discriminatory, racist, anti-immigrant, homophobic policy and societal contexts impact national and local policy making and design, women’s choices thus need to be considered in the context of intersectionality.

Additional barriers for women from ethnic background include:

- **Increased risk of poverty, suicide, self-harm and honour-based violence** (Sosenko, Bramley, and Johnsen 2020; Armstrong et al. 2019).
- Social trauma, including poverty, racism, and inequality is prevalent, yet **often not recognised as integral to personal hardship** by professionals (Sweeney et al. 2018). Mayock, Sheridan, and Parker (2012), for example, highlight structural obstacles for migrant women in Ireland to affordable housing due to their disproportionately high share of income poverty and housing discrimination.
- **Language barriers and frustration of generic interpretation services** are particularly challenging when accessing therapeutic services. In cases where women still live with an abusive partner who also acts as an interpreter, their partner may disempower them and make them feel misunderstood by the service (Sheffield Hallam University et al. 2020).
- **Little knowledge of legal rights and legal barriers** such as visa status might hamper their attempts to access appropriate services (Armstrong et al. 2019).
- Mental health problems are four times more common among asylum seekers. At the same time, asylum seekers are less likely to receive mental health support. Underrepresentation in programmes and services suggests that particularly Asian people are a “**hidden population**” whose needs are not entirely understood (Sheffield Hallam University et al. 2020).

- **Stigma** attached to, e.g., sexual health or addiction in certain areas and a misunderstanding of cultural norms. A 2019 study into addiction and recovery among Nottingham’s Black, Asian and Minority Ethnic community (BAME) (Bashir et al. 2019), for example, showed how service users with Sikh heritage hid their addiction to the shame and stigma attached in their communities. On the other side, assumptions about cultural needs, such as wrongly assuming that Muslim women do not need substance abuse services, may mean that a person’s needs are unmet and reluctance to engage.

While the Hard Edges report indicated that less than 15% of people identified as facing multiple disadvantage come from BAME backgrounds which is lower than the general population, data collected on minority ethnic groups is often incomplete and small sample sizes impede a better understanding of their needs. Services are not picking up on the complexity of needs within the respective communities.

While there is evidence and literature on disadvantaged women’s access and barriers to services, there is less evidence for different ethnic minority groups facing SMD (Sheffield Hallam University et al. 2020). The dearth of data and services that often lack an understanding of specific groups deters

“...support for women who have a learning or physical disability or identify as LGBTQI* is scarce...”

women from ethnic minority communities to access conventional services. Similarly, support for women who have a learning or physical disability or identify as LGBTQI* is scarce or absent, with services repeatedly ignoring the contexts in which SMD is generated.

In this context, the study seeks to explore the wider barriers for women facing SMD in Nottingham and how to deliver an effective service response across the whole system. While we are aware that experiences of discrimination and oppression are shaped in the context of race, gender, sexuality, class, and other individual characteristics, the report is limited to exploring the barriers for multiple disadvantaged women and women from ethnic minority backgrounds more generally.

How prevalent is SMD in Nottingham?

Nottingham has the 8th highest prevalence of SMD in the UK. There is a lack of data on people who experience SMD in Nottingham but research by Opportunity Nottingham in 2019 found that Nottingham had double the amount of people experiencing SMD compared to the average local authority in England. Estimates for people with SMD should be treated with caution as they are likely to be conservative and have been based on the original concept of SMD (Bramley, Fitzpatrick, and Sosenko 2020), which comprises of homelessness, substance use, mental health issues and contact with criminal justice and excludes domestic violence or abuse. This produces a cohort of people comprising 80% men, and SMD service development locally has tended to follow this. Opportunity Nottingham for instance has worked principally with men (72%) and homelessness funding priorities have tended to prioritise rough sleepers who comprise 80% men.

With “Changing Futures”, Domestic Violence and Abuse (DVA) has been added as a fifth disadvantage, balancing the number of men and women experiencing SMD, and Changing Futures in Nottingham plans to work equally with men and women. Nevertheless, when women experience SMD is considered, it often is in the context of specific services rather than a wider systemic response (One exception being the R2C evaluation (2016)). There is a need at the wider system operational and strategic level to better understand women experiencing SMD in Nottingham and how to effectively deliver relevant services to them.

As mistrust in services was identified as a key issue in the literature review and preliminary findings we had gathered, we decided to focus our evaluation on how different barriers relate to mistrust in



services for women and women from ethnic minority groups specifically. We built on our findings with best practices we observed in Nottingham which (re-)establish a trustful relationship and overcome barriers of mistrust for women.

For the purposes of this report, SMD is defined as experiencing three or more of substance misuse, contact with the criminal justice system, mental health issues, and DVA.

We acknowledge that the impact of racism, sexism and classism often cannot be separated. We attempt to not look at women as a homogenic group but to acknowledge different economic, cultural, and ethnic backgrounds and experiences to understand the barriers they face vis-à-vis men. The report employs the term “ethnic minority” to refer to general shortcomings of service provision to reflect culture and context and appropriately respond to people’s specific cultural identities without resorting to stereotypes.



Methodology

The report contributes to the literature with a more nuanced understanding of women’s decisions to (dis)engage with services and a deep dive into the mechanisms behind barriers to services. Finally, it explores good practice that can be used to overcome the barriers.

Specifically, the objectives of our evaluation are to understand:

1. *The current picture*

Gathering and analysing data relating to demographics and current circumstances and experiences including survival strategies, mental health and wellbeing, physical health, current accommodation circumstances, experience of services and public service use, social support networks goals and aspirations.

2. *Explore Service Provision engagement*

Understanding women’s interaction with gender-specific and intersectional services and potential barriers to engagement. Examine service providers’ experiences of working with women specifically and perceived gaps in service provision.

3. *Delivering effective services*

Including the organisational culture and operational methods of services usefully engaging with women experiencing SMD, and what constitutes good practice for women specialist services.

The organisations that took part are Emmanuel House Support Centre, Juno Women’s Aid, the Platform One Practice, Nottingham Muslim Women’s Network, The New Albion, POW, African Women’s Empowerment Forum, Al-Hurraya and Bac-In. The field research took place over a 6-months period from July 2021-December 2022.

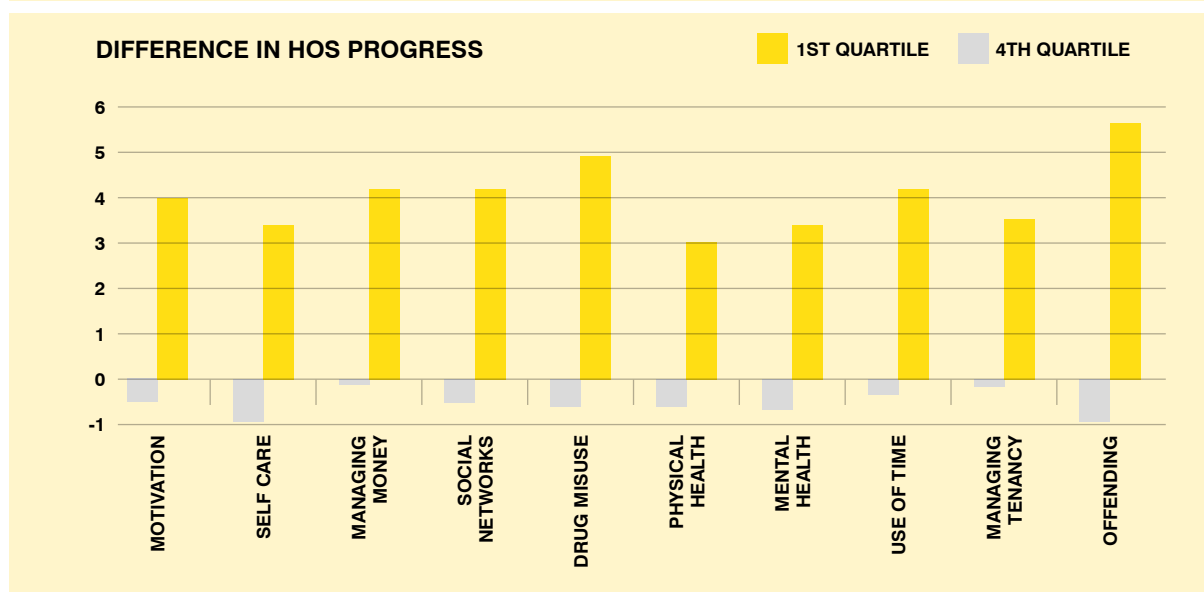
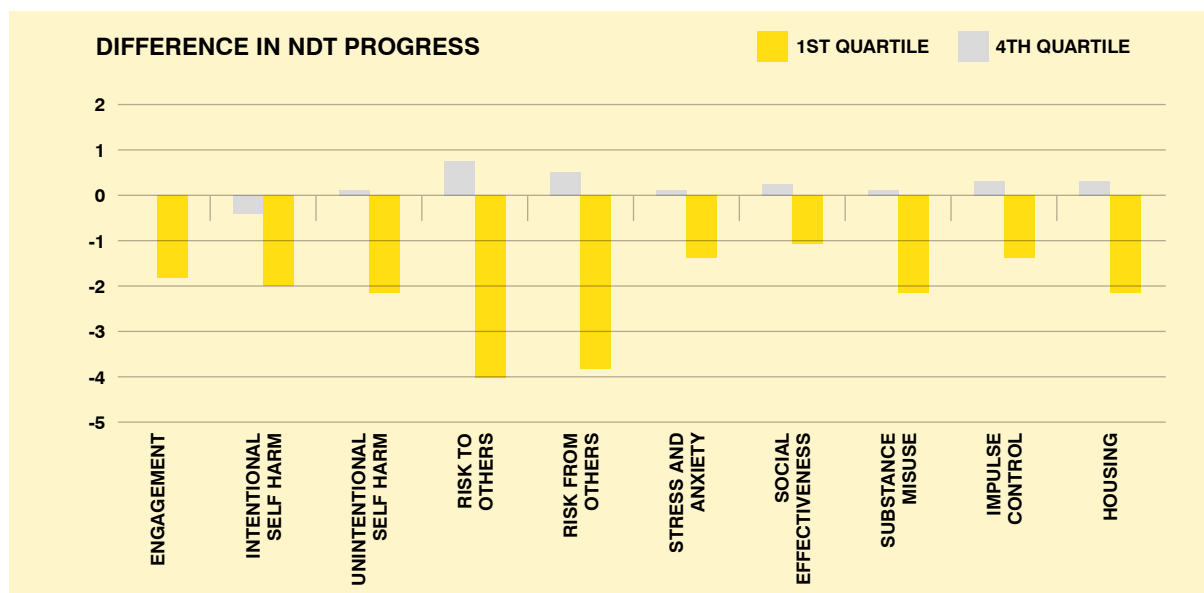
To include both providers and service user’s perspectives and obtain a more holistic understanding of women’s service utilisation and interaction, we decided to draw on a wider range of methods. The embedded research design, using several complementary methods, allowed us to acquire a diversity of views and a more complete picture of the situation (Yin 2006; Bryman 2016).

- Given the complex situation of women facing SMD, their transient nature and vulnerability, **qualitative research based on 11 semi-structured interviews** with service providers served as the core of our research. Participants were recruited based on their experiences and expertise using our own judgment and networks (Marshall 1996). The interviews with key informants, service providers, and practitioners that work with significant numbers of women who experience multiple disadvantage, based on their experience and knowledge of the women on their caseload, have been used to gain insights into the daily practice of the organisations and their understanding of the disadvantages women face. The interviews were flexible, allowing our interviewees to elaborate on their specialist areas and speak of personal experience. The interviews with staff members from organisations that support women and women from minority ethnic backgrounds in Nottingham were conducted either face to face or over video/phone call. With permission of the interviewees, the interviews were recorded, and later anonymised and transcribed. In situations where recording was not possible, field notes were taken during and directly after these interviews (Phillippi and Lauderdale 2018). Fieldnotes and interviews were analysed using thematic analysis (Cassell and Symon 2004).
- The risk of receiving overly positive statements by service providers and social desirability biases were mitigated through observations (shadowing) of drop-in sessions offered by identified services (POW, Emmanuel House Support Centre, The New Albion). **Observing gender-specific drop-ins** also helped us to better understand what practices work well, challenges, and potential areas of improvement (ibid.).

- Qualitative findings were triangulated, confirmed, and complemented with **descriptive secondary analyses**, of

- Opportunity Nottingham dataset of records gathered quarterly by ON staff on the characteristics, circumstances, changing support needs and personal progress of beneficiaries. Progress is documented through two indicators: The results of periodic New Directions Team (NDT), and Outcome Star assessments. The Outcome Star (HOS) consists of ten values, measuring self-management in beneficiaries' lives with increasing scores. The NDT, records progress with declining scores indicating "chaos" in beneficiaries' lives.

- A **survey on physical, mental, and sexual health needs of women experiencing SMD** was sent out and completed by workers of gender-specific services. It asked about physical, sexual, and mental health separately as well as asking about barriers women face to accessing health services and thoughts on how these could be overcome. Twenty-four separate responses were received from workers representing seven services. Altogether the workers who participated in the survey stated they were working with 525 women – although some of the workers will be working with the same women (see Appendix A). The survey is not therefore an attempt to quantify health issues and barriers but does provide substantial and corroborated feedback from workers who work with large numbers of women experiencing multiple disadvantages.



- The high emphasis on service providers increased the risk to potentially miss out on the voices of the clients. Given the difficulties to interview beneficiaries, especially those who had negative experiences with services, we decided to rely on secondary materials to capture beneficiary's perspectives. This included:

- 4 recorded interviews** with women who were engaged with Opportunity Nottingham and had previously been interviewed for different research projects. Consent to recycle the interviews for this project was obtained. The interviews portrayed the women's life history, obstacles they faced in relation to their multiple needs and how they overcame them. In addition to that, one **focus group with 2 expert citizen** was conducted on their experiences of using services as a woman. Their insights illuminated the experiences with services from a lived experience perspective, as well as validated and triangulated insights from the service provider interviews.

- A deep dive into and **analysis of 11 anonymised case file records and support plans**. The women were chosen from the Opportunity Nottingham Dataset; the support plans were chosen according to progress in the Outcome Star and NDT. By comparing the support plans of 6 women who made the least progress, and 5 women who made the most progress, we hoped to gain additional insights into common barriers the least progressing group (1st quartile) faced versus the highest achieving group (4th quartile).

Additionally, a Steering Group was formed to support the research. It consisted of practitioners and specialist workers supporting women facing SMD. Their expertise added to our findings, provided feedback for improvement, and highlighted important areas where women's needs were not being met. Through their knowledge of services in Nottingham, they were also able to signpost and facilitate contact with relevant services.

Due to the qualitative focus of our research, the research is not free from biases and societal context impacting on the recording and analysis of the data (Phillippi and Lauderdale 2018). The data collection process was dependent on voluntary participation, their willingness to conduct interviews or agree to observations of their practices. This enhanced the risk of having an overly positive response. The risks were mitigated, by including a wide range of methods to verify findings from multiple sources, critically reflect on the responses we received, and comparing and contrasting the results with present research (Bryman 2016; Babbie 2020).

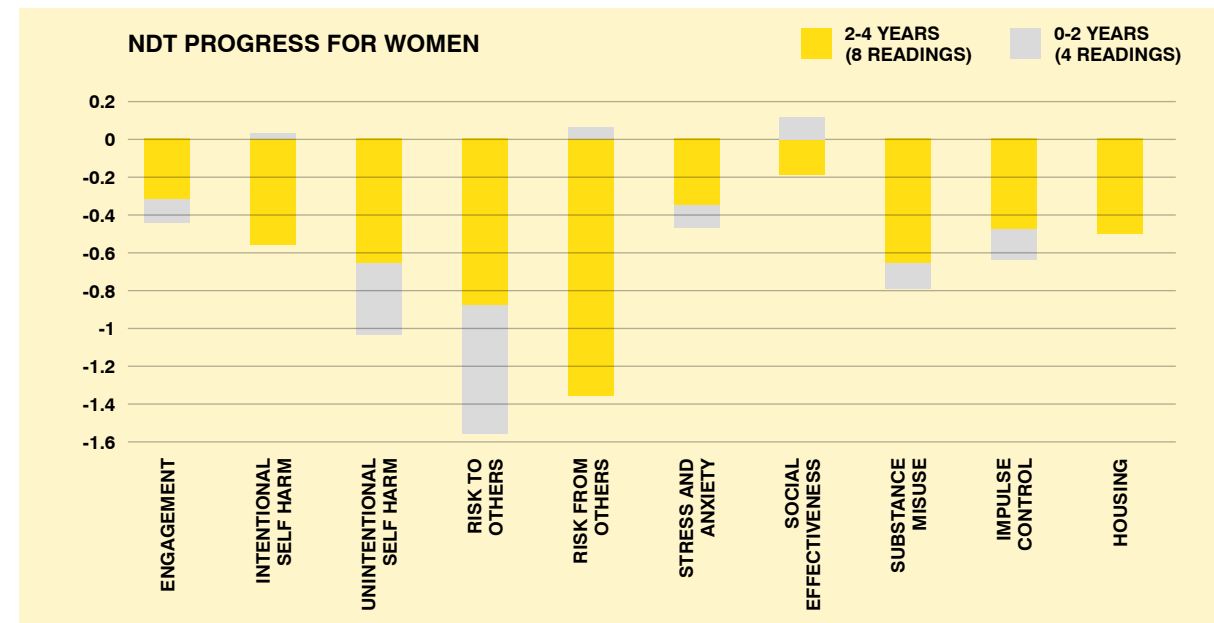


Findings

Do women need more time to trust?

The Opportunity Nottingham Data on Women revealed that **female beneficiaries spent on average 424 days longer on the programme than men** before they are deemed to not require support. The data also indicated that women who are experiencing DVA spent 100 days longer on the programme before being disengaged for not requiring support anymore, than women in general.

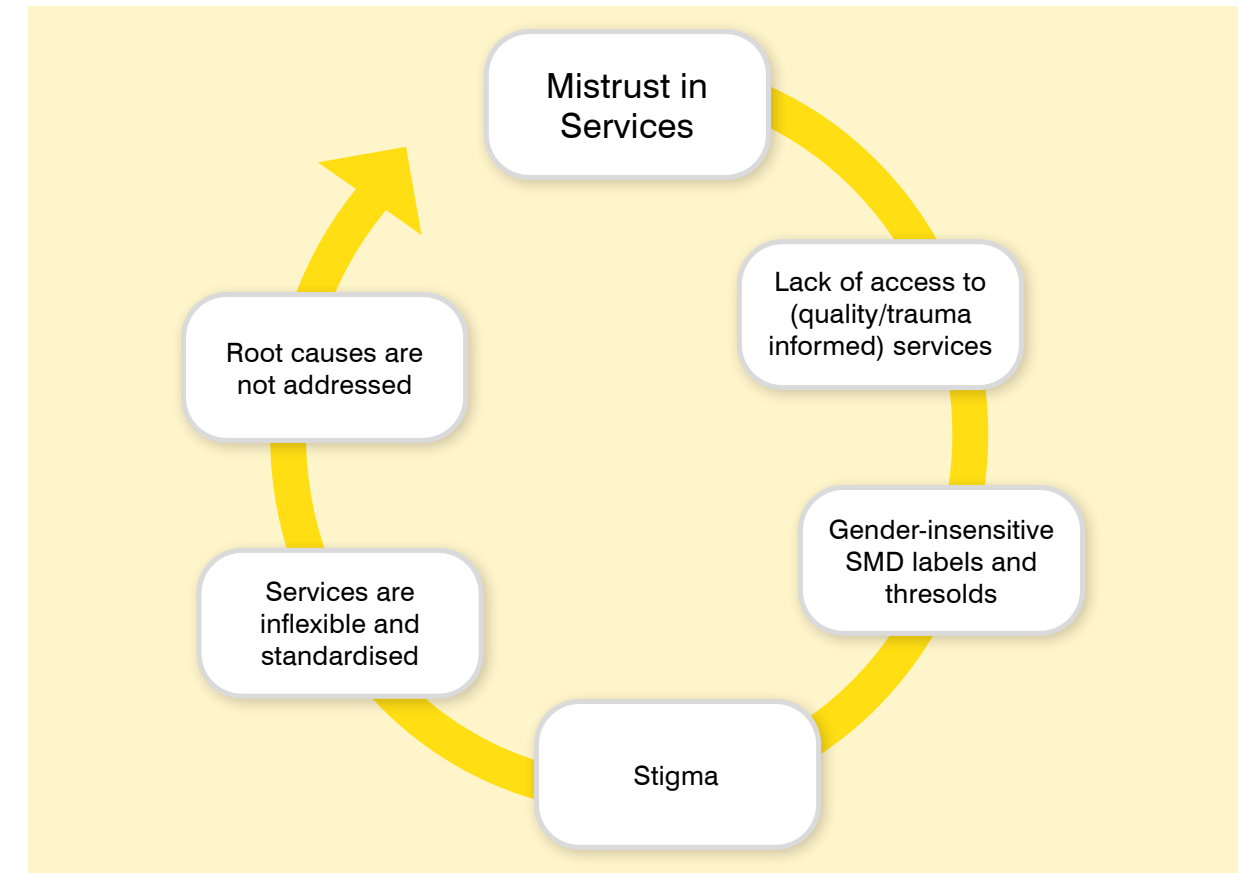
When looking at the difference in progress after two years for women, the NDT scores suggest greater progress in the first year for women than for the average Opportunity Nottingham population. Especially progress in “engagement with service”, which is 0.3 points higher for women. However, starting from the second year, the gap diminishes. Female beneficiaries’ progress between the second and the fourth year drops and even decreases for “risk from other”, “social effectiveness” and “intentional self-harm”, which could indicate hampered progress due to barriers related to DVA and increased mental health needs as a result of it. Similarly, when looking at the HOS, women made on average 0.9 points less progress than ON average across all indicators during the first year, and even 1.7 points after two years. Due to the small sample size and incomplete data collection on DVA among women, these estimates have to be treated with caution.



Nevertheless, the findings support the argument that women have more severe trust issues and experience more barriers when accessing and engaging with services; hence needing more time to trust and engage with service providers. In the following we aim to explore the notion of “mistrust” further and delve into the mechanism behind women’s disengagement and mistrust in services.

Mistrust in services

Our findings revealed significant barriers for women facing SMD when engaging with services: lack of access to (quality) services, gender-insensitive labels and thresholds, stigma, inflexible services, and disregard of root causes. These barriers are not isolated from each other but mutually reinforce and influence women’s access to adequate support, as well as feed into beneficiaries’ mistrust in services.



Although each of these barriers can apply to both men and women facing SMD, who have had, often several, negative experiences with services in the past, the study looks at how these barriers *play out for women specifically*. Based on findings from the health survey, observations and interviews with professionals and beneficiaries, seven important gaps in the access of services which led to mistrust among women were identified:

1. Lack of access to services


The processes that are necessary to go through as a prerequisite before receiving a service can be challenging for women who are grappling with multiple disadvantages.

Women are more likely to suffer from common mental health problems, which is a statement that has been confirmed by several of our findings. The health survey indicates that almost all women, on average approximately 95% (on the provider’s caseload) experience poor mental health. Also, the manager of a women’s counselling service describes how most women who come to their centre are treated for domestic abuse, trauma and anxiety, with the latter being associated to trauma they experienced in relationships and childhood. Yet, **despite the high prevalence of mental ill-health among the SMD cohort, the women encounter several barriers when trying to seek mental health support.**

Some of the obstacles our participants identified were of a purely bureaucratic nature. **Lack of access or difficulties accessing a GP or mental health services without a stable address** was frequently mentioned by our interviewees and respondents of the health survey. In cases where women with multiple needs were able to access a GP, the practitioner’s **training to spot psychological needs was often described as inadequate** or GPs themselves are ineligible to refer to secondary mental health care. When finally referred to secondary care, **long waiting times** to access the service are prevalent and the quality of treatment varies.


Evidently, also **money came up as a huge barrier**, with women with SMD being disproportionately

affected by low economic income. Having to rely on public services, thus significantly limits a woman's choice and agency in finding a suitable service:


 *"You can get your short-term CBT that doesn't work for everybody or will deal with one issue. Or you can get private therapy that is too expensive, or you can get through to secondary mental health services which are really stripped back, quite often what we see if people are referred to secondary mental health is it's just a regular appointment with a psychiatrist and then you're kind of luck when you get a good one, but you don't know what you're gonna get and what approach they have." W6*

Women are also often **unaware of options available** to them, including counselling options that allow beneficiaries to engage for more time than the typical six to eight weeks CBT offered by the NHS. The standard six-week options often turn out to be too short for women with severe mental health issues and is barely enough time to open up about their traumas and negative experiences. This is especially the case for women, who have covered up or avoided their mental health issues and traumas for a long time. They often just begin to address their multiple needs after a few weeks and risk "relapse" when mental health support is withdrawn too early.

A restricted time frame of services prevents women from opening up and accessing the help they need. Many beneficiaries don't disclose until *"you've got like a really kind of really close relationship and it's so individual at what point someone would tell you"* (W2). The more sensitive the issue (DVA, sexual health, etc.), the more difficult it usually is for them to disclose, which is emphasized by the following statement:

 *"She's in her late 30s and she'd been having kind of like psychiatric support on and off since about the age of five. She'd been in and out of care [...] she finds it very difficult to trust people because she just thinks that she's let down all the time and she's gone to ask for help whatever that she's gone to ask for help and it's not being offered or if it's been offered it's been for a short time [...] it takes a lot for them to build up that rapport with you in order to trust you enough to then sort of disclose some of their experiences. One of the women that I support, [...] I think it took at least eight months before she started talking about the abuse that she's experienced [...] and I wouldn't classify her as one of my higher support needs either. [...] She would be quite happy to have a conversation with you for an hour two hours and it'll be all about all sorts of things, but it won't be about the abuse." W3*

Women experiencing SMD also appear to be at higher risks concerning sexual health, such as female hygiene, STIs, and pregnancy. Yet, the health survey revealed that women are often **denied treatment because of underlying issues**, such as substance abuse. To compound this the "catch 22" situation of not being able to access mental health services because of not being "clean" from substance use was also described as a barrier.

 *"I feel like it's got alcoholic written in big letters on top of all of my case notes, and so, therefore, dismissing anything ... 'Or you know she said it's real it really hurts but they're just going on 'Oh it's because you drink.' Yea rather than actually going 'okay. We're going to take you seriously let's kind of do some you know for the diagnostic stuff related to that' and it's a huge barrier." W3*

While the health survey indicates that the highest barrier in accessing health services was inflexible appointment (85%), versus only 31% lack of trust, qualitative findings suggest that the inflexibility of services negatively influence the trust women have in services. Moreover, women who are the most distrustful of services won't be trying to get an appointment in the first place, are not on the radar of the GPs and services and **will thus distort the data**, which makes the indication of the health survey questionable.


Similarly, **substance abuse can keep women from seeking help**. The health survey shows that especially women with multiple needs, including substance misuse sufferers, often do not prioritise their health and going to a GP. Their "drug use means they neglect their physical health; it is a low priority for them compared to getting their next fix/scoring," (Health Survey) which emphasises the importance to offer the help, once the women are ready to reach out.

2. Lack of access to quality and trauma-informed services

That many **GPs and social services are not working in a trauma-informed way** deters many women from seeking help altogether. Two of the service workers, who used to work with SMD patients in their practice, mentioned that many of the young women who came into their practice and dealt with trauma, which had almost always developed from child abuse and trauma they suffered during childhood; however, not many practitioners have the training, experience, or time to work with such heavy trauma and abuse.

As one of the interviewee practitioners described: Trauma is *"quite an arbitrary area of mental health and a lot of it relies on opinion and the experience of the psychiatrist, they don't always understand trauma. I think they are getting better at this but quite often what's happening is that people are just being put on medication for years, and reviewed every three months if they are lucky, every six months sometimes. One woman we had, who had bipolar, quite severe bipolar actually and she just saw a psychiatrist every six months [...] who was unable to deal with all the stuff she has gone through her life."* W6

Along with the other interviews that were conducted, they revealed that also many GPs show a **misunderstanding of mental illnesses**, especially if women portray "atypical" symptoms. Certain personality disorder diagnoses are still rarely diagnosed for women and often overseen by GPs. For example, while ADHD for boys, is often picked up at schools because of a disruptive behaviour and an on average lower IQ, females and males with higher IQ are usually not picked up, as they won't show the "typical" behavioural patterns and hide it. Many women are therefore misdiagnosed or not diagnosed at all, for e.g., ADHD and Schizophrenia. Consequently, their mental health issues are not taken seriously, and they are offered less support, which is why ADHD for females is often presented with anxiety, and either self-harm or an eating disorder. Many of women with SMD will go unnoticed for years which could potentially hinder them from receiving appropriate help:

 *"Practices who don't think SMD is about them need to take a step back and think of people they know with mental health problems, victims of assault etc, elderly people with vulnerable housing, alcohol issues." W5*

W5, who is a practicing GP recounts how many of their patients with SMD had been turned away from previous practices because they are **perceived as difficult and erratic, and as living chaotic lives. These practices fail to acknowledge the underlying reasons for perceived "difficult" behaviour, SMD**, and how general practice can trigger lived trauma. People facing SMD try to access things in a way that can put people off, such as acting aggressive and short, and services don't always realise that this is the only way that they have learnt to ask for help. When then being



turned away, services actually add to the trauma as it confirms the client's anger that they are judged on initial behaviour and not given a chance.

If these patients are treated in a judgmental way, it can quickly turn into a **self-fulfilling prophecy**. The negative experiences of having been let down by providers feeds their belief *"that they don't matter so many of the women felt that they've not been believed by police and probation services [...] brushing it off rather than seeing the woman as a woman."* (S3).

This can have negative, even life threatening, consequences for wellbeing, and is exemplified by one of the case studies. They documented how the client, a transwoman, left a health clinic without being treated for her condition after being repeatedly asked insensitive questions about her gender, sometimes even in the waiting room in front of other people, being misgendered, and experiencing a general **lack of trans awareness**.

3. Stigma

Feelings of being stigmatised creates a big barrier of mistrust for women who feel judged by services, perhaps because of their poor mental health, because of sex working or because of substance use. This comes from actual bad experiences they have had with (health) services in the past, as this respondent stated: *"Reluctance to engage with health services due to negative past experiences of being judged/not believed/labelled as 'attention seeking'"*. Some of the women feel like they are 'unworthy' or 'undeserving' of help and support from services. In an interview with Expert Citizen (EC), a beneficiary at Opportunity Nottingham said that her Community Psychiatric Nurse (CPN) had met her 3 times briefly and had written a report claiming that she had stains on her clothes and her flat was unkept, which made her feel as though her CPN wasn't being supportive: *"Quick to judge but not take the time to care"*. This led to her relationship with her CPN to deteriorate and lack of motivation to engage.

Women internalise these stereotypes and as a result of being judged, labelled, denied support, not listened to, **they minimize their needs** and are not "vocal" about their support needs as a coping mechanism of the trauma they experienced:



"it's like the constant 'I'm fine.' Whether or not they're masking it with addiction, or whatever, but it's like 'I'm fine. I'm fine' because, as soon as you say that you're not fine that's kind of opening up where suddenly it all starts to unravel so I think there's a lot of masking and minimization with the women" W3

Consequently, they avoid such traumatising experiences and may even stop following up on their conditions all together. **Going back to a practice/ GP/ hospital, can trigger the traumas experienced**, the feelings of being judged and mistreated, rendering it difficult for women facing SMD to attend medical appointments, or attend them without any support. Their consequential reluctance to seek help and potentially relive the negative experiences, continues the cycle of deteriorating mental health and heightens mistrust in services.

"Not being fine" and reaching out for help is also **perceived as a sign of weakness among the homeless community**: *"If you say that you're not fine whether or not that's a mental health, physical health whatever it is that's a vulnerability and that kind of adds to the fact that you are not safe [...] and leads you open to further abuse."* W3

Due to their invisibility, bureaucratic and societal barriers, women often seek treatment later than men, when they have exhausted all other – often informal – ways. This combination of lack of trust and stigma combined with process barriers creates a "double whammy" that means much needed treatment is neglected or treatment is only sought once things become critical or even an emergency.



"If people get to the stage where they are ready [...] they've kind of been coping for all that time. You know they've exhausted all of their sometimes quite problematic coping mechanisms and then got to a point where they really need help." W6

3.1. Stigma among mothers

This barrier is particularly high for **mothers and mothers who had children removed**. According to the Manifesto for Change by Fulfilling Lives South East Partnership (2020), every local authority in the UK has worked with women who had children placed into the care system. Many of these women face multiple disadvantage. Due to their complex histories which often include having been in care themselves, gendered violence and abuse, substance misuse and mental ill-health, they often find themselves scrutinised by public services.

A judgmental attitude of a social worker can thus easily turn into the patient having their children removed and placed into the care system, as this quote exemplifies:




"They found drugs in her home, directly leading to child safeguarding; if someone is on the environment where every step is viewed negatively, they get all sort of things where, they are scrutinised." W4

Their **fear of having children removed** or re-living the triggering experience, leads many mothers to refuse and engage with social services, which adds a barrier to accessing services such as care packages and housing referrals. The consequence is that women miss out on vital support.


One example is a beneficiary who recounted her bad experiences with social services after having

felt threatened by them. Their hopes of keeping her child were conditioned on engagement with the service which increased her anxiety:


 *“Never did anyone take the time to explain why. ‘Why are you doing that?’ And you’re freaking out. You are a week off drugs, you’re newly clean, you’re dealing with normal life, and you’ve got no support, to fight these scary people who you think and feel are just there to take away your children. [...] psychological assessments are scary, and no one can tell you what’s going on; people with low mental health and personality disorder struggle without knowing the outcomes of things, need direction and ‘Tell me something’.” B1*

The process of working with social services can feel disempowering for women, especially when they feel that they have not received enough information and are not included in the process of what is happening to them and their children at each stage. They become “passive recipients of a process that was making permanent decision about their own lives and those of their children” (Fulfilling Lives South East Partnership 2020). B1 who has lost children to the care system describes **feeling let down, manipulated, and not being believed by the services** who she claims based their pre-birth assessments on personal judgments rather than facts. In her case, she described having had a personal development coordinator who advocated for her and accompanied her to safeguarding meetings helped her to receive a fair judgment and to be eventually reunited with her children. Yet not many mothers have that independent support to advocate for them.

Having had their children removed stripes a woman of motherhood. They develop a new identity of a “bad mother” and feel “shame” and being shamed:

 *“The stigma is massive, especially for women, especially for mothers, I must mention mothers, so having children removed, nobody, no matter how tough their skin is on the outside, wants to talk about the fact that their child got removed. They are in so much pain and it’s so important to meet that with empathy, it really is, [...] what is that woman going through? Society doesn’t tend to think like that, society can get angrier with women than they tend with men, so there is a lot of stigma.” W6*

This **stigma can be internalised and prevent a woman from openness with services and reaching out or seeking** help early enough, before the issue becomes increasingly difficult to manage and exacerbates prevalent mental health issues.

 *“The effects of having two children removed destroyed me, it took me to a lower level, it made my mental health worse, [...] I think it shaped me that I don’t trust professionals. [...] There’s special services for mental health, they’re special services for drugs and alcohol, there’s special services for sexual violence [...], why is there not a specialist service for pregnant women who are being assessed by social services? There needs to be someone there who is there for the mum.” B1*

Women who have had their children removed, are often left to their own devices. They often feel isolated and unsupported by the services and people around them. They may also lose services, such as housing or psychiatric support, due to not caring for children or being pregnant anymore, hence losing their “priority need status”. Many fall pregnant again, which likely repeats the cycle of having the child removed and adds to the trauma and stigma they are experiencing.

This is complemented by the evidence from the case record files. Two of the three women who were in the bottom quartile of overall NDT and HOS progress, were initially at risk of having their children removed and ultimately had them removed. While their pregnancy and focus on


motherhood, improved their motivation for a time, their record files indicate that after they had their children removed their **mental health and motivation quickly deteriorated** as “*their life just fell apart*” and their mistrust in services skyrocketed. In one of the case record files, it was noted that the beneficiary later refused to approach housing aid as she felt let down by them when she had her children and doesn’t trust their abilities anymore to put her in an inappropriate living situation.

While this is by no means a causal relationship, it indicates, along with the other findings, that the trauma women who have their children removed and the feelings of being left alone by social services, increases their mistrust in services, confidence decreases, leading to higher risk of disengagement and higher needs.

3.2. Cultural shame and stigma

In addition to the above barriers that are mostly structural or at service level, it was found that women from minority ethnic backgrounds may face increased levels of stigma and shame from their own community if coming forward about disadvantages they are facing.

Issues surrounding stigma are often fuelled by the communities’ women are in, specifically if they experience **pressure and cultural expectation from family and relatives**, making it more difficult for them to seek needed support:

 *“You know culturally it might not be appropriate for them to talk about [substance abuse] [...] it doesn’t mean it’s not happening. They [services] will say we’ve not gotten anyone with drugs or alcohol issues. Yeah you probably have it, it’s just they’ve not disclosed.” W3*

The issue of feeling stigmatised by members of one’s own community was identified as a specific barrier for women from minority ethnic backgrounds. One of the main considerations here was in relation to women experiencing domestic abuse. It is important to recognise that all women regardless of their race or culture suffering domestic abuse will share the devastating experience of being a victim long argued to be caused by their gender (Itzin 2006). Where this commonality is recognized, it should also be understood that there may also be specific complications that women face because of their culture.

For some women that access a community organisation supporting Muslim women in Nottingham, the difficulty of leaving an abusive relationship was described as being exacerbated by cultural pressures to stay in the marriage in order to not bring shame on the family (W9). It was also identified that coming forward about interpersonal violence or abuse may lead to further inter-generational violence such as honour-based violence or abuse. Therefore, leaving such a relationship may lead to being at higher risk or being completely isolated from the community (W9).

It was identified that the fear of bringing shame on the family can be used by perpetrators as a way of manipulating women into feeling stuck in the relationship. In one case, for example, a woman from Pakistan had married a man in the UK and was promised a better life and to send money back to her family in Pakistan. This woman, however, was expected to live out a ‘domestic servitude’ role with no agency over her own life and experiencing emotional abuse from her husband. In this situation, the perpetrator would state she would bring shame on the family if she were to return to Pakistan and end the relationship (W9).

In addition to interpersonal violence or abuse, issues such as substance misuse and poor mental health are not widely recognized in many cultures making it more difficult to come forward and seek support around this for many communities (W10). Some fear that they might be seen by someone they know or someone from the community and disengage:



“So I know that she ended up not going back to recovery network and had a change of worker there as well, she just went, ‘oh no I’m fine you don’t need any support now.’ She’s still drinking, she still needs our support, but she’s just disengaged by minimizing and saying that she’s fine now. It’s just the sort of the stigma involved with it within the Community, that causes a lot of problems, as well as with the family, you know the stigma around sort of our alcohol consumption and repeated hospitalization.” W3

In many circumstances, it was identified that keeping up appearances of everything being ok is more in keeping with the culture, making it more difficult for people from many backgrounds to seek support. It may be that feeling understood and listened to by services would be the key to beginning to break down such barriers, however, structural barriers create additional complications specifically for women from minority ethnic backgrounds (W9).

4. “Too hard to engage” - the SMD label and thresholds

The aforementioned barriers all provide indicators of why it might be more difficult and take longer for women to access specific services. Some women, however, are denied support in the first place, when they become labelled as being “too hard to engage”, “having too complex needs”, or don’t meet the SMD threshold. For instance, service workers highlighted that many service users experience **not being able to access services because of “too complex” or “too insignificant” needs:**



“Mental health has to be really severe like if it’s anxiety or depression, it’s ‘I’m sorry that’s not really bad enough.’ You know you have no idea that the amount of distress that person is experiencing or how it’s affecting them day by day. They could be depressed or suicidal or have something like OCD, which is controlling every aspect of their life. But is also not a psychotic illness or that’s not bad enough.” W2

The multiple needs label serves as “key” to access services and creating a “hierarchy of needs”. However, many women facing SMD do not define themselves as experiencing multiple needs, or do not exactly understand what it means. This creates the question of how SMD is defined and by whom and the consequences this can have:



“Someone here who kind of accesses the drop in regularly was referred to a complex need service and so well ‘I’m not complex needs? What’s complex needs?’ And then complex needs was explained, and they were ‘Oh yeah, you probably could describe me as complex needs.’ So they have multiple disadvantage, having this criteria, but then the people who’ve been referred to service is not necessarily knowing what that criteria is as well. It’s almost like the criteria is something separate for workers and like yeah, we will assess and decide if you’re in this group.” W1

While the label SMD opens doors for one service, it might also lead to further disadvantage and close doors for other services, sometimes even purely due to **different understandings of the terminology**. For example, the original definition of SMD excluded DVA and led to a gender imbalance in local SMD services who were following the original definition. With DVA added as a fifth disadvantage, the number of men and women experiencing SMD is roughly equal and services such as Changing Future in Nottingham are committed to correct their gender imbalance for the next “Changing Futures” project cycle.

This is particularly important, because, as discussed in the literature review, **women often**

experience disadvantages in a different way than men. For instance, women tend to sofa surf, stay with family and friends rather than sleep rough. This is also shown in the Opportunity Nottingham Dataset: Only approximately 3% of the women in the dataset were rough sleeping, which is far below the Opportunity Nottingham average, counting almost 28% of beneficiaries rough sleepers at the start of engagement. This is consistent with findings on rough sleepers on a national and local level. In 2020, 85% of rough sleepers in the UK were men compared to 14% females and 1% “not known”, the numbers being consistent across regions (Ministry of Housing, Communities & Local Government 2021). As rough sleeping and ending “visible” homelessness dominates our homelessness policies and rhetoric, this has an impact on the budget and accessibility of services for women and neglects female homelessness which can be as “extreme” and “dangerous” than sleeping in a doorway. The focus on visible rough sleeping portrays significant barriers for women accessing specific services that e.g., only target rough sleepers or could mean that they are not prioritised for the service unless becoming “street homeless” which is the case for few services including Housing aid and other accommodation schemes.

Furthermore, thresholds are often determined through the absence of a certain need which effectively ignores risks and vulnerabilities associated with this need:



“There is a lot of people on the streets that aren’t taking drugs, well there’s one or two, they are on the streets for different reasons but like I said they are not counted as being vulnerable, you know that needs to change. In my eyes, we are more vulnerable than the drug addicts on the streets, because we are vulnerable to overdosing, going back to it, you know, getting robbed, and all that kind of things.” B2

Although a certain threshold and criteria is important to identify the most vulnerable and those who will benefit the most from the service, the **“all or nothing” approach may lead to beneficiaries missing out on services they would have been eligible for.** This has particularly severe consequences for women who take a longer time to seek help and open up to a trusted service. It also incentivises minimizing or overstating needs and creates the paradox consequence that *“they [beneficiaries] have to be moulded to fit the system, rather than the system working for them. Or it’s like all ‘well to get onto this service, you need to make that bit sound worse than it actually is so you can get support’ and what’s the message that’s sending to people.” W1*

At the same time, programmes are not always aware that many **women facing SMD avoid diagnoses to prevent being stigmatised.** Without an official diagnosis, however, they are often unable to access specific services, they would be eligible for:



“I think some women would prefer not to have a diagnosis, because they don’t want to be labelled. But it’s that the way services is set up it’s almost like you have to have an official diagnosis, then in order to access all this extra support, but they don’t want that diagnosis because of the stigma attached to it or their preconceived idea that that stigma attached to it and so it doesn’t matter what you say you know if you explained to them that actually you could benefit from a diagnosis, they don’t want it.” W3

In a world, where **access to services is often determined by “little bullet points”**, “sort of a summary of a person’s entire life” and “cases files”, instead of “having a conversation with the person and let them speak to you at length about whatever needs there may” (W2), it can impede a woman from being referred to a service.

This has been exemplified by W6, who advocates that such scores and bullet points, whilst they are useful as a snapshot of how people feel at the moment and to determine areas to work on, should only be carefully used to measure progress. Especially in the beginning of women’s engagement



with services and once they start to build a trustful relationship with the service, their **awareness of their needs will change as will their level of disclosure to the services**. Being a practitioner herself she recalls that *“when women with SMD come along to a therapy session they are often not aware of their needs and score themselves higher than they will a few weeks down the line when they’ve become more self-aware.”*

Finally, **bureaucratic and paperwork barriers**, requiring beneficiaries to fill out several forms and assessments before being offered any support, reinforces the inhibition threshold, and deters many beneficiaries from trying to access services in the first place. A professional highlighted how she was working with a woman who has been rough sleeping consistently for over 10 years with her partner, and heavily using drugs and alcohol. She had been labelled by the services as “hard to engage” but was persuaded by the professional to attend a drop-in they offered. While the beneficiary refused to give their name and receive any support initially, but just came for some food and to be warm, she started to attend regularly. After three months she asked for additional support leading to a referral for drug services, emergency housing appointments, and important medical tests, and finally her and her partner being accommodated and linked in with appropriate services. The case study highlights how services who have high bureaucratic obstacles and/or are quick to sign off “unengaged” beneficiaries ruin all chances of building trust and relationships with this client group. There is a need to offer more low-threshold services or open drop-ins that allows women to seek support when they need and not when fitting the criteria.

5. Inflexible and standardised services

Women with SMD who have already had negative experiences with services such as being stigmatized need flexibility in order to regain trust. However, because some services are not working in a flexible way, this reinforces mistrust and leads women facing SMD to quickly disengage with services who are not accommodating to their needs. Some services are quick to take unengaged beneficiaries off the caseload without entirely understanding how their disengagement is shaped by their experiences of SMD:



“If somebody doesn’t engage then that’s it, you know they have to close services, which I understand you know when you’ve got such a huge influx of kind of referrals, and I think just speaking to some of the women that I support it is ... that trust it takes a long time” W3



“It’s like the classic three strikes and you’re out so if she’s not answered the phone in time or she’s not engaged or turned at that meeting, then she’s discharged from service.” W1

This leads to a fifth gap: The inflexibility or standardisation of services or lack to tailor support to the individual. Providers apply a standard way of “treatment” that does not work for everyone (or not even the majority) and does not show a lot of appreciation for person’s individual multiple and complex needs. One example that came up in the interviews was the **process of actually getting an - and getting to - an appointment**: Having to ring at certain times (some women may not have a phone) or getting only an Ansa phone message can be perceived as confusing. Since the start of the Covid-19 pandemic services have increasingly relied on phone and video calls as a means of contact. Some women experiencing SMD find these difficult, due to lack of access to digital technology or anxiety about appointments conducted in this way.

The importance of flexibility and allowing more flexibility for bending rules was also discussed by a CBT (Cognitive Behavioural Therapy) practitioner working with those experiencing SMD. She recounted those women she has worked with tend to miss more appointments and take longer to build rapport with than their male counterparts. Being flexible with the location and time of their meetings as well as being understanding if appointments are missed was deemed as imperative to breaking down barriers and building trust. In addition, offering support without a set end date but based on the needs and goals of the individual contributes to building trust. In mainstream CBT therapy, however, appointments are more likely to be based in a clinical setting, with a set amount of sessions and at a set specific time with little flexibility. Similarly, the Covid 19 Impact report (Everitt, Kaur, and Bowpitt 2020) has shown how during the COVID-19 lockdown, some services made an extra effort to make sure that people were okay. Pharmacies and GP practices applied a more flexible approach, such as using telephone engagement and delivering medication from the chemist which benefits women who struggle with anxiety and find it mentally challenging to leave the house and visit practices and counsellors, have care responsibilities or are otherwise prevented from attending face-to-face appointments.

In addition to that, the lack of cooperation between services and having to set up multiple appointments with several services rather than sorting it out altogether, renders engagement more difficult. Barriers due to **childcare and caring responsibilities**, and **transport** (or the lack of money for transport) to get to -often several- appointments are hurdles that were mentioned by health survey respondents and the interviewees.



“The women I work with are always saying stop sending us to different places. You know the more needs you have and the more buildings you have to visit and the more relationships you have to build. And women in particular are affected by relational trauma, so they don’t find it easy to build trusting relationships with people.” W6

The timings of appointments too can be unsuitable in relation to the complex lives women experiencing multiple disadvantage tend to lead. As can the rigidity of appointments and the loss of access to a service if appointments are missed. W3 revealed that many women who are rough sleeping, or engaging in sex work, are often **unable to access services due to their different day routines**. Outreach teams are usually out at night, when sex workers are working. Even if they are not working, women rough sleepers are less (or try to be less) visible out of safety concerns.

Consequently, women who are in precarious accommodation or rough sleeping are less likely to be (visibly) rough sleeping than men, in order to avoid being unprotected on the streets, and being further subject to violence, (sexual) abuse, and rape.

Public services, including mental health, drug, and housing services, who do **not allow clients to choose their worker by gender**, can be frightening for women, especially if they have experienced domestic and/or childhood abuse. The **fear of running into their perpetrator or violent ex-partner, the fear of being exploited** or feeling unwelcomed and rejected by services due to bad experiences in the past, often means that they go unseen by homeless services, increasing their vulnerability and isolation.

One aspect of this this relates to the difficulty engaging with (health) services when in an unsettled situation. This barrier particularly relates to **women living with or escaping domestic abuse** and the impact of the controlling behaviour of the perpetrator:



“...if women are still living with the perpetrator, they can be prevented from attending much needed appointments OR the perpetrator can always be with them, so they are unable to disclose certain health issues” (Health Survey)



“People think, oh it’s so easy, let’s walk out of this abuse but its not easy. It doesn’t work like that. They don’t get the manipulation. They don’t get the things they do, just to keep you there. You’re left doubting all the time. ‘Was it really that bad? [...] I barely touched you, or not slapped you’. They’re making you doubt yourself.” B3

6. Misunderstanding intersectionality & secondary disadvantages

It was found that from speaking with community groups and organizations within Nottingham City that specifically work with women from minority ethnic backgrounds, many of the women experience multiple disadvantage within the secondary domains of disadvantage as set out within the Gender matters report (Sosenko, Bramley, and Johnsen 2020). This report identifies a specific cluster of women that experience only one primary domain of disadvantage (mental ill health) but several secondary domains including social isolation, with a higher proportion of women from minority ethnic backgrounds within this group.

This report supports the Gender Matters findings as many of the disadvantages identified by professionals fell into secondary domains of disadvantages, as listed below. Although this study has not had the scope to analyse how many individuals experience primary and secondary domains in conjunction with one another or how these interact, drawing on experience from professionals has helped identify some of the disadvantages that women from ethnic minorities experience. In addition, how women are supported locally in Nottingham by voluntary, community and grass roots organisations.

Most of the professionals interviewed who worked with women from ethnic minority backgrounds (W7, W9, W10) discussed cases that had experienced several of the secondary domains of disadvantage, however, only one or two of the primary domains.

PRIMARY DISADVANTAGES IDENTIFIED	OTHER DISADVANTAGES IDENTIFIED
Homelessness	Experience of racism
Mental ill health	Language barriers
Victim of interpersonal violence	Social isolation
Substance use	Child removals
Eviction	Going through the asylum process
Hostel Exclusion	Fear of cultural; shame and stigma
Homeless upon prison release	Poverty
Local connection issues	Partner with substance misuse problems

In order to reach more women in general as well as more women from diverse backgrounds, services may need to recognize secondary domains as part of their criteria and be aware of the impact these issues may have on the individual.

6.1. Experiences of racism

Many of the professionals highlighted that service **users will sometimes avoid mainstream services because of racism that they experience or have experienced**. This may be direct discrimination or the experience of the system being inherently racist, with treatments and systems geared towards supporting those from white British backgrounds and showing little understanding of different cultures. This was described as a reason that women will withdraw from mainstream services and contributes to the isolation of women from minority ethnic backgrounds (W7). One interviewee stated women will then look to their own community to have their needs met, rather than accessing mainstream services and risking feeling discriminated against again (W7).

It was apparent that the racism being discussed is from both members of the public as well as facing stigma from professionals (W10). It is therefore, understandable that **feeling this level of stigma may contribute to a mistrust in services that are not culturally specific**.

6.2. Lack of understanding of cultural differences

There was a distinct **lack of understanding of different cultures** identified by the professionals that participated. Coupled with this, a lack of representation of minority ethnic groups within staff teams and in management or boards of trustees. It was felt that this contributes to a lack of understanding of different cultures.

In addition, this leads to a **standardisation in the way that services are run that fails to be flexible to the needs of all**. Where person-centred approaches are regularly discussed as being an organisation’s way of working, this was described as not always the reality but often ‘lip service’ (W7). An example of this was participants explaining that as an organisation they have intervened and given advice to social care teams who have had little understanding of the multigenerational family structure in Muslim cultures. They had expected a woman and her children fleeing domestic abuse to live with another family member, however, were not aware they are not necessarily safeguarding the woman and children as they may then face honour-based violence from the wider family (W8). Another example was a woman fleeing domestic abuse from her partner and then experiencing domestic abuse from her children (W9).

Where it is not appropriate to make assumptions based on an individual’s culture, **having an awareness of such risks, how to create open spaces for disclosure and to recognise the signs** appears to be an area severely lacking within mainstream services.

6.3. Language barriers

Each of the professionals interviewed discussed the **issue of language** barriers. It was identified that this can be an issue with many layers.



“Even if English is your second language, when you are trying to process difficult emotions and difficult experiences, the last thing you want to be doing is censoring yourself with another language.” W6

Although translation services are available over the phone, **not all organisations have sufficient funding for this and the nature of having to involve another service creates an extra barrier**. For example, women that have experienced trauma may benefit from counselling or therapeutic services. There are, however, few counselling services that are not in English. It was explained that women will not feel they can open up to someone that cannot understand them, it is in an

immediate barrier. In addition, where the language barrier can be mitigated by a translator, women need someone to understand their 'cultural needs' which may be more complex (W9).

In support of this view, (Costa 2013), states that language support of any form whether it be **interpreting or another form can add to the feeling of anxiety and disempowerment**. Often, partners or family members will act as a translator for a woman when engaging with professionals. Although sometimes a convenient and quick way of overcoming the language barrier, this can be problematic if the male is a perpetrator of domestic abuse, for example. It should also be recognised that domestic abuse may not be just within one generation but there can be perpetrators from multiple generations within the family (W9). Therefore, women are not always able to reflect their true feelings or situation if a translator has a personal relationship with the service user. This may be an example of a failure to create a safe environment in which a woman can feel they are able to disclose and be understood.

One example that came up was women that have had social services involvement with their family. It was identified that the **system can be incredibly complex and challenging, so for women who aren't able to communicate in their first language**, it is likely this will be a very confusing and stressful experience. In this example, a child has been removed due to the impact of an abusive father, however, the mother did not feel that she fully understood the reasons she was not able to care for their child alone. It may be that social services have explained the facts to the mother and used a translator, however, has this been done in a culturally sensitive way and was sufficient care taken to ensure everything was understood? The impact here can result in a mistrust of mainstream services due to fear of further negative experiences (W7).

6.4. Legal barriers

Another barrier can be the **role of immigration status**. Professionals spoke of women feeling trapped in a relationship due to being in the UK on a Spouse Visa fearing they will have no recourse to public funds (reference) and may face homelessness and destitution if leaving the relationship. Where help and support is available when a relationship ends due to domestic abuse and women may be eligible for indefinite leave to remain, this is not widely known and where to get help around this is not signposted sufficiently.



"95% of our women, they don't know what to do or where to go [for immigration support]" W9

7. Root causes are not addressed

The previous paragraph suggests that **services don't always have or take enough time to understand "why" someone is unengaged and that their lives are chaotic**. Services often fall short in understanding that disengagement of services is not purely "by choice" but is influenced by the circumstances and context of the women who face SMD. People fall off the radar for being disengaged and/or are taken off the record.

The **lack of trauma-informed and flexible services**, means that root causes often go unaddressed and the women's disengagement or refusal to use one service, will exclude/ dis-engage her from the service altogether:



"They are distrustful [of a specific service] and it might be because, for example, this particular woman didn't want to be housed in the complex needs service at the Aidan House because previously that was like a mother and baby unit and [her child] was taken away from them then and so she didn't want to go there, so that limits your

options [...] accommodation now or rough sleeping ... you've refused our offer of housing. That lack of understanding as to why somebody might make that choice to go homeless. So much of it is trauma-based." W3

This is also an issue when dealing with severe mental health issues and trauma. When trying to access a specific service, many women are required to recall traumatic events "on the spot". **Not being given the time to build a relationship with their service worker** decreases the likelihood of them disclosing relevant information:



"She said she's only going to recall particular events when she is in that personality and that personality might be months between that personality and so I think with the prosecution last time and that involved domestic abuse, sexual abuse, she's been trafficked before, so the prosecution service decided not to go ahead with that particular prosecution because there wasn't enough evidence ... It was so much evidence, but she just couldn't recall it at that time in that one interview. And so there's a lack of understanding there, and if a woman with DID [Dissociative identity disorder] or any other kind of issue where she's going to struggle kind of recalling facts, it's almost a way of discrediting her experience because in [...] if they can't come up with all the facts that are needed to go ahead with the prosecution then it's not going to be happening and again that adds to the distress." W3

The first reaction of services is often to **sign the beneficiary off, without having understood or engaged with the root causes** (domestic abuse, mental health, language, or legal barriers) leading to their disengagement. Being too quick to discharge a service user, however, reinforces their perception of not being understood and listened to, reinforcing their negative beliefs about themselves and the services.



"[mental health] interventions that are offered really put people off. If people do somehow get into [mental health] service they get their six or twelve sessions, they feel quite blamed, they feel defective because they've got all these strategies but they're not able to use them whereas actually it's just not the right approach for them." W6

Being signed off and labelled as being "hard to engage" – despite the courage it often took them to engage / the barriers they had to overcome in their first place - reinforces in the beneficiary, the feeling of being let down and increases their mistrust in services once again.

Lack of safe spaces, including gender-specific refuges, and secure accommodation

Although building long-term and trustful relationships are important, our findings illustrated that also the location and creating safe spaces and a sense of safety for women matter and play a significant role for women to open up and disclose their trauma and needs to relevant services.

Several obstacles for women when trying to access a safe space, be that in the form of a gender-specific drop-in, specialist refuge, or secure accommodation were identified:

1. Lack of capacity and privacy in premises

A general lack of specialist refuge spaces impedes women and women with multiple disadvantage to access safe spaces in accommodation. There is a **lack of capacity for gender-specific, multiple needs and specialist refuges**. The few specialist refuge spaces that exist are oversubscribed and underfunded. Out of 529 hostel spaces in Nottingham city, only 43 refuge spaces are saved for women. The Central refuge, the main provider of specialist refuges for domestic abuse survivors, currently rejects 73% of all referrals, mostly because of a lack of capacity. That means that more than three quarters of specialist refuge demand is unmet.

The problem with that is that interviewed service providers repeatedly emphasise that women rarely disclose in mixed-gender services, especially if their needs are related to sexual health, or gender-specific traumas, e.g. child removal/ DVA. The problem seems more severe when women face pressure and cultural expectations from family and relatives. One of the service providers recounted that some women use “some sort of code word” if they feel unsafe and need to talk away from the room; another mentioned that some of their colleague’s consultations have taken place in public toilets at the train station/ behind trees etc which highlights the needs for more safe spaces for women. **Limited specialist refuge spaces for women** thus fails the experiences of women who feel uncomfortable in mixed-gender hostels and accommodation; some of them avoiding mixed-gender services altogether.

1.1. Barriers created by intersectionality

In mainstream organisations, it is **unlikely that staff teams will be representative of the ethnic diversity of the general population**. According to national statistics, the employment rate for ethnic minorities is 62% where for white workers this is 75% (DWP 2016). Furthermore, those from a Pakistani or Bangladeshi background have a lower employment rate of 54.9%. This is, however, specific to certain types of job roles. For example, those from an Asian background are overrepresented in the NHS comprising of 34% of all NHS medical staff (‘NHS Workforce Statistics - March 2020’ 2020).

These figures offer a background to the lives of women from ethnically diverse backgrounds accessing mainstream services. It is more likely that women will be treated or supported by someone from a white background that **may not have an understanding of their culture, resulting in women not feeling it is a safe space to open up**, especially when women have felt marginalised or discriminated against by services in the past.

Project workers from one culturally specific organisation highlighted that many of the women that are supported by their services are fleeing violent or controlling relationships. Some women will be encouraged to move to the UK with the promise of a better life and sending money to family in their home country, and then find themselves in a situation where they are expected to care for their husband and sometimes their husband’s family. Living out a kind of ‘domestic servitude’ role. It was described that women often will not know the language and therefore have very little agency

over their own lives as they are completely reliant on their partners in order to be able to navigate complex systems (W9). This example of isolation provides insight into an extra barrier for some women from ethnic minorities to finding safe spaces where they are able to speak openly about disadvantages they are facing.

1.2. Barriers created by gender-based and domestic abuse

This is particularly an issue for women, who are exposed to gender-based violence, exploitation and abuse on the streets, survival sex and domestic violence. The consequence a lack of capacity can have, is highlighted by the following quote that has been taken from Katie Finnegan-Clarke’s research (2021):



“I can think of one particular woman – all day on the phone trying to find refuge space and we kept getting the same reply that [the] woman’s needs were too high and she would put other women at risk or she would put other children at risk because of her drug taking or mental health issues, and then she was killed. Literally that happened on the Friday [trying to find refuge] and I came back into work on the Monday and she was killed. I can think of 6–7 women that we know have been killed at the point of trying to say ‘I am not safe and I need to go [into refuge]’ but their needs were ‘too high’ for those services.” **Health Shop Professional**

Of the 11 domestic homicides reviews in Nottingham since 2012, eight (73%) of the victims were female and all the perpetrators were male. 63% of the victims and 75% of the perpetrators were experiencing SMD.

Lack of female safe spaces also increases the **fear for women survivors to run into their violent ex-partner** or confront trauma related to (sexual abuse) which again prevents them from accessing a service or disclosing needs and health issues.



“If someone was sexually abused as a young adult, probation don’t realise that male touch is hideous, even a male worker assigned to them; even at the earlier stages they would not go to the appointment.” **W5**

The lack of safe spaces where women can disclose has been exacerbated by the recent pandemic, which made the creation of safe spaces difficult when a woman who is suffering from DV is sharing their place with the perpetrator.



“...if women are still living with the perpetrator, they can be prevented from attending much needed appointments OR the perpetrator can always be with them, so they are unable to disclose certain health issues” **Health Survey**

2. Difficulties to move on/out, due to potential loss of services and/or protection

Another obstacle is that women are often reluctant to go to refuges in different areas, because that means that the **support that they have in place may be withdrawn**: *“They might have taken months to build up that rapport with their worker and even though they need to go elsewhere in the country for their own safety that means that they’re starting from scratch there’s a huge disparity in the system”* W3

This is often amplified by a **lack of a supportive social network and family bonds**. Especially for women fleeing domestic abuse, not having the right support in place or social networks they can

rely on, makes it difficult to escape an abusive partner, as they often function as their only support and safety, especially when rough sleeping.

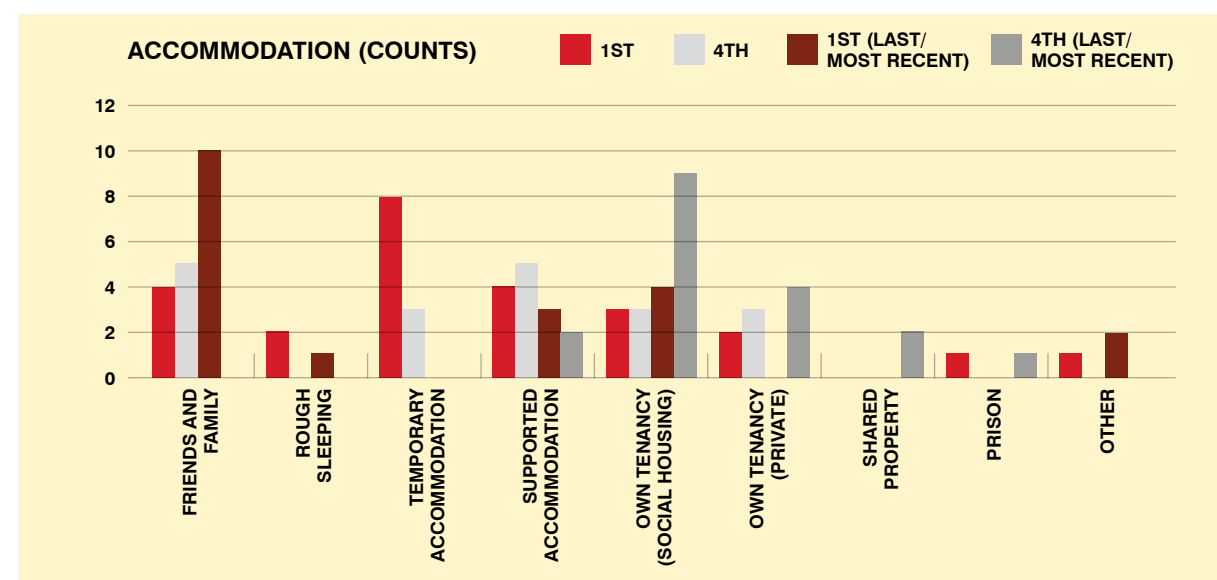
The result of this, is a **trade-off between staying with a potentially abusive partner and maintaining (perceived) protection from their partner**: *“the women that I work with are constantly risk assessing the entire time, going well okay it’s not great, that I kind of get beaten to a pulp twice a week, but actually that safer, then, me kind of getting raped because I’m rough sleeping by myself”* W3. In some cases, this will mean that – because of the way some services, are currently working - the fear of and the history of actual negative experiences with services contributes to women survivors it may feel safer to stay with their perpetrator, rather than risking losing the protection of being in a relationship. Also, the women in the bottom 25% bracket of progress tend to be living in unstable accommodation, engage in survival sex, or entering relationship with accommodated partners, as opposed to staying in (mixed-gender) hostel accommodations or going back to the streets and rough sleeping. The support plan of one of the women indicates that she is sofa surfing at her ex-partner’s place, due to “not having anywhere to go” and because of the trauma of having been raped by three men when on the streets.

Living in an abusive partnership may encourage drug use, lowers self-esteem, and hinders women’s progress. The problem can be worse if children are involved. For example, in one instance the children were used by the perpetrator to manipulate their mother into staying with them. The perception of safety in combination of the **controlling behaviour (coercive control)** of the perpetrator makes it difficult for women to engage with health and social services in an unsettled situation.

3. Thresholds and criteria for certain services/schemes are often gender-insensitive

Owing to a lack of safe spaces in services and specialist refuges, the securing of safe accommodation becomes crucial for women experiencing multiple disadvantage to acquire some stability to tackle their support needs and rebuild better relationships with their families and social and support networks.

The **significance of secure accommodation** is, for example, highlighted by the Opportunity Nottingham dataset. The graph illustrates that women who made more progress were more likely to move from temporary and unstable accommodation to stable accommodation, whereas women in the bottom 25% tended to rely on sofa surfing and in temporary accommodation. This was also confirmed by the support plans indicating that moving into their own tenancy was the mutual key factor for the women with the highest progress.



For instance, one support worker reported limited progress of their beneficiary due to spending time in another city and having lost her social network. Her support plan indicated that once she moved into a tenancy, she was able to acquire a more positive social network, motivation to engage in social activities and more control of her substance use and mental health issues. The same is true for two of the other women with the highest progress, who have a history of domestic abuse. One of them was housed in a hostel where she did “not feel comfortable around the male tenants who are intimidating”. Although there is no narrative directly attributed to them being housed, their activities suggest that they have been able to maintain their wellbeing and coping well due to being securely housed. Issues around DV and alcohol consumption seem to have been significantly reduced since being housed. For one of these women, being housed also allowed her to be in control of her partnership and ongoing DV through a non-molestation order that gives her power to exclude him from the tenancy if she chooses.

One example of a successful housing programme is the Housing First Scheme, where Opportunity Nottingham currently houses 13 women (and 11 men). Housing First started as an intervention to overcome long-term and recurrent homelessness by providing affordable housing and case management services. The problem of the scheme was that the “typical” housing first tenant initially was rough sleeping and male, **not recognising female patterns of homelessness**. Women are often less visible for standard services in housing. Their portrayal of multiple needs and homelessness often defers from the standard perception of “a person with severe and multiple disadvantage”, affecting women’s access to services and schemes.

One of our interviewees described how she had difficulties accessing support or the housing first scheme due to her needs being perceived as not complex enough which led to her total disengagement with services:



“They wouldn’t even put in a hotel or anything to help me, no. They just kept saying ‘you’re not vulnerable enough, you’re not vulnerable enough, because you’re not on drugs anymore. ‘One of them even said to me ‘you might just want to say that you’re on drugs, you do better that way’ . And that really really wound me up, so I kinda was rebelling even more then so I walked out and I was like ‘I ain’t ask you for nothing after that.’” B2

When asking how she became engaged with services and the housing first scheme, which led to her being accommodated, she responded:



“They saw me in the doorway for that long and then people ... Framework and that started getting interested and wanted to know a little bit of background of me and when they found out why I had come to Nottingham, you know, I got kidnapped by my ex, and he basically broke all my legs up and so when they found out why I was here and they found out that ... see I ended up going back to drugs at this time and ... I’m getting upset... I ended up going back to drugs, and I was really bad on mamba and I was so skinny. [...] And then I think people just started taking notice of me.” B2

This shows how minimising and disengagement with services due to mistrust and previous negative experiences, prevented the beneficiary from accessing a service she had been eligible for. It showed how the multiple needs she was experiencing were not immediately visible to the outreach teams and service workers, because of her outward impression of “being fine”. Not getting the support she needed at the time, led to her to re-engage in substance misuse, and sleeping in doorways for a sustained period of time, increasing her risk of experiencing further physical and sexual violence which could have been prevented.

Building trust – Some good practice principles and examples

Throughout the study and research, our findings show how specific ways of working within services can be particularly beneficial in meeting the needs of women that experience SMD.

The findings stem from observations at a women's service to support sex workers, a women only drop-in service, and a mixed gender homeless accommodation services. As well as conducting interviews with service users from Opportunity Nottingham, regarding their personal experiences at different services, touching on what works well and what is best to avoid. Furthermore, an interview has been conducted with the manager at another women's service to speak about accessible counselling services for women with SMD.

The main themes that have been extracted are:

- 1. Person-Centred approach within services**, with a great emphasis on services understanding the meaning of this and making conscious decisions in the service to put this into practice, therefore avoiding using the term as a buzz word.
- 2. Agency and choices for women**, including a gender and ethnically diverse work force, understanding a woman's barrier to engagement, and allowing individual recovery.
- 3.** Understanding the gendered and intersectional notions of society to create a basis for meeting the needs of women with SMD that are using services and the individual barriers women encounter.
- 4. Referral and liaising.** This allows services to work together to meet all the needs women with SMD have, without having to repeat telling their story, and without having to be passed around services and repetitively start new relationships with different workers. Therefore, Services being able to collaborate helps regain trust in services. This is particularly useful when working with women from minority ethnic backgrounds as mainstream services can be too standardised limiting their ability to meet cultural needs.
- 5. Counselling services and advocacy.** Women with SMD are often deemed too high risk to participate in statutory or general counselling services and/or mental health services, and therapeutic aftercare for women and mothers who had their children is often absent. However, creating a space which is flexible and transparent for women with SMD helps perpetuate trust in services and facilitates better mental health and overall wellbeing. Mothers should be included in each stage of the process and be helped to understand what is going to happen to them and the child and how they can work towards keeping their children and/or re-establishing contact with children.
- 6. Supportive physical settings and interpersonal interactions** promote a sense of safety and safe space for women. Providing a female-only safe space and enable feelings of safety for women in mixed-gender services, increases the likelihood of that person feeling able to disclose sensitive information. Women only and trauma-informed spaces, or no-threshold drop-ins that allow women to come and go as they prefer, have proven to be a simple and effective way to (re-)build trust.
- 7. Resources to culturally and gender-specific organisations.** Many culturally specific organisations in Nottingham have limited funding and need to carry out fundraising events in order to keep projects running. Each woman's experience of SMD will be different dependant on their demographics, therefore, women should be able to access services that have an understanding of their experiences.

Person-centred approaches

Throughout the findings, services using a person-centred approach towards women with SMD has shown to be particularly useful to strengthen service user-worker relationships and encourage long term support. **Workers cannot work in a judgemental way, as this would go against the core principles of being 'person-centred'**, which is to see the person as a whole individual, rather than just their issues, problems, disadvantages, or disabilities. For example, an Opportunity Nottingham beneficiary spoke of a negative experience with what she perceived to be a judgemental worker:



"They were quick to judge but not take the time to care."

It is safe to say, the dynamic between the worker and the service user had shifted and the engagement from the service user had diminished. Comparatively, the service user had also spoken of positive experiences they had with their Multiple Needs Tenancy Support (MNTS) worker:



"There was encouragement not judgement."

Despite the obvious importance of taking on a non-judgemental approach when working with service, this is not always the case. Not only can a judgemental approach negatively affect trust with that worker or service, but it **may also cause mistrust in many other services, possibly resulting in insufficient support being provided for women with SMD.** This is vital, considering that generally, women experiencing SMD, have formed a mistrust in services due to the lack of acknowledgement in relation to their gender specific needs.

Additionally, the women's service has been found to take a person-centred approach with the women that use the service. A good example of this whilst observing, was that staff spoke in a humane way that demonstrated they saw the women for who they are, without judgement or particular focus on their 'issues', unless specifically raised by the service user. This had resulted in the women 'opening up' and more open to receive emotional support from staff, reinforcing the sentiment that a non-judgemental, person-centred approach works well for enabling women with SMD to be receptive to support provided. A particularly good method that they used is offering 1 to 1 support. Women who want to access this service can do so when they are available, choosing a time and date that is suitable for them, emphasising **the flexible nature that this service takes, a crucial part of being person centred.** Not only does this take the time to have a more personal understanding of the women using the service, but this makes it more accessible as there is no pressure for them to attend at certain times and dates. Operating in this way creates a basis of understanding of women experiencing SMD- it acknowledges that there may be other factors that can prevent them from sticking to rigid timeframes.

Following on from this, The mixed-sex service also provides similar 1 to 1 session's that residents can access on an elastic basis. Again, this conveys an understanding of how **those with SMD may have other factors that affect their desire or ability to stick to rigid time frames.** As the understanding is conveyed through flexible 1 to 1 session's, this is often perceived well from residents with SMD, as they then feel that they are understood. As well as this, from speaking with staff at this accommodation service, they are committed to getting to know their residents on an individual basis. Staff can tailor the way they work to suit their needs and gain an understanding of how best to work with residents to get their support needs met. The idea is that **services are open to access at difference times, with no expectations for women to seek further support,**

letting women engage at their own time. In doing so, the service has received praise from former residents on being a particularly good service. Although this is not a women's only service, this is a good example of how a mixed-gender service can still use a person-centred approach to accommodate women experiencing SMD. When women with SMD are met in this way, even in mixed-gender services, this gives staff the chance to understand the woman's personal needs and adapt to it. This may also encourage female residents to engage with the staff, setting the basis for a good working relationship that promotes support.

Understanding gendered notions in society

Findings from the fieldwork emphasized that when workers are aware of the gendered notions in society, this can contribute a better understanding of the safety needs for women with SMD, that use services. Understanding social constructs such as gender roles, helps give insight into how and why **violence against women has been, and is, currently a serious social issue that underpins the need for specialised support.** It is not to say that men do not experience disadvantage and inequality, however, the way gendered notions are constructed in society **emphasises that women experience multiple disadvantages differently to men.**

A good example of this in our findings was services employing only female staff, creating a safe space with the safety needs of women with SMD in mind. Employing female only staff reiterates that the service is **based on women's safety and is trauma informed,** acknowledging that with a female only workforce, there will be deemed no immediate risk of male violence against women. This is important because there is a likelihood that women who are using the service, may have experienced trauma due to gender-based violence. As certain behaviours and responses can be attempts to cope with trauma, this can also lead to a misunderstanding of a beneficiary's action if staff are unable to look through the lens of their trauma.

Although it is acknowledged that there should be more women's services/ accommodation, creating strategies that enable feelings of safety for women in mixed-gender services are vital in encouraging women with SMD to engage with workers in services. The staff at the mixed-sex accommodation service were conscious of the effects that gender-based violence can have on women with SMD, thus putting this into practice by having strong security measures put in place around the accommodation. The staff had mentioned that they are aware some of their female residents have encountered domestic abuse or are still in an abusive relationship. **The security helps eliminate any potential harm and creates a safe space for women with SMD.** As well as this, the staff demonstrate an understanding of gender-based violence by speaking to the women who have experienced this on an individual basis, using empathy and understanding to engage the women. On some occasions, the female staff would speak of their own experiences to relate to the women and show a great depth of understanding of the circumstance's women with SMD may face. When staff were asked whether there were any separate dorms or spaces for women, they had mentioned that because of the strength of the working relationships between staff and resident, this was not needed, as individual and specific issues were dealt with quickly. There was an emphasis on the need to build back trust with men, and that this was a safe and monitored environment in which this can be utilized. This way, women who have experienced gender-based violence may start to integrate with others with a limited sense of fear over a period of time-promoting healthy relationships between men and women.

Furthermore, the environment of women's services / accommodation can help contribute to good practice in relation to women with SMD, as this enhances their feelings of overall safety. This is evidenced by an interview with an Opportunity Nottingham expert citizen, saying that she had a particularly good experience with a Women's hostel due to a good staff to resident ratio and a "cosy environment". Ensuring **that accommodation services provide an environment that accommodates to the need of feeling safe enhances the engagement,** as they will feel more comfortable to engage with the service and staff. This also personalizes the experience of women



with SMD when they are in a "cosy environment" with a good staff to resident ratio, promoting psychological and physical well-being due to the thorough care.



"It was really cosy, and there was about as many staff as women staying there, they just made you feel really comfortable".

However, it is important to acknowledge that although there are some women-only services/ accommodation, women with SMD often find themselves in mixed-gender services, where there is less of an emphasis on the safety needs for women. The mixed-service that the fieldwork has been conducted in, has demonstrated a significant consideration for gender-based violence experienced by their female residents, however, this is not always the case in other mixed services. To implement better practice for female service users with SMD, there needs to be an understanding of why this is so important.

Homeless Link are working on a gender-informed toolkit that is informative on how to operate in a way that meets the safety needs for women in mixed-sex hostels. This is a positive example of understanding the gendered notions of society and applying this knowledge to services to better meet the needs for women experiencing SMD. This is part of their Women's Homelessness project.

Empowerment as a focus

Many of the structural barriers identified specifically facing women and especially women from minority ethnic backgrounds have been found to be mitigated in many ways by **culturally sensitive grassroots organisations and community groups in Nottingham.**



“Empowerment creates a platform to help someone understand their true potential.” W7

Empowerment also includes involving beneficiaries in all stages of support and social work processes. For example, as the “Breaking down the barriers” (Armstrong et al. 2019) report shows, women who have gone through the trauma of having their children removed may continuously feel disempowered and let down by services by receiving “fixed penalties” and subsequently having all children removed - despite improvements in circumstance. Rather than shaming women by removing all services after having their children removed and adding to their trauma, **it is vital to offer adequate postnatal care and a high level of advocacy that empowers women to work on their multiple needs** and remain with their babies or eventually taking them back into their care. Further good practice includes preventive work with parents at an earlier stage, undertaking outreach work within communities and work with parents around the concerns and risks to their children.

Another of the consistent themes in terms of good practice was an emphasis on helping women to become empowered through the support that community groups are offering. A focus on **gaining employment and helping women look into starting their own businesses** (W7) was described as an important part of the support one organisation working with African women discussed. One organisation specialising in supporting Muslim women (but open to all women) is in the process of creating a **confidence building course for women that access their services**. This has been introduced due to the experience that many of the women they support, who have often lived the majority of their lives in another country, or when in the UK have had little agency over their lives due to this being in the control of the family or partner (W9). The course aims at building confidence in communicating with others, managing finances and accessing services and support which are all barriers identified in the previous section of this report. One service worker stated that women want to be given the opportunity to tell their own story (W7).

Two organisations run women’s groups aimed at bringing women together and encouraging social interaction and peer support. In addition, service worker new to a role aimed at engaging more women specifically spoke of plans to organise **group social activities outside of office environments to help reduce feelings of isolation** (W10). Although staff discussed the need for more counselling services that can be in multiple languages and culturally competent, access to **one to one counselling is available in some organisations and deemed as important in enabling women to open up in a safe space** and work through some of the trauma they have experienced (W8).

Ethnically diverse/specific workforces & safe spaces

Culturally and gender specific organisations where **women can expect they will be treated in a culturally sensitive way and feel confident they will not face discrimination** can be essential in gaining trust. Many of the community groups that participated in the study spoke of matching an individual to a staff member from their own community where possible. This would help with any language barriers and understanding of cultural differences (W7). Also, one organisation felt that employing staff with lived experience was helpful in gaining trust with their service users (W9). An example here was one female staff member from a Muslim background that had fled an abusive relationship felt that women in a similar situation were able to connect with her and potentially feel better understood due to this.

On the other hand, one organisation highlighted that employing a white British counsellor has been beneficial as some women and young people have felt less judged or stigmatized by someone white British therefore more able to open up than they would speaking to someone from their own

culture or community (W8), which goes to the importance of providing a person-centred approach and allowing “choices” for women. Similarly, a culturally responsive drug and alcohol recovery support service employ a white staff member specifically to engage the women in their service. This staff member stated that being culturally competent, and non-judgmental was key to carrying out this role. Alongside this, it was felt that **creating an environment where the service user feels understood, being open, honest, without using tick boxes are imperative in delivering appropriate support** (W9).

In the same way low threshold and non-service led female-only sessions can be initiative to provide a safe space, inclusion into a wider female community, and emotional support for women to feel more powerful. For example, the women only rough sleeper’s drop-in at St Peter’s church provides a safe and relaxing space for vulnerable and homeless women. **Women are made comfortable as if they were “going for a coffee with a friend and offload [...]” (W1) but also get supported in areas such as housing, employment, and mental health** etc. The drop-in being a low threshold services allows women to seek refuge and take their time to open up without any commitment or bureaucratic barriers and chat with any of the present workers. Once the trust is built, the services’ workers are ready to signpost and refer to specific services according to the attendee’s needs and wants.

Collaborative working

From the observations that were made while visiting the services noted above, a key element to good practice was ensuring that there is efficient signposting and knowledge of other services/agencies that may be useful. **Liaising with other services helps avoid the cycle of services signing women off and referring to another**, creating a repetitive cycle of repeating stories, and having short-lived working relationships with workers. Repetitive cycles can be problematic for many reasons, including possibly re-traumatising women by asking them to re-tell their story multiple times, only for them to be signed off quickly. This will only perpetuate mistrust in services and lead to insufficient support. For good practice, it is important to avoid this, and instead ensure services liaise and signpost when useful. This encourages **working together** to provide support, so that all needs are being supported and acknowledged.

A positive example of good practice in relation to useful signposting and liaising is a women’s service working directly with Nottinghamshire Police to gain pictures and information of men that pose a threat to women sex-working in the Nottingham area. The images of these men were then placed on a board within the service, so that service users and staff were aware of potentially dangerous situations for women sex-working. This emphasises the usefulness of liaising; without this in place, women with SMD may have been re-traumatized due to getting involved with men that have a history of abusing and assaulting women sex workers. For good practice, it would be useful for services **to liaise with institutions such as the police, so that workers and residents are aware of potential dangers**. Especially since gender-based violence is a significant occurrence within the UK and women with SMD are particularly vulnerable to this due to being exposed to more risky environments than those without SMD.

Additionally, they had exhibited excellent liaising while working with a service user who had been offered accommodation in an area that she had previously had trouble in. A staff member had told street outreach on the phone that this was not a safe area for the woman, and therefore spoke of other accommodation services that are outside the area. Firstly, this portrays the caring attitude to women with SMD that is needed to gain trust from service users. Secondly, **the ability to liaise with outreach quickly and effectively had potentially saved the service user from rough sleeping or being exposed to another dangerous situation**, like staying in a hostel where she may have encountered violence/ abuse. Not only this, but it had avoided this woman having to be passed around accommodation services until she had found somewhere suitable, experiencing short-lived relationships with workers that could reinforce mistrust in services. Ultimately, services

could ensure that they are networking and liaising with workers from other services/ institutions that may be of use for women with SMD, to avoid potentially re-traumatizing them through further dangerous situations and/ or having to repeat their story.

In an interview with an Opportunity Nottingham beneficiary, the importance of collaborative working was also highlighted. They had said that they have a particularly good relationship with their MNTS worker who has continuously shown them transparency, reliability, and honesty. This worker actively encouraged and supported engagement between the beneficiary to other services and workers that she could use for specialised support in particular support needs e.g., drug and alcohol recovery services, whilst still maintaining a strong relationship with them. An emphasis on long-term working relationships was placed here, as the support of the MNTS worker had encouraged and built enough trust with her to seek support from elsewhere as well. **This shows that signposting, rather than signing off a service user and referring them to another service, works better and continues to build trust in services.** Ultimately, this way of working enables women with SMD to have the support and consistency of workers, therefore receiving the support they need to work through their disadvantages.

We have also observed the practice within a mixed-sex accommodation that currently liaises with other services that provide support for addiction, mental health, domestic abuse, and many other issues. As well as this, they help navigate beneficiaries to workers that may be able to fulfil particular needs, such as their PDC's. As previously mentioned, they work in a person-centred approach that individualises any support plans; this works well when working with women that experience SMD. This way, women experiencing SMD are more likely to have their support needs recognised and enhances staff's ability to recognise who best to liaise with to gain support for women with SMD in specialised areas. Again, the person-centred approach and the trust built between residents and staff enables residents to continue to gain support from staff whilst developing new relationships with other workers from different services.

Similarly, many organisations who work with women from minority ethnic backgrounds mentioned that the key to reaching out to them is working with multiple agencies. Organisations spoke of running **surgeries (mutual aid) with the local drug and alcohol recovery service (W10) and also working in conjunction with Women's Aid and the Women's Centre to deliver support to female victims of domestic abuse and access to counselling (W9).** A part of supporting women who have experienced domestic abuse, one organisation has been involved in translating The Freedom Programme into Urdu with culturally competent examples that the women they support are more likely to relate to (W9).

In addition, services spoke of the importance of **early intervention with young women and girls and their collaboration with school and social care** in order to educate and engage young girls around **grooming and honour-based violence (W8, W9).** Organisations also spoke of offering training to mainstream services around being culturally sensitive.

One participant was new to the role when interviewed, but spoke of their plans to engage with more women from ethnic minorities. It was acknowledged that there are many communities that tend not to access the culturally specific drug and alcohol service, and that an effort would be made to reach further communities by **outreach to places of worship or community groups in order to actively encourage engagement and increase knowledge of what support is available.**

Counselling services

After interviewing the manager of a women's service, it is evident that women with SMD benefit from counselling services, made accessible to them through a flexible and transparent approach.

This service sees approximately 45 women for around 6 months to 1 year in a therapeutic setting.

This includes women experiencing SMD, a lot of women that have been referred by domestic abuse support services and engage with counselling for various reasons. Although the most prevalent reasons are **anxiety, relationship issues, trauma (including relational trauma), issues stemming from abuse in childhood and personality disorders.** Operating in a **trauma informed and person-centred** approach is paramount to how the Women's Centre deliver their service, using humanistic therapy techniques to engage their clients. As noted above in the section regarding the usefulness of a person-centred approach, it is imperative for services to remain empathetic and truly person centred; many women that experience SMD have a background of trauma, including childhood trauma.



"Relational trauma sets the scene for more difficulties later on and for CPTSD, they have more chance of being re-traumatized in life". W6

This is specifically important in a therapeutic setting that engages with female clients that are experiencing SMD, as mainstream services generally deem those with SMD "too high risk". Or the types of therapy that are available are not suited for those with SMD due to the extensive and long-term care needed to deal with complex and traumatic life events and/or situations- many IAPT sessions only offer 6-week Cognitive Behavioural Therapy (CBT). This emphasises the need to adapt how counselling is run, so that women experiencing SMD are still gaining the support they need and rebuilding trust with the counselling process.



"Traditional counselling has a rigid reputation- strict boundaries, no contact out of session. We won't penalize people; we've had to give this (rigid boundaries in counselling) up". W6

A good example of how a counselling service can be adapted to engage with women experiencing SMD is found at the Women's Centre. The Head of Client services has told us:



"Be completely transparent... we tend to get a lot of paranoid women [PD or just generally paranoid] I encourage showing paperwork to them if they are in doubt and access to that when they like, about being really clear and getting consent and really involving the woman in every step of the way in their care".

This approach was corroborated by the CBT practitioner, highlighting that **openness and honesty is imperative**, maintaining clear boundaries of what support she can and can't offer whilst explaining each step of the process. This was described as making efforts to **give women the power back**, by working together and allowing the women to take the lead.

Considering that women who are experiencing SMD may have a high amount of mistrust in services already, including counselling services, adapting and being aware of how SMD affects women is important to work with them effectively. This understanding help accommodate the needs that women with SMD may have in order for them to engage with counselling:




"You have to adjust expectations when working with people experiencing SMD... We never sign them off, if they aren't consistent we never sign them off, we like to let them know they can always come back to us... better communication is needed [for women with SMD] ... multi-disciplinary work is really useful to avoid them having to go over the same paperwork over and over." W6

This is a good example of how a counselling service can use a flexible approach in order to offer counselling to women who experience SMD. It demonstrates that **there needs to be adjustments in the normative approach to counselling that is rigid with boundaries**. Such as, being flexible when women do not turn up for a session or deploying thorough safeguarding measures to ensure that everyone is safe despite the seemingly high-risk factor women experiencing SMD pose. If this were not done, it would seem as though many women experiencing SMD would continue to ‘slip through the cracks’ and miss out on getting the mental health support that they need and deserve. In particular for **women with multiple needs who lost children to the care system, they are often left on their own devices once social work involvement terminates**. Therapeutic aftercare – despite it having the potential to break the cycle of trauma and the repeat removal of children (East 2021) - is often absent. Similar conclusions were also reached in the previous Opportunity Nottingham study “A Safe Space” (Everitt, Gallagher, and Kaur 2019).

This was further supported by a CBT Practitioner who works with both male and female clients with SMD and has found that **women generally need longer to begin to build the trust needed to make meaningful progress in a therapeutic setting** (W11). She spoke to the importance in flexibility of length of time allocated to working with women and allowing flexibility around missed appointments in order to keep the relationship open. The ability to undertake sessions in a setting where the woman feels comfortable was also considered valuable, whether this be in their own home, a cafe or walking in the park. This offers an alternative to the clinical environment of an office space and already begins to break down barriers for women.

As part of CBT with women facing SMD, it was found that setting personalised goals and reviewing those goals was central to women realising what progress they have made and maintaining focus in sessions. The practitioner develops a scoring system based around each individual’s personal goals set out at the beginning of their engagement and they will be able to score where they feel they are every 3 months (W11). This approach **allows the space for a responsive approach to CBT therapy but also helps to bring the focus back to the therapeutic nature of the work and can help to boost confidence**.

Moreover, relevant and specialised training is needed in counselling services so that women experiencing SMD can engage safely with the service. At a women’s service, specialised training is delivered to volunteer and paid counsellors, ensuring that the **counsellors are trauma informed and are aware of any triggers or potential safeguarding issues**. As well as this, as mentioned in the ‘Workers to understand the gendered notions in society’, offering a safe place with Women experiencing SMD is imperative to gain engagement. The service is a women’s only space in general, and this reinforces the safe space concept. They had acknowledged that generally, statutory counselling services do not offer an option to pick the gender of the counsellor they will be given and there is limited gendered services. Again, this would continue to implement women experiencing SMD being put off from accessing this due to the gendered violence / trauma that they may have encountered.

 *“Interventions offered put people off “IAPT service- 6 sessions, they are defective, you can’t choose by gender often, homeless/ addiction services are usually full of “angry men”, they have reasons to be angry, but that makes it threatening for women especially as a lot have experienced things such as domestic violence.” W6*

Overall, this highlights the need for more **women only counselling services, that are trauma informed and trained on SMD**.

Conclusion

Overall, the research conveys that currently, there are multiple barriers for women experiencing SMD in accessing well-rounded support from services in Nottingham. This includes **a lack of acknowledgement on gender specific and SMD needs, a history of being stigmatised and judged** which prevents women from wanting to initially engage and a **lack of flexible working**. Furthermore, the research depicts how women from ethnic minority backgrounds experiencing SMD encounter additional and different barriers to those that are not from a BAME background. These include **language barriers, legal barriers, and cultural stigma**. These barriers promote mistrust in services, resulting in women with SMD to be apprehensive about engaging with services. However, the fieldwork emphasised that tailored support is needed to ensure that women with SMD do not ‘fall through the cracks’ in society and in support services. Good practice includes applying a **person-centred approach** efficiently, **specialised workforces that focus particularly on BAME women service users, flexible approaches in services, collaborative working** that limits women telling their story multiple times to different workers and an **understanding of the root causes** that lead women with SMD to need support; including an **understanding on the gendered barriers in wider society**.

It is important to note that this area would benefit from further and more detailed research as the scope of this study has just touched the surface of intersectional barriers and how services are supporting women with secondary disadvantages and women from minority ethnic backgrounds with SMD. The way SMD is understood and defined may benefit from being reconsidered to include more secondary domains of SMD with the aim of reaching a more representative service user group.

Where this study has highlighted how women may experience disadvantage differently and may be more likely to experience certain disadvantages, it should be acknowledged that all women are individual, and their experience of society is dependent on a number of factors. As stated in McCarthy et al. (2020) it is important not to pathologise specific communities based on cultural or social norms, but the importance is in services recognising that **each woman’s experience of her disadvantage will be different depending on a whole host of external factors**.



“The experience of partner violence and the options to a ... woman are different if she is a highly acculturated citizen from a non-colonised group, if she is an immigrant of twenty years in a large cultural community, if she is a recent refugee who has relocated into a small cultural community, or if she is a member of a community that has been subjugated over generations.” Yoshioka 2008

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Appendix

A. HEALTH SURVEY PARTICIPATING ORGANISATIONS

	Number of Surveys Returned	Caseload of workers participating (will involve overlap not unique individuals)	Average percentage of respondents described as experiencing physical health issues	Average percentage of respondents described as experiencing sexual health issues	Average percentage of respondents described as experiencing mental health issues
Breaking Barriers Building Bridges	1	8	63%	Not answered	100%
Nottingham Muslim Women's Network	1	150	53%	Not answered	Most
POW Nottingham	5	143	73%	58%	93%
Emmanuel House (including Night shelter)	8	101	74%	44%	100%
Opportunity Nottingham	5	21	85%	Not answered	95%
Nottingham Central Women's aid	1	11	36%	Not answered	90%
Juno Women's Aid (including Pet Project)	3	80	50%	Not answered	95%

B. INTERVIEWEES

Service Workers Role	Gender	Code
Drop-in worker	Female	W1
Drop-in worker	Female	W2
Complex needs professional	Female	W3
Health service alliance	Female	W4
Health service Practitioner	Female	W5
Manager at a women's service	Female	W6
Chief Exec of social enterprise for women	Female	W7
Founder of culturally responsive community organisation	Male	W8
Project worker	Female	W9
Community engagement worker	Female	W10
CBT Practitioner	Female	W11

Beneficiaries Role	Gender	Code
Opportunity Nottingham Beneficiary	Female	B1
Opportunity Nottingham Beneficiary	Female	B2
Opportunity Nottingham Beneficiary	Female	B3
Opportunity Nottingham Expert citizen	Female	B4
Opportunity Nottingham Expert citizen	Female	B5

