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“They said if you come you can’t drink. I thought, I can’t stop.”

Exploring the journeys to support among women who experience co-occurring substance use and domestic abuse.

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A thesis submitted in partial fulfilment of the requirements of Manchester Metropolitan University for the degree of Doctor of Philosophy

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Research abstract

Although 30-40 percent of people in England seeking treatment for substance use are women, little research explores their experiences of support when domestic abuse is also present. There is also a gap in service provision for women with multiple and complex issues such as problematic substance use and domestic abuse. Ongoing austerity measures continue to impact health and social care services in the UK, which in turn, has an impact on the support options available to women. What women do to seek help, how they feel about the support they receive (or lack thereof), and information about the type of support available to them, is a missing conversation in both substance use and domestic abuse research and other related literature. As such, this research seeks to understand women's journeys to support, when they experience co-occurring substance use and domestic abuse. The research aims to take an in-depth look at women's motivations for support seeking, explore the barriers and/or enablers to accessing support, determine the wider influences on women's decision to seek help, and, identify the practice of substance use services and domestic abuse agencies in supporting women with dual needs. Influenced by feminist research theory and hermeneutic phenomenology, this thesis will present data from 12 interviews with women who have experienced co-occurring substance use and domestic abuse. Using interpretative phenomenological analysis (IPA) to analyse the interviews, a sample profile, 12 pen portraits and five superordinate themes will be presented. A discussion of the findings focuses on the complexity of support seeking among women with co-occurring's substance use and domestic abuse. In particular, this research shows that the women in this study experienced multiple complex histories of abuse and substance use. The relationship between motivations and barriers of support seeking, the impact of systematic barriers and, a discussion of trauma informed approaches to support are also key themes discussed in this thesis. Overall, this research presents the journey to support, and the experiences of support, for women with histories of substance use and domestic abuse. This research creates a new knowledge, because it is the first-time women's voices have been heard in terms of their own support journey. By listening to the voices of women, this research presents the lived realities of accessing support in a climate where support is reducing.

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Thank You

i stand
on the sacrifices
of a million women before me
thinking
*what can i do
to make this mountain taller
so the women after me
can see farther*

legacy - rupi kaur



(Rupi Kaur, *The Sun and Her Flowers*, 2017)

This thesis is dedicated to all of the strong women in my life.

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Part One

Introduction to the Research

Chapter 1

Introduction to the Research

This research explores the journeys to support among women who have experienced co-occurring substance use and domestic abuse. This research is important, because it is the first time women's journeys to support have been heard in research within the UK. Understanding women's experiences is particularly important because they are on the receiving end of national and local health and social care policy and practice, and experience both its intended and unintended consequences. Therefore, by understanding the experiences of women with co-occurring substance use and domestic abuse, and by taking '...the view from below' (Ettorre, 1997:18), we are afforded the opportunity to learn from women. Women's collective voice has the potential to impact substance use and domestic abuse policy and practice. By asking about their experience, and showing genuine interest in their lives, we also tell them, that their voice matters.

Quite often women's needs are not met through service provision, which means their voices are not heard. This is because services tend to be siloed in the support that they provide. For example, women who want to flee domestic abuse are less likely to receive a space in refuge if they are using drugs and/or alcohol problematically. This has been highlighted in annual surveys from the national UK charity, Women's Aid, for many years (Women's Aid, 2016, 2017, 2018b). From my personal experience working in a domestic abuse service, women who used drugs were often referred to homeless services if refuge could not be provided. Although follow on data does not exist, it is speculated that many women return to their abusive partners in the event that suitable and safe accommodation cannot be provided. The siloed service provision is further impacted by funding. Currently in this period of economic austerity, drug and alcohol services and domestic abuse services are losing local authority funding (ACMD, 2017; McClenaghan and Andersson, 2017; Grierson, 2018 Alcohol Change UK, 2018) and these funding cuts have an impact on the services that can be provided (or not provided) to women. Yet, despite these siloed services and

funding cuts, women with multiple and complex needs still exist and continue to need support. What women do to seek help, how they feel about the support they receive (or lack thereof), and information about the type of support available to them, is a missing conversation in both substance use and domestic abuse literature. This research will create conversation on this topic. Thom, wrote about the need for this perspective in 1986 when she said,

If services are to be adapted and developed appropriately – for women or men – it would seem important to obtain as clear a picture as possible of the anxieties, fears and practical problems which militate against help-seeking and of the needs for help which finally prompt action resulting in contact with a service. (Thom, 1986:777).

Unfortunately, 30 years on, services do not adequately meet the needs of women affected by substance use, and literature on the topic, particularly academic evidence, is lacking. That is why this research is important.

1.1 Why Women, Substance Use and Domestic Abuse?

Throughout history, there has been a double standard regarding gender and substance use. In the Roman era for example, male drunkenness was not abnormal behaviour, yet women's drinking was considered a grave offense and punishable by divorce or even death (Dobash and Dobash, 1979). The turn of the eighteenth century saw a rise in the availability and consumption of spirits in both the USA and the UK (Plant, 2008). The rise of excessive consumption drew attention to societal drunkenness (Lloyd, 2010), and health practitioners began to explore the growing use of substances. Practitioners soon theorised this excessive use as an addiction, defined as a chronic relapsing brain disease, where individuals were identified as 'sick' (Campbell and Ettorre, 2011). However, women's use of substances was not



Figure 1. Hogarth's Gin Lane

considered a disease, but rather a moral and societal issue. National wellbeing was the main topic of debate at the time, because infant mortality was on the rise and the national population, particularly in the lower classes, was decreasing (Zanetti, 1903; Thom, 1994). Women who used alcohol were seen to be impinging on the wellbeing of society (Levine, 1980), so campaigns such as the Temperance Movement sought to focus on women's behaviours in a bid to tackle the 'degeneracy of the race' (Thom, 1994:35). This perception of women as alcohol users is famously depicted in Hogarth's 'Gin Lane' (figure 1) for example. As we can see from the image, the main female character in the painting is depicted as a bad drunken mother, as her child is shown to be falling. The perception of mothers who use alcohol did not end here. The Temperance movement throughout the nineteenth century continued to play a role in supporting women's abstinence and 'reversing' deviant drinking behaviour so they could comply with their assigned gender norms (Thom, 1994). As a result, the disease model of addiction continued to be regarded as a male disease and gender sensitive theories relating to women substance users continued to be non-existent (Campbell and Ettore, 2011). Due to the gender-blind understanding of problematic substance use, substance use in the lives of women, even now, is shrouded in 'damaging, prejudicial, unjust, outdated images' (Ettore, 2015:vi). The malecentric view of addiction has also affected service design, as Ettore explains:

Traditionally the lack of a body of knowledge about women and substance use led those, specifically psychiatrists and clinical psychologists working in the field, to assume that substance use was primarily a 'man's disease' or a 'male problem'. (Ettore, 1992:17)

Substance use is not 'primarily a 'man's disease' or a 'male problem' (Ettore, 1992:17). Figures from the NHS (NHS Digital, 2017) report that 12% of women in England binge-drink, while women made up just over one-third (400,000 approx.) of alcohol-related hospital admissions in 2015/16. According to the Crime Survey for England and Wales, around 6.2% of women aged between 16-59 have consumed drugs in the past year (Home Office, 2018), while drug-related deaths among women has increased by 19% in the past 10 years in England and Wales (Office for National

Statistics (ONS), 2017). Recent figures from The National Drug Treatment Monitoring System (NTDMS) (Public Health England (PHE), 2018) found that 27-28% of opiate and non-opiate using individuals in treatment in England and Wales are women. The report also found that 27% of the treatment population with combined non-opiate and alcohol issues are women, while, 40% of the alcohol only treatment population are women. Yet, despite statistics proving that women use drugs and alcohol problematically, a gendered imbalance in service provision still exists today as Greenfield et al. (2007) explains in their commentary piece:

Women with substance use disorders are less likely over the lifetime to enter treatment than their male counterparts, and women with substance use disorders are more likely to seek treatment in non-specialty settings. (Greenfield et al., 2007:6)

The lack of understanding regarding female substance use, and the gender imbalance in service provision also means that the wider influences relating to women's use of substances, such as domestic abuse, are only recently being explored in research and practice. In the UK, reports continually show that 1 in 4 women will experience domestic abuse in their lifetime (Women's Aid, 2018a), while findings from the Office for National Statistics (ONS, 2017a) estimate that 1.2 million women in England and Wales experienced domestic abuse between April 2016 and March 2017. However, when exploring figures relating to co-occurring substance use and domestic abuse victimisation, statistics are lacking. The only statistic reporting a relationship between substance use and domestic abuse victimisation among women came from the Crime Survey (ONS, 2017b) where it is reported that 7% of domestic abuse victims were under the influence of alcohol and 1% were under the influence of illicit drugs at the time of the abuse (ONS, 2017b). This lack of quantitative findings will be discussed further in the literature review.

Because of the slow progression of knowledge regarding women and substance use, particularly knowledge regarding women with co-occurring issues, there are still many gaps in understanding. Knowledge from the perspective of women who use

substances and have histories of domestic abuse, is a topic that is lacking in both substance use and domestic abuse research and wider literature in England. The limited service provision available to these women further isolates them from being recognised, cared for, or listened to about their experiences. This research, therefore, sets out to recognise these women and listen to them about their lived experiences of accessing support.

1.2 Thesis Outline

This thesis will explore the experiences of support and help-seeking among women affected by co-occurring substance use and domestic abuse. Part two will present the literature review. The literature review is presented in four chapters and will justify the overall research aims by demonstrating what is already known about women who experience co-occurring substance use and domestic abuse. By exploring what is known, the literature review will also highlight the gaps in knowledge regarding women's experiences of substance use and domestic abuse. In particular, chapter three will highlight the lack of UK based research, including qualitative research. Chapter four will discuss the identified gaps in service provision in England and Wales and chapter five will discuss the identified gaps in policy by exploring key national policy documents relating to substance use and domestic abuse. Overall, the literature review will justify the need for more research relating to substance use and domestic abuse among women and inform the overall purpose and aims of this research.

Following the literature review, part three of this thesis will present the methodology and methods over five chapters. Chapter six will present the overarching research aim in more detail. Chapter seven will then discuss the influences of feminist research theory on this research, as well as the role of phenomenology as a secondary epistemological influence. Because this research centres on women's experiences, feminism and phenomenology were identified as the most fitting philosophical paradigms. The two epistemic standpoints naturally guided the research towards a qualitative approach to research design. Chapter eight will also explore the use of interpretive phenomenological analysis (IPA) as the most appropriate method of

analysis. To ensure transparency, chapter nine presents the step-by-step approach that I took to recruit the women who participated in this study. Chapter 10 will present the ethical considerations in the form of a reflective piece. While chapter 11 will close by detailing my analytic approach and how I selected the five themes presented in this thesis.

Part four of this thesis will present the findings from the interviews that were conducted with the women who took part in this research. Chapter 13 will present a sample profile of the research participants, demonstrating the women's age, sexuality and ethnicity. The sample profile will also present the number of children the women had and detail the services the women engaged with throughout their substance use and domestic abuse experiences. Chapter 13 will also present a pen portrait for each woman. Because each woman gave me her time and trust I wanted to ensure her experience was shared as fully as possible. Pen portraits are an effective way of communicating each woman's story in her own right before breaking up their experiences into themes. Reflecting on the overall aims of the research, chapters 14-18 will explore five themes that I interpreted from the analysis of the women's narratives.

Part five of this thesis is the discussion made up of five chapters. Chapters 19-22 will discuss key messages relating to service provision and support for women who experience co-occurring substance use and domestic abuse. Based on the discussion presented in chapters 19-22, and a reflection on women's experiences, chapter 23 will discuss the need for support that is specific to women, and chapter 24 will present further recommendations for future practice, policy and research.

As this thesis will show, research and practice does not reflect the specific needs of women who use substances. The women's narratives, therefore, present an opportunity to fully engage with their lived realities of support and help-seeking.

1.3 Definitions

Throughout this research, the term 'domestic abuse' will be used because it accounts for more than physical violence. The definition of domestic abuse comes from Women's Aid, a national charity that supports women affected by domestic abuse. The organisation defines domestic abuse as

...an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour, including sexual violence, in the majority of cases by a partner or ex-partner, but also by a family member or carer. It is very common. In the vast majority of cases it is experienced by women and is perpetrated by men. Domestic abuse can include, but is not limited to, the following: coercive control (a pattern of intimidation, degradation, isolation and control with the use of threat of physical or sexual violence), psychological and/or emotional abuse, physical or sexual abuse, financial abuse, harassment and stalking, online or digital abuse. (Women's Aid, 2018a, online).

This research focusses on women as victims of abuse and so the Women's Aid definition has been chosen because it references the gender differentials between perpetrator and survivor. Throughout this thesis, terms such as 'intimate partner violence' (IPV) and 'domestic violence' may also be used when discussing literature on the topic. Such terms reflect the language used by other authors who choose to use that terminology.

The term 'problematic substance use' and 'substance use' are used interchangeably throughout this thesis and refers to,

...problems associated with alcohol and other drug use rather than low levels or occasional alcohol or other drug use which does not lead to social or health-related problems. (Galvani, 2015:4).

Terms such as 'addict(ion)', 'substance misuse' or 'alcoholic' will be used when citing other authors or research participants who choose to use that terminology.

Finally, the term victim is used throughout this thesis because at the time of recruitment, women were invited to take part if they had experienced domestic abuse either historically or currently. The term survivor was therefore deemed not appropriate because of its emphasis of past experiences.

The following chapters will now present this research and demonstrate the need to, and importance of, listening to the lived experiences of women with co-occurring substance use and domestic abuse.

Part Two

A Review of the Literature Relating to Substance Use and Domestic Abuse

Chapter 2

Conducting the Literature Review

This review aims to set out what is known about co-occurring substance use and domestic abuse, and identify gaps in knowledge relating to the topic. This literature review will therefore shape the overall research question and subsequent research aims, therefore, guiding the data collection, analysis and outcomes of this study.

2.1 Finding the Literature

I accessed a wide range of literature for this review, including peer-reviewed journal articles, books and book chapters, and grey literature. To identify the most up to date and relevant research, I used a systematic approach to search for peer-reviewed journal articles. Articles were identified using the online database at Manchester Metropolitan University Library. This library hosts a number of relevant online databases including SCOPUS, ASSIA and PubMed, databases that are relevant to social care research. Because the topics of substance use and domestic abuse can span a variety of academic disciplines including medicine, law, social work and social care and health, the entire online library database was searched during the initial review. Search terms relevant to the topic, as well as search parameters, Boolean terms, and inclusion and exclusion criteria were set prior to searching (See Appendix one for detail of the literature search terms and parameters used). This technique helped to reduce the volume of unnecessary articles and ensure clarity in the review process.

To identify articles that I felt were relevant to this research, I consulted Aveyard's (2010) book *Doing a Literature Review in Health and Social Care*. In this book, Aveyard presents a step-by-step guide to conducting the literature review. Once I defined the search terms, parameters, and the inclusion and exclusion criteria, I began searching on the library database. Abstracts were skimmed and saved electronically if they met the inclusion and exclusion criteria. I then did a speed read on each of the saved articles to decide whether they were relevant to the inclusion and exclusion criteria.

A hand search of articles was also conducted using reference lists and bibliographies from the studies identified. The selected studies were then read thoroughly and thematised based on the research methodology used, the articles' focus on women's experiences and the focus on service provision.

Government policies were identified using the gov.uk website and through colleague recommendations. Grey literature also featured in the review in the form of service policies and research material that was not peer-reviewed. These documents were included because they were identified as being an important source of information regarding support and service provision for women with multiple issues.

Chapter 3

Co-occurring Substance Use and Domestic Abuse

Understanding Prevalence

Literature relating to the topic of substance use and domestic abuse can be broadly broken down into two categories: the perpetrator's use of substances and the victim's use of substances (Humphreys et al. 2005). While conducting the literature review I found that research relating to perpetrator's use of substances outweighed the number of available studies about victims who use substances. Although there is an awareness that female victims of domestic abuse use substances, little peer-reviewed research exists that explores this relationship further, particularly in the UK.

Statistics relating to substance use and domestic abuse victimisation are lacking in the UK. As such, figures from the USA are often referenced when trying to ascertain the scale of the issue. For example, Humphreys et al. (2005) provided an overview of substance use and domestic abuse literature in an article for the *British Journal of Social Work* in 2005, but the literature that was referenced was predominantly from the USA. Devries et al.(2013) further highlights this gap in UK understanding in a meta-analysis which sought to examine the association between IPV and alcohol consumption among women. Devries et al.(2013) identified 55 studies from 21 different countries, and of these countries, no research was conducted in the UK.

To understand the issue within the UK, Agenda (a UK based organisation who raise awareness of violence against women and girls), conducted a secondary analysis of the Adult Psychiatric Morbidity Survey (APMS) (Scott and McManus, 2016). They reported that 31% of women who have experienced extensive physical and sexual violence are twice as likely to have an alcohol problem when compared to women who have little experience of violence and abuse. Their report also showed that 45% of this cohort have used drugs in the past and 8% were potentially using drugs problematically at the time of the survey (Scott and McManus, 2016). Other studies such as The Drug Outcome Research in Scotland Study (DORIS) (McKeganey, 2005)

found a correlation between women's substance use and domestic abuse victimisation, however, these findings were not a central aim of the DORIS research. Sampling 1033 individuals who used drugs, the DORIS study aimed to evaluate the overall treatment provision for people who used drugs in Scotland. Of the 1033 respondents, 312 (31%) were female. Over two-thirds (n=197) of these women reported past experiences of physical abuse, and over one-third (n=113) reported past experiences of sexual abuse. Over half (59.3%) of the women who reported past sexual abuse said it had been perpetrated by a relative or close family friend, while a third (29.2%) reported being sexually abused by a sexual partner; with one in 10 stating they had been abused by a relative or family friend and a sexual partner (McKeganey, 2005). The researchers also found that those who reported physical abuse were more likely to be female, to have children, and to have engaged previously in treatment for drug use.

Although the findings presented from Agenda and DORIS are important in demonstrating the prevalence of co-occurring substance use and domestic abuse among women in the UK, they do not derive from empirical research that specifically focused on domestic abuse victimisation and co-occurring substance use; rather, both findings were a by-product of larger studies with a wider focus.

The search for literature identified a small number of UK based studies that directly explored prevalence of co-occurring substance use and domestic abuse among female victims. Coid et al. (2003) recruited 1207 women through a self-reporting survey from 13 GP surgeries in London and found that alcohol and drug use was common among women who had experienced domestic abuse. Graham et al. (2004) explored personal drinking patterns and severe incidents of domestic abuse among 2027 British adults (taken from GENACIS study) and found that 13% of the women (total number of women=1052) reported physical aggression by a partner in the past two years; 20% reported that both were drinking at the time of the incident, 1.5% women said they were only drinking at the time of the incident, 20.7% said their partner was drinking and 57.8% said neither had been drinking. The authors also found that drinking prior to aggression by a partner was associated with perceived

severity of aggression, anger and fear, and as hypothesized, this was greater for female victims of male aggression. Evaluating independent domestic abuse advocacy services in the UK, Howarth and Robinson (2015) found that of 2427 women assessed, 5.5% reported their own drug use and 11.5% reported having issues with alcohol. Over half (53.5%) of the women reported alcohol use by the perpetrator and 39.8% reported partner drug abuse. However, women's own use could be higher than the self-reported results indicate, as fear, stigma and shame may deter them from truthfully reporting their substance use intake, especially when domestic abuse is present.

When conducting this literature review, the aforementioned studies were the only peer-reviewed, journal articles identified that focused on co-occurring substance use and domestic abuse victimisation among women in the UK. As the publication dates show, most of these studies were conducted more than 10 years ago. Although the study by Agenda (Scott and McManus, 2016) goes some way to highlight the scale of co-occurring substance use and domestic abuse, their research was a secondary analysis of the Adult Psychiatric Morbidity Survey and only focused on physical and sexual abuse, rather than the non-physical aspects of domestic abuse. The aforementioned studies also only focused on the physical and sexual aspects of abuse. Prevalence patterns are therefore limited in their ability to estimate the number of women in the UK who are problematic substance users and victims of domestic abuse. More recently, the Crime Survey for England and Wales (ONS, 2017b) demonstrated this correlation somewhat. The survey revealed that 27.1% (4.5 million estimated) of women reported domestic abuse victimisation at least once since the age of 16. Of the women who had experienced domestic abuse, 12-18% of female victims believed the perpetrator was under the influence of drugs and/or alcohol at the time of the abuse. Although there was not statistical significance between male and female victims' self-report of substance use during abusive experiences, 7% of victims reported that they were under the influence of alcohol at the time of the abuse. However, when asked about their own or the perpetrator's substance use during abusive experiences, between 17-21% of survey respondents answered 'don't know' or 'don't want to answer'. Further results from the Crime

Survey found that women, who reported being drunk less than once every couple of months, were more likely to experience domestic abuse victimisation when compared to men (6-12%). Women who reported never being drunk also reported experiences of domestic abuse (5%).

The Crime Survey offers the most realistic picture of co-occurring substance use and domestic abuse in the UK. However, the figures should be read with caution. The role of fear, stigma and shame may inhibit some participants from reporting their own substance use or domestic abuse experiences, and this is indicated by the 21% of people who answered 'don't want to answer' in the survey when asked about substance use. The Crime Survey also relies on participants to self-report which has implications for reliability as participants often try to portray themselves in the best light. The memory of the participants may also influence their ability to answer questions truthfully; particularly because of the impact substance use can have on memory (Gould, 2010). Furthermore, the Crime Survey only includes responses from participants aged 16-59, neglecting a large sample of those over the age of 60. Although the Crime Survey does have limitations, it is the only national piece of research that gives some insight into the prevalence of co-occurring substance use and domestic abuse in the UK. For other statistical examples, research from the USA and Europe is now explored to further understand the association between substance use and domestic abuse victimisation among women.

3.1 Co-occurring Substance Use and Domestic Abuse – Understanding Prevalence Using International Research

The relationship between co-occurring substance use and domestic abuse victimisation is explored more widely within the USA. A study by Testa et al. (2003) examined the association between women's substance use and subsequent experiences of intimate partner violence (IPV) and, their IPV experiences in relation to subsequent substance use. Testing for bidirectional effects of substance use and IPV, the authors recruited 724 women aged 18-30 to conduct a longitudinal study over a 24-month period. At wave one (initial survey), 11.7% reported experiencing severe violence and over a fifth reported minor violence in their current

relationships. At wave two (12 months follow-up) over a quarter of women reported minor violence and 12.2% reported severe violence in the previous 12 months. Findings from Testa et al. (2003) also highlighted that women who use drugs were at increased risk of experiencing subsequent IPV. However, it is important that these findings are not over generalised as the results may be impacted by the narrow age margins (women aged between 18-30) of the research participants. Furthermore, Testa et al. (2003) did not find statistical significance between violence and drug use or periods of heavy episodic drinking. However, Devries' et al. (2013) meta-analysis of 55 research studies, aimed to estimate the association between domestic violence and alcohol use. They found a pattern between women's IPV victimisation and their subsequent alcohol use, but also between a woman's use of alcohol and subsequent IPV victimisation. Weaver et al. (2015) also reported consistent patterns of bidirectional relationships between substance use and IPV exposure in a review of targeted studies that focused on women's substance use and IPV experiences. An increase in alcohol consumption has also been found to increase the risk of being a victim of domestic violence (Miller and Downs, 2000), and using substances post domestic abuse experiences (Barnett & Fagan, 1993; Miller & Downs, 2000; Rees et al. 2011).

North American research by Golder and Logan (2010) focused specifically on women's experiences of substance use and domestic abuse. The researchers examined the prevalence of different types of victimisation among women who use crack. Three quarters of the sample (total number= 386) reported physical IPV from their partner (male or female) while psychological victimization by an intimate partner was reported by 87% of the women and 23% reported sexual abuse by an intimate partner. Similarly, El-Bassel et al. (2004) conducted face-to-face interviews with 416 women in methadone maintenance programmes in New York to understand the different associations between IPV and drug use. Of the 414 women who provided IPV data, 88% reported at least one experience of physical or sexual violence in their lifetime; nearly half (47%) reported injuries relating to physical or sexual IPV in the past 6 months, and 19% reported severe injury in the past 6 months. A previous study by El-Bassel et al. (2003) also found a correlation between abused

victims and levels of substance consumption. Interviewing women in emergency departments in the USA, the authors used the AUDIT (Alcohol Use Disorders Identification Test) (Babor et al., 2001), and DAST (Drug Abuse Screening Test) (Skinner, 1982) screening tools to identify levels of alcohol and drug use for low level triage patients in the emergency department. The study found that those who were physically abused in the past year (15% of 143) were more likely to report higher AUDIT and DAST scores when compared to non-abused women. Women who reported experiencing sexual abuse in the past 12 months also reported higher DAST scores. Although these results did not prove to be statistically significant because the reports for AUDIT and DAST were below the threshold to indicate problematic use, these results do indicate a relationship between substance use and IPV victimisation.

Outside of the USA, research has continued to identify a relationship between substance use and domestic abuse victimisation. In a sample of 49 women (men in sample, n=203) attending out-patient treatment support for drug addiction in Spain, Fernández-Montalvo et al. (2014) found that those with histories of abuse were more likely to experience more severe addiction. Although the findings cannot be generalised to the wider population of substance using women due to the low number of females in the sample, the results do correlate with previous studies discussed so far in this chapter. Additionally, the use of a mixed gender clinical setting may have an impact on these results, as the presence of men may be a deterrent for a woman to speak about her abusive experiences.

In Norway, Stene et al. (2012) examined the prescription of potentially addictive medication to women who have experienced IPV. The longitudinal study used IPV information from the 2000-2001 Oslo Health Study and linked the findings with information taken from the Norwegian Prescription Database from 2004-2009. Using information from 6081 individuals the researchers found that 13.5% of the women reported experiencing some type of IPV in their lifetime. Data also illustrated that women who experienced IPV, were prescribed potentially addictive drugs more frequently and, they were more likely to obtain prescriptions from multiple physicians. The researchers also found that women with lifetime experience of IPV

received prescriptions for potentially addictive drugs 2-4 times more frequently than those who were not abused. Unlike studies by Fernández-Montalvo et al. (2014), Golder and Logan (2010) and El-Bassel et al. (2004), who used clinical samples, Stene et al. (2012) used a population-based sample. Using samples outside of clinical populations is perceived by Gilbert et al. (2015) as an '...untapped opportunity... [to find women] ...beyond the reach of social services and health care.' (Gilbert et al. 2015:315). Despite the use of non-clinical samples in their study, Stene et al. (2012) note that women who were unmarried, from low socio-economic backgrounds, of non-western origins and who were receiving disability benefits or pensions were underrepresented. Furthermore, this research only sampled women aged between 30-60 years, so the prevalence rate is likely to be higher than presented.

Also using a non-clinical sample, Sullivan et al. (2012) hypothesised that greater Post Traumatic Stress Disorder (PTSD) symptoms, depressive symptoms and avoidance coping strategies were associated with greater alcohol-related problems. Of the 143 women recruited through community samples who met criteria for experiencing at least one act of physical IPV, and who also used substances at least once in the last 30 days, the authors found that over half of the women (56%) screened positive for problematic drinking using the AUDIT screening tool. A further 8% met criteria for current alcohol abuse, and another 36% were identified as alcohol dependent. The study also found that PTSD symptom severity, severity of physical IPV, and age, were risk factors for alcohol problems. However, IPV cannot be solely associated with this dependency, as other contributing factors to PTSD were not considered. These include childhood sexual abuse, which has also been found to affect PTSD and subsequent substance use, as illustrated by Gutierrez and Puymbroeck (2006) in their review of literature on the topic. Sullivan et al.'s (2012) study does allow for an understanding of the self-medication hypothesis (Khantzian, 1997) of substance use, a theory popularly associated with domestic abuse and childhood sexual abuse victims and subsequent substance use. This theory explains that those who use substances with traumatic histories do so to medicate their negative feelings associated with their abusive experiences.

Outside of clinical populations, Golinelli et al. (2008) conducted a cross-sectional study of 590 women in homeless shelters and low-income housing in the USA to test whether female substance use and partner substance use contributed individually to the risk of IPV. The findings highlighted that 42.8% of the women reported using substances and nearly two thirds of their partners also used. Nearly 10 percent (9.9%) of the women said they experienced physical IPV in the past six months and 40.5% reported psychological violence. Individual's substance use contributed to the prediction of substance use but use by both partners did not. However, this does not identify use as problematic, as women were asked to self-report their use of substances and no measures were used to identify levels of use. This research illustrates that victims of domestic abuse who use substances, can be found in a number of locations including homeless shelters and low-income housing.

The research reviewed so far tells us that there is a bi-directional relationship between domestic abuse victimisation and the problematic use of substances. However, this research does not ascertain the exact causal effect between the two as Galvani and Humphreys (2007) explain:

The link between substance use and domestic abuse is complex. There is no reliable evidence of a cause-effect link between the two. However, where problems with substance use exist, domestic abuse is often present too. (Galvani and Humphreys., 2007:10).

Exact causality of substance-related domestic abuse will never be fully understood because not every victim of domestic abuse uses substance problematically and, not every individual who uses substances problematically will be a victim of domestic abuse. This is highlighted by Testa (2004) who states:

Substance use does not lead to violence or to victimization in all circumstances. A woman who drinks a bottle of vodka every night incurs virtually no risk of subsequent victimization as long as she drinks alone in her home and not at a bar or party or in the presence of men who may potentially

perpetrate violence. Similarly, men's substance use can lead to violence only when there is a potential victim in proximity. Although overly simplistic, these examples illustrate the important point that substance use in itself is not a sufficient cause or trigger of violence. (Testa, 2004:1499).

The research presented so far demonstrates a clear relationship between problematic substance use and domestic abuse victimisation among women. In reviewing literature relating to women, substance use and domestic abuse, Call and Nelson (2007) write:

...theorists, researchers, and clinicians have written a great deal about the complex interactions between partner abuse and women's misuse of substances, [but] women are seldom given a voice with which to tell what they have experienced. (Call and Nelson, 2007: 335).

As such, this review turns to qualitative research to understand the experiences of substance use and domestic abuse victimisation.

3.2 Co-occurring Substance Use and Domestic Abuse - Understanding Prevalence Using Qualitative Literature

During the initial stages of literature searching, more studies were identified that focused on the perpetrator's substance use compared to the victim's substance use. This difference was also noticeable in the methodology of the studies. During the review process, more studies using quantitative approaches were identified compared to qualitative studies on the topic. Quantitative studies are vital in understanding the prevalence and patterns of substance use and domestic abuse, however, quantitative studies cannot explore how an individual experiences co-occurring substance use and domestic abuse, nor can they give voice to the individuals at the centre of the correlations, risk factors and descriptive statistics. Qualitative studies allow researchers to go beyond the figures to understand what happens to women who experience substance use and domestic abuse concurrently. This methodology also gives the researcher the opportunity to understand what

these experiences mean to women. As this research seeks to explore the experiences of support among women affected by co-occurring substance use and domestic abuse, the review of literature is particularly interested in research that qualitatively explored substance use and domestic abuse. However, very few peer-reviewed journals articles were identified during the search stage of the review. For example, Payne (2007) sought to qualitatively explore the influences of heroin initiation for women in North Cumbria and although domestic abuse was not the central focus of the study, the researcher found that half (n=15) of the women experienced domestic abuse. Similarly, Bostock et al. (2009) interviewed 12 women to understand social processes and women's experiences of domestic abuse in Northern England. Again, the study did not intentionally aim to explore substance use, however, the research found that some of the women in the study used medication, drugs and alcohol as a way of coping with abuse. Unlike Payne (2007) and Bostock et al. (2009), Wright et al. (2007) investigated substance use and domestic abuse more specifically. Interviewing 45 drug using women in England, this study sought to explore whether peer injecting was a form of IPV for drug using women. The authors found that the women who used drugs often felt coerced into injecting for reasons such as fear, lack of skills or knowledge, and economic 'benefits'. Some women also highlighted a dependence on the injector because they lacked the skills necessary to inject safely, however, others noted that they ceased contact with the male partner when they learned to inject themselves. The predominately male injectors referred to throughout the study, were identified by the women as controlling because they limited the amount of heroin given to the women, which often led to arguments and sometimes physical abuse (Wright et al. 2007). Although Wright et al. (2007) does not claim all drug-injecting relationships lead to abuse, the study does illustrate the role of coercion in drug injecting. Wright et al. (2007) also highlights the potential for future research that investigates substance use as a form of domestic abuse. The three qualitative studies (Payne (2007) and Bostock et al. (2009) and, Wright et al. (2007)) presented are small-scale, however, by focusing specifically on women's experiences, the authors demonstrate the relationship between substance use and domestic abuse among women.

The role of coercion was also identified by O'Brien et al. (2016) in their study exploring the role of substance use for women who had been court mandated to an IPV parenting programme following domestic abuse victimisation. Of the 22 women recruited to the study, over one third reported AUDIT scores for hazardous drinking, and a third were identified as being at risk drinkers. Two thirds of the women interviewed also reported using substances to avoid negative feelings associated with IPV. Over half also reported their partner's substance use as influencing their own use, with some women sharing that using substances was a means of connecting with their partner and gaining their partners acceptance. However, some women also stated that their partners used the substances as a form coercion and control, similar to findings from Wright et al. (2007).

The qualitative studies referred to in this section use the voices of women to explore the experiences of substance use and domestic abuse, something quantitative methods cannot easily achieve because of its different methodological focus (Bryman, 2001). However, like the quantitative research that has been reviewed in this chapter, there is a lack of qualitative research in the UK that explores co-occurring substance use and domestic abuse victimisation. As such, studies from the USA are again relied upon to understand the experiences of women who are effected by co-occurring substance use and domestic abuse.

3.3 Co-occurring Substance Use and Domestic Abuse – Understanding Prevalence Using Women's Voices

Exploring domestic abuse among 125 women in treatment for substance use, Call and Nelson (2007) used questionnaires to understand the experiences of co-occurring substance use and domestic abuse. Questions explored partner abuse, the women's connection between substance use and partner abuse and, self-reports on the strengths and resources the women developed to help them cope. Fifty-three percent of the women reported that their current or most recent partner had some kind of problem with substances, ranging from 'a little' to severe. Nearly 24% of the women said their current or past partners had coerced them into taking substances, using threats in their coercion tactics; again, aligning with findings by Wright et al.

(2007) and O'Brien et al. (2016). Nearly 15% of the women said they sought treatment as a way of being protected or avoiding partner abuse, while 12.8% reported this reason in prior treatment. Nearly half of the women in the study reported some type of abuse (psychological, physical or sexual) before their substance use became a problem, and 33.6% of the women reported using alcohol or drugs often, very often or always before an IPV incident. However, 40.8% reported that they never or rarely used prior to an abusive experience. In the qualitative open-ended questions, 30 women described IPV abuse as relating to their use of substances. Of these, some wrote about the abuse itself while others wrote that the substances helped them deal with the abuse. Thirteen of the women highlighted their own substance use as preceding abuse incidents with one woman stating, 'I believe that I was physical[ly] abused because of my alcohol and drug abuse [. . .] I might of gotten more respect from men than I did in my addictions.' Another wrote, 'Yes, because if [I] wasn't using, I wouldn't have none of those abusive issues.' (2007:341). Some women also said that they were more assertive when they used substances, which may have been perceived by their partners as justification for using violence against them.

Macy et al. (2013), also identified similar themes when they explored women's experiences of partner violence and substance abuse. The researchers were particularly interested in how women understood this connection in their own lives. 15 women were recruited from a women's substance abuse treatment facility that specialised in trauma. All participants shared experiences of violent and non-violent IPV, with some women reporting experiences of more than one violent relationship in the past. The majority of respondents also reported experiences of childhood abuse including psychological, physical and sexual abuse. Some women also traded sex for substances. The majority of the women mentioned early initiation to substance use, as they recalled using substances in childhood or adolescence, which was often facilitated by a peer or family member. Some women also mentioned substance use as a way of coping with victimisation too. Macy et al. (2013) found that many women reported that their partners facilitated their move from use to abuse and dependence, but some reported progression to abuse unrelated to their partner.

Facilitation from substance use to abuse and dependence by a partner played a major role for many women in Macy et al. (2013). Some women reported substance use as having a positive effect on their relationship including better sex, using to have something in common, emotional closeness, using for pleasure. For some, having a partner who was a drug provider also hastened their progression to abuse. Like Wright et al. (2007), many women in Macy et al.'s (2013) study described how mutual substance using in their relationship led to problems and violence: 'crack and relationships don't mix' (2013:891), with some women reporting that their partners coerced them into trading sex for drugs. However, learning about healthy relationships influenced many women in their recovery from substance use and domestic abuse. Personal strengths including positive self-worth and a better cognitive understanding of their experiences were cited by some women as also helping them in their recovery from abuse. The authors note the treatment facility as probably affecting this new self too. Religion, children and friends were also reported as strengths in the women's recovery and several women believed that the counselling they were receiving for their domestic abuse would help them not to relapse as they had done in previous treatment.

A further qualitative study identified during the review was by Nehls and Sallmann (2005) who examined physical and sexual abuse, mental health and substance use from a phenomenological perspective. Focusing on women's histories of trauma and co-occurring substance disorders, 30 women were interviewed using a phenomenological epistemology. The authors write that the goal of their research was not to establish a truth, but instead gather a common experience through 'fully' listening:

Listening for different lived experiences among women with histories of abuse, mental health, and substance use problems is important, because it challenges the assumption that there is a 'right story'. (Nehls and Sallmann, 2005:376).

The common experiences captured by the authors and supported by qualitative methods, establish that there is no one route or cause of substance use, domestic abuse and mental ill-health.

3.4 Summary of Chapter 3

The overall aim of this chapter was to understand the prevalence between problematic substance use and domestic abuse victimisation among women. Reviewing data from a number of sources and thematising them based on national and international quantitative figures as well as qualitative studies, this chapter has shown a correlation between substance use and domestic abuse victimisation. However, this review of the literature has also demonstrated a gap in knowledge. As this chapter has shown, there is little empirical research from the UK that explores the co-occurrence of substance use and domestic abuse among women. International figures help shed light on the potential scale of the issue, however, cross-comparisons are limited between countries as health and social care systems differ. Furthermore, the legal and cultural definitions of domestic abuse as well as social attitudes to problematic substance use varies between countries, which may influence responses to the topic in a research setting. However, the studies presented demonstrate an association between women's substance use and domestic abuse victimisation and serve to bolster the need for more research in this area within the UK. The limited qualitative research available from the UK on the topic also highlights the need for more research that explores the lived experiences of co-occurring substance use and domestic abuse among women in the UK.

Chapter 4

Service Response to Co-occurring Substance Use and Domestic Abuse

This review has established a relationship between women's use of substances and their experiences of domestic abuse. However, despite this acknowledgement, Humphreys et al. (2005) cites a separation of practice and policy in service provision for those impacted by domestic abuse and substance use. Humphreys et al. (2005) note, that despite the relationship between substance use and domestic abuse, services tend to work within an either/or framework with limited crossover between substance use services and domestic abuse services. This divide in service provision sees '...people who do not fit within the sector's dominant policy and practice framework become invisible, [and] their needs remain unacknowledged...' (Humphreys et al., 2005:1304). This is echoed by a number of research participants in the qualitative study by Macy et al. (2013), where participants highlighted a gap in their own service provision:

Yeah, [name of domestic violence program] were helpful, but they didn't directly address the drug use. I guess that they relied on other agencies to take care of [survivors' substance abuse problems]. (Macy et al. 2013:893).

The findings by Macy and colleagues, although a by-product of the study's primary research aims, present a point rarely discussed in dual substance use and domestic abuse literature; that of women's own experiences of service provision. This is echoed by Andrews et al. (2011) who states:

In spite of the high rate of women entering substance abuse treatment with a history of IPV, little is known about the comprehensive services they receive in treatment, [...] Even less is known about the effect of comprehensive services on substance use outcomes for women with a history of IPV. (Andrews et al., 2011:551).

The studies by Andrews and Macy are from the USA, but similar sentiments were

shared in a UK study by Galvani and Humphreys (2007). The authors conducted a literature review on the topic and found a ‘...severe lack of research evidence on the impact of domestic abuse on the engagement and retention of women in substance use treatment.’ (2007:29) in the UK. They also wrote that research in the area of substance use and domestic abuse is especially ‘...devoid of qualitative research that seeks to represent service users’ views.’ (2007:29).

4.1 Service Provision for Women Affected by Co-occurring Issues

Assessing the number of women with substance issues in domestic abuse refuges in the USA, Schumacher and Holt (2012) conducted a review of literature focusing on three types of studies; domestic violence staff perceptions of client’s substance use, retrospective estimates from client records and, refuge residents’ self-reports. Focusing on studies where clients self-reported their substance use, Schumacher and Holt (2012) identified six studies. Although the methodology varied between the six studies, Schumacher and Holt (2012) found that between 22%-72% of women in domestic abuse refuges had a lifetime or current history of substance use. Reviewing a further three studies that focused on the perceptions of staff in domestic violence agencies, Schumacher and Holt’s (2012) also identified that refuge workers believed that only a minority of residents used substances. However, the authors note that policies regarding substance use needed to be considered in this assessment as some domestic violence services had stringent rules regarding the use of substances in the refuge, therefore influencing staff perceptions of client substance use. Such policies may also impact the researcher’s measures if there were women who did not admit to substance use for fear of eviction (Schumacher and Holt, 2012). Although the studies identified in Schumacher and Holt (2012) review vary methodologically, their findings do illustrate a gap in service provision among women affected by co-occurring substance use and domestic abuse. The impact of substance use policies is also an important point to consider and is a common theme in research exploring substance use and co-occurring domestic abuse. Often, domestic abuse refuges do not accommodate women who use substances problematically, for reasons including a lack of self-contained accommodation, a lack of full-time 24/7 staff on site, and, children may live on the premises. Such concerns stereotype substance using women

as dangerous individuals or bad mothers, reinstating the negative narrative associated with women as substance users. As a result, women who use substances are less likely to be obvious in refuge research. However, substance free refuges do not mean that women are not using substances. Research by Sato-DiLorenzo and Sharps (2007) explored the health records of women in a 'substance-free' domestic violence service in the USA. Findings showed that the women in the shelter were not currently using substances, but past use was reported by 42% (74) of the women, while only 3% reported symptoms concurrent with alcohol issues.

Gathering the perceptions of staff, Martin et al. (2008) surveyed domestic violence services in North Carolina to understand how they accommodated the multiple needs of women. A total of 71 domestic violence services completed the survey and nearly half believed that 26-50% of their clients experienced problematic substance use, while nearly a quarter of the services believed that more than half of their clients had experienced problematic substance use. The survey was sent to services with no requirement for a specific staff member e.g. manager, to respond to the survey. The results therefore need to be interpreted with caution, as the respondents may vary in their perception of substance use among clients compared to their colleagues. Martin et al. (2008) also found that of the 62 services that provided refuge, 81% reported routinely asking about substance use, however, fewer than half had substance use policies in place, despite knowledge that substance use was present in a woman's life at some stage. Despite nearly all the services asking about substance use, Martin et al., (2008) found that the services varied in how they would respond to substance use. A third of the services reported that they would turn women away from the refuge. This study highlights the vast difference in asking and acting when dual substance use and domestic abuse has been identified. The figure difference in substance use enquiry (81%) compared to having policies in place responding to substance use (n=33) demonstrates a gap in service provision. Zweig et al. (2002), also found this detachment in their examination of services. The authors explained that 'Although many victim service programs have multibarriered women as clients, very few specifically tailor services to the unique needs of such women [sic]'. (2002:163). Zweig et al. (2002) surveyed 20 services in the USA to identify domestic

violence services that provides specific support for women with multiple needs (including substance use). Although the initial number of services in their population exceeded four thousand, only 86 services served as the sample frame. However, upon review, only 20 services were identified as matching the study's inclusion criteria. Such a small number of programmes available in the overall pool of women's services serves as an indication of the scarcity of support options available to women facing multiple barriers (Zweig et al., 2002).

Exploring the potentiality for service coordination or integration, an American study by Kunins et al. (2007) sought to assess staff perceptions of service integration between substance use services and IPV services. Kunins et al. (2007) conducted seven focus groups, with 41 staff members from treatment services in the USA and found that IPV awareness was common among staff. Training on IPV was given to the majority of staff, however, those who received deeper levels of IPV training reported more positive experiences in understanding and supporting women. Inadequate training for some lead to a fear of opening 'Pandora's box' despite the majority of services screening for IPV in assessment. Systematic barriers (lack of funding, lack of staff readiness to deal with women's histories of trauma, and the lack of time in integrating the two) and, professional barriers (a belief that substance use should take prime focus and a belief that clients could achieve recovery like their counsellors/staff did) were also cited (Kunins et al. 2007). Blakey and Bowers (2014) conducted interviews with 20 staff members at a substance treatment service and found similarities to Kunins et al. (2007). Blakey and Bowers (2014) reported a need for change in '...the structure and system at policy, administrative, research, practice, and educational and training levels, [which begins] in the classroom.' (2014:268). Kunins et al. (2007), highlighted organisational structures as affecting the ability to provide sufficient support as some staff noted the importance of addressing IPV but being able to do it all at the same time, while other focus groups demonstrated frustration in treating IPV over substance use. The authors found that overall, there was a lack of experience in integrating IPV services into treatment programmes, but staff were open to providing these services with the right support from management and sufficient training. Zweig and colleagues (2002) echoed these barriers when they

asked practitioners about the issues facing help-seeking women who face multiple barriers. Findings cited transportation, employment, housing, education and poverty, lack of services in communities, being traumatised by the perpetrator and then by service, a lack of awareness regarding available services, and their right to use services were also discussed. These findings were similarly identified in the UK by Galvani and Humphreys (2007) who likewise used the voice of the service practitioner to understand service provision and the barriers facing women who experience dual substance use and domestic abuse. Interviewing 13 professionals working in drug and alcohol-related services in England, Galvani and Humphreys (2007) explored the experiences of domestic abuse on admission, completion and relapse from substance use treatment. Like the barriers shared by research participants in Macy et al.'s (2013) study, childcare was cited as influencing a women's access to services. Pressures from the perpetrator and services, the risk to women and children, the ability to cope with the dual issues and the practical barriers were also highlighted as influencing the retention rates for the substance using women who accessed support.

As the reviewed studies show, the need for training and education, policy implementation, and the coordination and/or integration of services are continually cited as the way forward in meeting the needs of the service using women (Macy et al. 2013; Schumacher and Holt 2012; Andrews et al. 2011; Martin et al. 2008; Galvani and Humphreys 2007; Humphreys et al. 2005; and Zweig et al. 2002). Mason and O'Rinn (2014) also identified these recommendations in their review of meta-analysis and systematic reviews. By asking, 'What do clinicians and frontline workers need to know in order to provide appropriate care to women who may experience co-occurring IPV, mental health and/or substance use problems?' (2014:2), Mason and O'Rinn (2014) noted the need for better collaboration, coordination and integration across the three sectors. Macy and Goodbourn (2012) also identified similar recommendations in their review of literature that aimed to gather recommendations for collaboration between substance use and domestic abuse services.

4.2 Collaboration Between Substance Use and Domestic Abuse Services

Recommendations in substance use and domestic abuse research, such as the studies outlined in this review, point to the need for integration of, or coordination between, substance use and domestic abuse services. However, evidence by Torchalla et al. (2012) found insufficient results to determine whether integrated treatment was superior in outcomes to non-integrated treatment. Conducting a meta-analysis evaluating integrated treatment on PTSD and substance use symptoms, they found that integrated treatment effectively reduced both symptom types over time, but similar reductions were seen in non-integrated treatment. They recommended that practitioners ‘...base their decisions on factors like client preference, program availability and expense.’ (2012:74). Nevertheless, some programmes are integrating, or trialing integration between substance use and domestic abuse programmes.

In Ireland, Morton et al. (2015) explored initial outcomes and learning points from a well-known domestic abuse agency, who implemented a harm reduction response to female domestic abuse survivors who were also using substances. Prior to the integration, women who presented with substance use issues were referred to a homeless agency. However, moving to a housing-first approach, the domestic abuse service believed the ‘...provision of safe and secure shelter should not be contingent on accessing treatment or other services and that providing housing gives opportunities to reduce risk and harm in women’s lives.’ (2015:41). Findings highlighted how on-the-premise intoxication did not increase over the twelve-month period when women with dual issues were welcomed to the shelter. This has been associated with the ‘...rigorous attention paid to drafting and implementing a substance use policy in the organization, which gave clear guidelines for responding to a large variety of scenarios that might arise.’ (2015:342). Additionally, staff were trained to understand the effects of substances, including poly-drug use and such training reported a greater level of confidence for staff in discussing safety measures with women regarding their substance use. The authors also highlight the benefits of ‘safety-first’ shelter for women experiencing dual substance use and domestic abuse but, to fully understand the benefits of this service on the women, external factors

such as family, peer support and the role of the perpetrator need to be considered. Similar themes also emerged in a North American study by Bennett and O'Brien (2007) whose research evaluated the collaboration and integration of substance use and domestic abuse service in Illinois. Receiving either coordinated or integrated support for dual substance use and domestic abuse, 128 women reported significant changes in feelings of self-efficacy and substance use following support (Bennett and O'Brien, 2007). Although positive results were highlighted, the women also reported being more adversely affected by violence at the end of the programme. The authors posit women's newfound sobriety and competence as potentially opening their eyes to the seriousness of the violence they were victim to, as substance use may have previously numbed this realisation.

Another point illustrated by Morton et al. (2015) is the benefit of staff training and education in effectively supporting women's dual substance use and domestic abuse, something shared by Mason and O'Rinn (2014) who state:

To better address the learning needs of those who work with women who experience these co-occurring problems requires collaborative, cross-sectorial, and multidisciplinary cooperation and systematic evaluation of new education and training initiatives. (Mason and O'Rinn, 2014:13).

The collective findings demonstrated within this chapter, highlight important issues faced by services who support women affected by substance use and/or domestic abuse. As the various findings and study recommendations show, there is a lack of support for women with multiple needs, a lack of resources for women to get the support they need and a lack of resources for practitioners. The limited number of studies on this topic also evidences a gap in research relating to support, substance use and domestic abuse. The recommendations identified throughout this literature review advocate for more training, service integration and better support for women affected by co-occurring substance use and domestic abuse; recommendations that have been influenced by including practitioners as research participants. Although the voice of the practitioner is important in understanding the service landscape,

literature relating to co-occurring substance use and domestic abuse is missing essential perspectives, experiences and knowledge. The direct inclusion of women as research participants is therefore necessary, to understand, not only their own experiences, but the impact wider structures such as service provision and policy has on their needs.

4.3 Women as Research Participants – Their Views on Services

Seeking to identify service provision and service user needs for women in domestic abuse shelters in the USA, Lyon et al. (2008) collected entry and exit surveys with over three thousand women who were accessing domestic violence refuges. Results showed that the needs of many refuge residents were not being met, particularly for women who identified as having substance use needs. Domestic abuse refuges were also used by Poole et al. (2008), (see also Greaves et al. (2006)) to explore the relationship between substance use, using-to-cope behaviour and levels of stress among women. The authors accessed refuges that provided varying levels of support to substance using women, ranging from minimal intervention (willing to discuss substance use and make a referral) to significant intervention (proactively discussed substance use, assisted them in identifying their level of use, type of support required and support in referring to necessary services). However, services did not differ in the provision of general domestic violence support. One hundred and twenty-five women met the criterion for substance use (using substances a minimum of 5 times per week/ poly use a minimum of once a month or five times a week/ self-report problematic use) and were interviewed upon entry into refuge. Follow up interviews were completed with 74 women following refuge stay and results highlighted a decrease in women's use of alcohol and stimulants however, 40% of the entry-level participants were not surveyed at the follow-up stage. The decrease in use also needs to be considered when interpreting the results as those receiving 'significant intervention' decreased their use more than those receiving 'minimal intervention'. The role of the perpetrator also needs to be examined further to identify their role in substance use pre and post refuge stay (Poole et al. 2008). Moreover, close to half of those screened did not meet criteria for substance use as outlined in the inclusion criteria, however, nearly half reported alcohol use at least three times in the past

month and over half reported cocaine/crack use in the same period. Further research should be conducted to investigate the role of substances in refuge outcomes for this group of women (Poole et al. 2008). Finally, this study only screened 10% of the total number of women accessing one of the 13 refuges used in this study, therefore, generalisations cannot be made regarding the efficacy of the refuge in decreasing substance use. However, a decrease in substance use was found and highlights the benefits of a housing first approach as discussed by Morton et al. (2015). Poole et al. (2008) writes of the benefits in this approach highlighting that such an approach ‘...can have a pivotal impact in helping women restructure their lives and reduce their use of substances.’ (2008:1143).

The benefits of providing multiple services for women with dual substance use and domestic abuse was also illustrated by Andrews et al. (2011) who sought to examine whether women with and without a history of partner violence differed in their substance use at treatment intake. The authors also explored whether the same women differed in their receipt of services during treatment. Arguing, ‘...women entering treatment who are presently involved with an abusive partner may face additional obstacles to treatment progress.’ (2011:552), the author sampled 1123 female clients from 50 different treatment units in the USA. Nearly half (519) of the sample reported current or past experiences of IPV, however, the author only asked participants ‘have you ever been beaten by a spouse or partner?’ therefore failing to account for other forms of abuse associated with domestic incidences. The authors failed to find a significant difference in use of substances on entry to treatment between women who did and did not have IPV experiences. However, receipt of family services, like those outlined by Poole et al. (2008) included parenting, domestic violence counselling, family services, assertiveness training, life skills, family planning, and nonmedical pregnancy services, were associated with decreased substance use among women who had IPV experiences. Andrews et al. (2011) also demonstrated the importance of comprehensive services for women who experience substance abuse and IPV. This was also illustrated in the UK by Howarth and Robinson (2015), who used data from IDVA (Independent Domestic Violence Advocate) entry and exit assessments. Using data from 2427 women upon entry to an IDVA service 11.5% of

women reported alcohol misuse and 5.5% reported drug misuse at the time of their initial assessment. Exploring follow on data from 48.1% (n=1167) of this sample three months after entry or, at the closure of a woman's case, the authors found that women who experienced more severe abuse (as indicated by the IDVA assessment) were more likely to remain in contact with the IDVA service, than women who did not experience severe abuse. However, there is no data to highlight how IDVA support may have influenced this outcome. The researchers also found that women who accessed IDVA support were often encouraged and referred to other community agencies to help with their needs, including substance use support. Such encouragement and referral resulted in 6.1% (total number=1167) of women accessing support from drug and alcohol services. The study found that '...access to multiple community resources in combination with frequent contact with an IDVA appears to be the most effective way of working to reduce severe domestic abuse.' (Howarth and Robinson, 2015:19). Similar sentiment is shared by Poole et al. (2008) whose study '...reveals the potential for collaborative approaches between substance use treatment service providers, domestic violence services and a host of other women-serving agencies.' (2008: 1144). A belief also shared by Andrews et al. (2011) who recommends securing women's safety before tackling other areas of need.

Although these authors focus on the female services users to try and influence both practice and policy outputs, qualitative data is still lacking. Rather, the literature presented refers to figures and assessments gathered from women, rather than direct information from women. This review has demonstrated a distinct lack of women's voice in the conversation regarding substance use and domestic abuse service provision, despite the various opinions highlighting the need for more women-focused services. Galvani and Humphreys (2007) also discussed this lack of women's voice within research of this type in their research exploring engagement and retention rates for women in substance use treatment. The author's literature search identified 11 relevant UK studies, however, only two specifically addressed substance use and domestic abuse. Macy and Goodbourn (2012) identified similar search results, identifying the same two UK research studies (Barron, 2004; and Humphreys et al. 2005a) in their literature review. One of the two UK studies was

conducted by Humphreys et al. (2005a) who conducted semi-structured interviews with key informants, gathered questionnaires from substance use services and domestic abuse agencies and, held interviews with 19 women from refuge, domestic violence advice and advocacy services, substance use agencies and perpetrator programmes. This is one of few UK studies to include the voice of the service user to ‘...ascertain service user experiences of help-seeking and service provision.’ (2005a:4). Questionnaire results found that 33-86% of women who contacted one of four refuges or outreach services in a one-week period used substances problematically. Unfortunately, the authors did not report the number of women in their sample. The researchers also reported that a minority of service users received support from both agencies, but generally, service users either chose substance use support or domestic violence support, ‘...with the opportunity to work with both problems being missed.’ (2005a:11). However, service users encompassed both victims and perpetrators of abuse; therefore, more data specific to victim’s support experience is needed.

Research that has influenced this research because of its focus on the service user is *The Stella Project* (AVA, 2007), a UK pilot project that produced good practice guidelines on working with survivors of violence who are also problematic substance users (AVA, 2007). The service is run by AVA, a second tier UK charity offering training, research and consultancy to services working in the violence against women sector. They also work with substance use services to promote multi-agency working to help identify and support women who experience multiple disadvantage. A central aim of AVA’s work is to include service users in their research. For example, in their report to inform the *Complicated Matters* (AVA, 2013) toolkit, the authors (Holly and Scalabrino, 2012) conducted surveys (n=31), interviews (n=8) and focus groups (number of focus group participants=60) with female survivors who had experienced substance use and/or mental health difficulties. Key findings highlighted the importance of being treated like a human, the importance of trusting relationships with practitioners, the limited access to therapeutic support, the lack of accommodation-based services, waiting lists, the importance of peer support and the lack of childcare. The Women’s National Commission (WNC) in their 2009 report *Still*

We Rise (WNC, 2009) identified similar findings. Focus groups were carried out across England to gather the views of women and girls about what they thought would make them feel safer and their proposals for preventing violence. Like Holly and Scalabrino (2012), the role of support and substance use was also discussed. The WNC research findings highlighted the role of stigma, women's want of women's only services, the lack of child contact and support, the need for safe accommodation, the need for immediate access, and the availability of one-stop shops to support multiple issues.

4.4 Summary of Chapter 4

While chapter three demonstrated the need for research that explores co-occurring substance use and domestic abuse among women in the UK, chapter four has shown the need for research that focuses on the experiences of support among women who are affected by the two issues. As chapter three demonstrated, research on the topic is more likely to be quantitative with a focus on perpetrators. As such, the majority of studies discussed so far have been from the USA and although informative, they cannot be generalised to the UK because of the differing health and social care systems between the two countries. This chapter has also presented research demonstrating the benefits of integration and co-ordination between substance use services and domestic abuse agencies, however, the studies identified were not from the UK. As this review also demonstrates, little qualitative research has been conducted in the last 10 years on this topic. Conducting research on women's experiences of substance use, domestic abuse and support is particularly important in this current climate in the UK, because of the impact of austerity on health and social care services. The following chapter will highlight these policies.

Chapter 5

The Policy Context

As chapter three and four have illustrated, there is lack of UK research that focuses on women's experiences of co-occurring substance use and domestic abuse. Research relating to service provision, as well as gaps in service provision in the UK were also identified. Similarly, within policy, there are gaps in information regarding substance use and domestic abuse in the lives of women. The UK Government has produced policy and strategy focusing on both substance use and violence against women and girls, but the issues remain siloed. To understand whether the co-occurring issues are discussed in policy and strategy, I examined various national UK drug, alcohol and domestic abuse policy and strategies. A review of each strategy will now be presented.

5.1 The Ending Violence Against Women and Girls Strategy (2016)

HM Government's 2016-2020 Strategy (Homes Office, 2016), Ending Violence Against Women and Girls (VAWG), lays out the Government's plans to tackle VAWG over four years. Following a review carried out by the Department of Communities and Local Government (2016:29) the strategy acknowledged that victims with the most complex needs were not accessing the appropriate support. However, specific reference to the relationship between various complex needs such as drug and alcohol use was not provided. In the 59-page document, a word search found the words 'alcohol' four times, 'drug' twice and 'substance' five times. The strategy also acknowledges that support for complex needs is not widespread enough but health services including drug and alcohol services, are well-positioned to identify abuse. As such, Parliament will promote resources for health and social care professionals, including drug and alcohol services, to respond to domestic abuse and recommends more training to detect early signs of abuse. The strategy also focuses on the integration and coordination of services, with a specific focus on multi-agency working as a means to provide the most 'effective support' (2016:10) for women affected by wider vulnerabilities. The strategy describes how the Government will

aim to transform multi-agency working by 2020, ensuring services, including drug and alcohol services, have a ‘...VAWG partnership, rigorous needs assessment and local strategy’ (2016:35). This includes the provision of specialist support including accommodation-based support for most vulnerable victims and those with complex needs. This will be conducted by supporting local commissioners to transform service provision through the National Statement of Expectations (NSE), launched in December 2016. The NSE aims to ‘make clear to local partnerships, what good commissioning and service provision looks like’ (2016a:10). Like the VAWG Strategy, the NSE strongly focuses on ‘working together [...] on the frontline’ (2016a:1) and highlights its expectation to put ‘the victim at the centre of service delivery’ (2016a:2). By achieving this, the statement explains, every victim of VAWG ‘is an individual with different experiences, reactions and needs’ (2016a:2); as such, services are encouraged to be ‘flexible and responsive to the victims’ experience and voice’ (2016a:2). This is encouraging, because the statement takes a victim centered approach within support. The recommendations also encourage commissioners to take a ‘strategic, system-wide approach to commissioning; (2016a:3) and highlight the need to consider complex needs including mental health problems and drug and alcohol dependency when developing business cases and funds for services. The statement also encourages commissioners to consider how other services detect and respond to victims of VAWG. Both the VAWG strategy and the NSE outline the importance of taking a victim centered approach and multi-agency working, but the responsibility is down to local commissioners to direct budgets in this area. However, not enough money is being allocated to meet the NSE. The strategy highlights that the cost of domestic abuse due to the provision of public services and the lost economic output is £15.4 billion per year (2016:9), however, only £80 million has been pledged over the four-year period with specific provision for ‘...innovative services for the most vulnerable [people] with complex needs.’ (2016:11). An additional £20 million was allocated in the 2017 Spring Budget.

5.2 The 2012 Government’s Alcohol Strategy

The 2012 UK Government Alcohol Strategy (Home Office, 2012) demonstrated a gap in understanding relating to female substance use. Reviewing the strategy with a

gendered lens, an initial word search was conducted looking specifically for information relating to domestic abuse and women. The word search identified the word 'women' (female and woman were not identified) nine times throughout the document (excluding footnotes), however, this was predominantly focused on pregnancy, foetal alcohol syndrome and units of consumption. The search also identified the word 'domestic' a total of three times; once in relation to domestic trade, once in relation to the Government's 'Troubled Families' initiative and once in relation to domestic violence. Although the strategy acknowledges the role alcohol use can play in 'some cases of domestic violence' (2012:25), the strategy fails to go any further in its exploration. The only paragraph dedicated to the topic references the VAWG *strategy Call to End Violence against Women and Girls. Taking action – the next chapter* (2012), where it says that, 'a detailed range of supporting actions [...] including ensuring that front-line practitioners are equipped so that they can respond appropriately to perpetrators and victims' (2012:23). However, upon reviewing this VAWG strategy, the word alcohol was not used once throughout the document. Since the publication of the *Alcohol Strategy* in 2012, no update has been published; however, the recently published *2017 Drugs Strategy for England and Wales* does refer to both drugs and alcohol acknowledging 'the importance of joined-up action on alcohol and drugs' (2017:7).

5.3 The 2017 Drug Strategy

The *2017 Drug Strategy* (Home Office, 2017) highlights how the Government will respond to problematic drug use in the UK at a local and national level. Setting out actions to reduce demand, reduce supply, build recovery and take global action, the strategy's overall aim is to 'reduce all illicit and other harmful drug use, and increase the rate of individuals recovering from their dependence' (2017:6). As the strategy focuses on elements of drug use not relevant to this research, two aims were reviewed with a gendered lens within the strategy, 'Reducing Demand' and 'Building Recovery'. According to Hamilton in *The Conversation* (2017), 'Nowhere is the lack of consideration of women's specific experiences with drugs more apparent than in the UK's Drug Strategy 2017' (Hamilton, 2017). Reading the strategy with a focus on women and co-occurring substance use and domestic abuse an initial word search

was conducted. The strategy mentioned 'women' four times, once in relation to drug-related deaths, once in relation to sex work and twice within the same sentence relating to intimate partner violence and abuse. Under the aim 'reducing demand', the strategy sets out how the Government will reduce the demand of drugs by targeting groups most at risk, including victims of intimate partner violence and abuse. Although the strategy acknowledges intimate partner violence and abuse as a specific at-risk group, the 112-word paragraph does little more than pay lip service to the co-occurrence of substance use and domestic abuse. The paragraph (on page 12 of the strategy) highlights the relationship between substance use and domestic abuse but stops short of explaining how the Government will act to support those at risk of co-occurring issues. Instead, the strategy outlines how the government will 'build on work looking at the relationship between intimate partner abuse and drug misuse to support innovative approaches to working with victims and perpetrators and achieve sustainable reductions in repeat offending and misuse' (2017:12). The strategy does not outline how the Government will look 'at the relationship between intimate partner abuse and drug misuse' (2017:12), nor does it outline how it will support individuals impacted by co-occurring use and abuse, despite the acknowledgment that 'women with experience of extensive physical and sexual violence are more likely to have an alcohol problem or be dependent on drugs' (2017:12). The inclusion of intimate partner violence and abuse within the strategy only offers a reference to an at-risk group of individuals and fails to account for the gendered experiences of substance use.

Finally, under the 'building recovery' aim within the strategy, reference is made to the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (Department of Health and Social Care, 2017) as providing 'high quality advice on pharmacological and psychosocial interventions known to be effective' (2017:31). I therefore conducted a review of these guidelines looking specifically for references to co-occurring substance use and domestic abuse. The guidelines acknowledged the relationship between substance use and domestic abuse in greater detail when compared to the UK 2017 *Drugs Strategy*. The guidelines acknowledged that victims of abuse are more likely to use substances and experience mental ill-health issues

and also highlights how better substance use treatment outcomes are reported for 'evidence-based integrated trauma-informed interventions for women currently experiencing IPV or PTSD and co-occurring substance use' (Department of Health and Social Care, 2017:43). The guidelines also recommend that professionals ask service users about domestic abuse victimisation or perpetration as part of ongoing assessment and risk management. Finally, the guidelines recommend the NICE (National Institute for Health and Care Excellence) *Domestic violence and abuse: Multi-agency working* (2014) guidelines to staff employed in substance use treatment services. Overall, the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (2017) highlights the relationship between substance use and domestic abuse in greater detail when compared to *the Alcohol Strategy* (2012) and the *Drug Strategy* (2017), however, other than NICE (2014) there is still a lack of dedicated guidelines specifically aimed at co-occurring substance use and domestic abuse.

5.4 NICE 'Domestic Violence and Abuse: Multi-agency Working' (2014)

As the *Drug Misuse and Dependence: UK Guidelines on Clinical Management* (2017) recommends the NICE (National Institute for Health and Care Excellence) guidelines *Domestic violence and abuse: Multi-agency working* (2014) for drug and alcohol practitioners, a review of these guidelines was conducted. NICE is a service providing national guidance and advice to improve various health and social care outcomes in the UK. Exploring guidance relating specifically to substance use and domestic abuse together, I identified the *Domestic violence and abuse: Multi-agency working* (2014). The guidance provided better context to the substance use/domestic abuse conversation when compared to the *Alcohol Strategy*, *Drugs Strategy* and *VAWG* strategy outlined above. The recommendations from NICE included: 'ensuring that those who presented with substance use are referred to the relevant health, social care and domestic violence and abuse services; ensuring support is offered in settings where people might be identified or disclose abuse; the importance of basic training to all staff to inform them of the dynamics of abuse and its links to substance use and mental ill-health; the role of commissioners in mapping services that may support domestic abuse; and ensure staff are trained in all settings to ask about violence and

abuse.’ (NICE, 2014: online). However, recommendations offered by NICE do not differ greatly from those identified by researchers in the studies presented in this review, nor are they dissimilar from the various governmental aims also outlined. The call for integration and coordination across services is continuously repeated by practitioners, strategy and researchers, however, a lack of dedicated funding inhibits effective integration and coordination.

5.5 Summary of Chapter 5

Chapter five presented a critique of policy documents relating to substance use and domestic abuse. As the key strategies showed, language relating to co-occurring substance use is not illustrated in any great detail. This was found in both the *VAWG* strategy, the *NSE* as well as the *Alcohol Strategy* and the more recent *Drugs Strategy*. Although the drugs strategy does acknowledge the relationship between substance use and domestic abuse, the strategy failed to explain how the Government will support those impacted by both substance use and domestic abuse.

5.6 Summary of Part 2

This literature review has evidenced many gaps in research, practice and policy relating to co-occurring substance use and domestic abuse among women in the UK. Chapter three highlighted the lack of research focusing specifically on women’s substance use and experiences of abuse, therefore, impacting our understanding of their experiences within a British context. Chapter four identified and discussed gaps in substance use and domestic abuse service provision in the UK, focusing on recommendations for more coordinated, integrated and multi-agency work between substance use and domestic abuse services. Chapter five highlighted the limited interplay between substance use and domestic abuse in the UK’s national strategies. The policies recognise a relationship between the two issues; however, actions regarding service provision are limited. This literature review has, therefore, shown the need for more recent, relevant and women-centered research from the UK. By identifying women’s actual experiences of substance use and domestic abuse support, this research will highlight the need for more practical responses to the co-occurring issues in the UK.

Part Three

Methodology

and

Methods

Chapter 6

The Research Aims

The literature review identified many gaps in research relating to women's experiences of substance use and domestic abuse. In the UK in particular, there is a lack of available statistics measuring the number of women who are dually affected by substance use and domestic abuse. Public health organisations such as NICE, have produced guidance (2014) advocating for multi-agency working within substance use, domestic abuse and mental health services. However, *The Stella Project* (2007) appears to be the only available 'instruction manual' that offers support to practitioners in the UK. The annual Women's Aid survey (2018, 2017, 2016) also highlights that women are turned away from domestic abuse refuge because staff were not trained to respond to substance use nor were there suitable structural resources, such as 24 hour staffed housing, available to meet the needs of women with co-occurring substance use and domestic abuse. Research within the literature review also illustrated a need for more training and more financial resources for staff who encounter women affected by substance use and domestic abuse. With a lack of knowledge surrounding the experiences of women who experience co-occurring substance use and domestic abuse, coupled with a lack of services available to meet the varying needs of this cohort of women, a question emerges that focuses specifically on the women at the centre of this situation: What are the experiences of help-seeking and support among women who have been affected by co-occurring substance use and domestic abuse? In understanding these experiences this research aims to:

- Identify their motivations for seeking support
- Explore the barriers and/or enablers to accessing support
- Determine the wider influences on women's decision to seek help, e.g. children, friends, financial difficulty
- Identify the practice of substance use services and domestic abuse agencies in supporting women with dual needs.

By achieving these aims, this research will contribute to the relatively limited dialogue that currently exists in the UK regarding the co-occurrence of substance use and domestic abuse among women. As the literature review found, few studies used women's own voices to understand the experiences of co-occurring substance use and domestic abuse. This was echoed by Call and Nelson (2007) who said that '...women are seldom given a voice with which to tell what they have experienced' (2007:335).

As such, the following chapters will illustrate the steps taken to answer the question outlined above. The next chapter will begin with a focus on the theoretical framework that underpins this research study and justify why it is necessary to conduct research that places women's voices and experiences at the centre of understanding. Specifically, the influence of feminism will be discussed demonstrating that this study is a feminist piece of research. Focusing on the voice and experiences of women, a hermeneutic phenomenological methodology will be adopted and illustrated. However, simply documenting the voices and experiences of women does not serve legitimacy in answering the overall research question. Subsequent chapters will discuss the methods for analysing and understanding what the research participants have shared. In ensuring accuracy and transparency throughout the research process, the next section will also illustrate the process of participation recruitment, researcher reflexivity, ethical considerations and methodological limitations that were encountered throughout the various stages of the research process.

Chapter 7

Epistemological and Methodological Understanding

Feminism and Phenomenology

...never in historical or religious writings has a woman been named and discussed as an individual except in terms of an exceptional ability or inability to fulfil family obligations...

(Dobash and Dobash 1979:32).

7.1 Focusing on Women's Experiences

As the literature review has presented in part two, drug and alcohol policy fails to recognise the specific needs of women substance users. The literature review also demonstrated a gap in research from the UK that focused on women's experiences of substance use and co-occurring issues. Research fails to reflect the voices of women affected by substance use and domestic abuse. As such, knowledge 'from the perspective of women's lives' is lacking (Harding, 1991:106). By listening to women, we privilege their 'issues, voices and lived experiences' (Hesse-Biber, 2014:3) and by privileging these experiences we are also afforded an opportunity to learn from women, to create an opportunity to impact change and to create a new knowledge that is specific to women (Haraway, 1991; Hesse-Biber & Yaiser, 2004; Harding, 1991).

As Dobash and Dobash demonstrated through their 1979 work *Violence Against Wives*, listening to women's experiences can impact change in policy and practice. Their work was one of the first pieces of research to focus on women's experiences of domestic abuse in the UK, and subsequently paved the way for legislative change in this area (Griffiths and Hanmer, 2005). The importance of listening to women's experiences is also emphasized by services such as AVA (Against Violence and Abuse) and Agenda; women's services that seek to end violence and abuse through collaboration with 'experts by experience' i.e. women who have experienced domestic abuse, substance use, mental ill-health, criminal justice involvement and

homelessness. By acknowledging the lived experiences of women, Agenda and AVA seek to challenge policy-makers and practitioners to think about, and respond to, women's specific experiences.

7.2 Navigating Feminist Research

Using women's experiences to affect change is theoretically influenced by feminism (Hesse-Biber & Yaiser, 2004). Although many researchers and feminist theorists have debated the definition of feminist research (Ramazanoglu with Holland, 2002; Stanley and Wise, 1993; Skinner, Hester and Malon (Eds.) 2005), a general consensus shows that research is feminist if it focuses on the experiences of women (Abbott, Wallace, & Tyler, 2005). For example, Ramazanoglu with Holland (2002) define feminist research as being,

‘politically for women; feminist knowledge has some grounding in women's experiences, and in how it feels to live in unjust gendered relationships’ (2002:16).

Stanley and Wise (1993) argue that the central tenets of feminist research should acknowledge that women are oppressed, the personal is the political and there exists a feminist consciousness. Whereas Skinner, Hester and Malon (2005:11-15) define five principals of feminist research (labelling it feminist methodology) as:

1. A focus on gender and gender inequality, and a focus on women's experiences.
2. A rejection of the ‘standard academic distinction between the research and researched’ (2005:11).
3. Enabling the voice of women and other marginalised groups to be heard and their experiences valued.
4. An importance on political and emancipatory research.
5. A focus on researcher reflexivity.

Maynard writes that feminist research 'must begin with an open-ended exploration of women's experiences, since only from that vantage point is it possible to see how their world is organized and the extent to which it differs from that of men' (1994:12). Kelly (1994) similarly writes about feminist research as originally centring 'on the creation of knowledge about women through research with women' (1994:29). These authors all share common principals when defining feminist research, namely a focus on gender, on women's experiences, and on the political. Principals that guide and influence the theoretical direction of this research because it seeks to focus on women, to understand their own individual lived experiences and to create change in the area of support. However, conducting research that is feminist is not without its challenges.

There is no specific ontology, epistemology or methodology that feminist theory can lay claim to (Maynard, 1994). Like feminism in general, there are a multitude of understandings associated with the term. The various waves of feminism have produced different ways of defining what is feminist, and this has also influenced how we think about feminist research (Skinner, Hester and Malon, 2005). Research can be conceived as feminist if it adheres to the basic principles outlined above yet, the concept of truth is continually debated among feminist scholars. As various authors (Ramazanoglu with Janet Holland, (2002); Skinner, Hester and Malon (2005); Stanley and Wise (1993)) have discussed, the ontological and epistemological positioning of feminist research can move between positivism and relativism. Haraway (1991) uses the analogy of a greased pole to highlight the position female ontology and epistemology sits in achieving truth. Ramazanoglu and Holland (2002) explain Haraway's analogy when they write:

The point of climbing the pole is to produce valid knowledge of gendered social life. With one hand, the feminist researcher holds on to feminism's inheritance of commitment to science and reason, in order to provide knowledge of what gendered lives are really like, and to compete successfully with patriarchal knowledge. Feminists do want 'enforceable, reliable accounts of things' (Haraway, 2001:188). With the other hand, she is unwilling

to let go of the relativist claim that the 'knowing feminist', the 'reality' she 'discovers', and the 'truths' she tells are all socially constituted in particular situations, cultures and ways of thinking. It is difficult for feminists wholly to abandon the pull of either relativism or reality, and so they tend to slip around, or feel forced to choose between them. (Ramazanoglu and Holland, 2002:61).

However, Kelly (1994) believes that the search for objectivity and definition within feminist research, takes the focus away from the central aim of conducting feminist research:

What troubles us most about the current 'romance with epistemology' is that it seems more concerned with attempting to convince the predominantly male academy that a privileged status should be accorded to 'women's ways of knowing' than with enabling us to better discover and understand what is happening in women's lives, and how we might change it. (Kelly, 1994:32).

Although I agree with Kelly, this research is also influenced in part, by feminist standpoint theory as a way of defining a feminist epistemology.

7.3 Feminist Standpoint Theory

Feminist standpoint theory is discussed by Harding (1987) as a way of justifying feminist knowledge as something real and even a 'successor' to traditional research practice. The central argument of standpoint theory is the belief that women's lives differ to men's and so women's subjected position creates a different/better knowledge (Harding, 1991). The theory seeks to follow '...the feminist tradition of bringing in voices of the silenced and/or oppressed to mainstream dialogue' (Hesse-Biber, 2014:6). These voices are deemed relevant because, according to Harding (1991), women's oppressed position within society gives them rich insights into the society they are positioned in. Deriving from the Hegelian 'master-slave' dialectic (Harding, 1987) and Marxism influence, standpoint theory is understood by feminist

theorists such as Haraway (1991), Harding (1987), and Smith (1997) as being 'embodied in specific actors who are located in less privileged positions within the social order and who, because of their social locations, are engaged in activities that differ from others who are not so located' (Hesse-Biber, 2014:27). A feminist standpoint occurs through experience where women are 'the experts of their own lives and local practices' (Smith, in Abu-Loghod, 1999:69).

Feminist standpoint theory's position on women as holding a standpoint based on experience resonates with the aims of this research. However, standpoint theory has come under criticism for sitting within a relativist ontology. Hekman (1997) refers to the role of multiple standpoints as being treated equal in validity, which means one set of beliefs cannot be considered truer than another. This infers that women's knowledge is no truer than men's knowledge for example. However, Assiter (1996) urges that we accept limitations to relativism. She advocates for a consideration of emancipation when defining truth and 'suggests that, as a minimum, a value [truth] is more emancipatory than another if it has the effect of removing a person or a group of people from subjugation.' (1996:84). Within this research, a relativist position is taken because the focus is on women's varied experiences of substance use and domestic abuse, experiences that are subjugated. The women in this research have a standpoint specific to their experiences which therefore enables them to discuss help-seeking in a different perspective than those with who have not experienced such experiences. Smith (1997) believes.

To begin in women's standpoint is to begin on women's side of the divide [...]
It means beginning in the everydayness of a work that is situated in a particular local site in relation to particular others (Smith, 1997:40).

This research aims to recruit knowledge from 'women's side of the divide', to learn from them about their experiences of substance use and domestic abuse help-seeking because, 'their reality, their varieties of experience must be an unconditional datum' (Smith, 2004 in Hesse-Biber 2004:35).

Although standpoint theory has been criticised for being too relativist, Harding argues that it is not relativist, because it can achieve strong objectivity through the reflexive process of the researcher. Conducting research through standpoint theory requires the researcher to examine their part in the research process. Although arguments persist regarding the role of 'I' or 'me' within the research due to the exclusion of neutrality, feminist standpoint theory, like feminist research more generally, encourages reflexivity, defined by England (1994) as,

...self-critical sympathetic introspection and the self-conscious analytical scrutiny of the self as researcher. Indeed, reflexivity is critical to the conduct of fieldwork; it induces self-discovery and can lead to insights and new hypotheses about the research questions. A more reflexive and flexible approach to fieldwork allows the researcher to be more open to any challenges to their theoretical position that fieldwork almost inevitably raises. (England, 1994:244)

Reflecting on, and paying attention to background beliefs as a researcher, including my position of power within the research, (something Harding argues other science and research fails to do because of its focus on value-free, neutral research) encourages a better level of objectivity according to standpoint theory, because more angles have been considered (Harding, 1987). Although the notion of objectivity is debatable within feminist research praxis, the idea of including a reflexive process to help bias is something that attracts me to feminist standpoint theory. Examining my position within the research, including my feminist beliefs and any pre-conceived opinions, challenges me as the researcher to ensure bias is avoided; this will, in turn, hopefully, strengthen the analysis of the overall data identified. A reflexive piece is therefore offered in chapter nine and chapter 11.

However, the question of truth still remains within feminist research. As standpoint theory is critiqued for being too relativist, more objective praxis has been critiqued for being too masculine due to its adherence to an objective truth. Personally, I believe truth is constructed based on how we experience and interpret the world

around us. I believe, we interpret the world based on our experiences with people, relations and things, and our conception of truth is influenced by these interpretations. Therefore, for me, truth sits within a relativist ontology, which is influenced by the different strands of feminist theory discussed so far in this chapter.

While examining the various ontological, epistemological and methodological structures that influence this research, similarities were found between the basic tenets of feminist research and that of hermeneutic phenomenology.

7.4 Including Phenomenology

This research is also influenced by phenomenology and hermeneutics. Phenomenology as an umbrella term encompasses both a philosophical movement and a range of research approaches (Kafle, 2011). It is typically qualitative, begins with the lifeworld (Van Manen, 1990:6; Finlay, 2009) and is fundamentally concerned with the description of experience (Harper and Thompson, 2012; Reiners, 2012; Finlay, 2009). Simply put, 'Phenomenology asks the simple question, what is it like to have a certain experience?' (Van Manen, 1990:44). As a methodology, the researcher must engage with the research participant's impression of how it is or what it's like, when describing an experience (Harper and Thompson, 2012). Van Manen (1990) writes of phenomenology as offering '...us the possibility of plausible insights that bring us in more direct contact with the world' (1990:9). While Harper (in Harper and Thompson, 2012) says it is the 'subjective experience from the perspective of research participants themselves' (2012:89). For researchers who are interested in the subjective nature of experience, as I am by carrying out this research, phenomenology is best suited as a research methodology according to Harper (2012).

Phenomenology is suspected to have formally began with Husserl who describes the philosophy as 'transcendental' (Kafle, 2011; Harper and Thompson, 2012). Its basic creed aligns with experience as transcending to discover reality (Kafle, 2011). This branch of phenomenology is concerned with experience as perceived from the first-person point of view (Finlay, 2009, Cohen, Hahn and Steeves, 2000; Sloan and Bowe,

2014) and advocates for experience taken 'at face value' (Cohen, Manion and Morrison, 2007:22).

Within phenomenological research the '...researcher describes the lived experience of individuals about a phenomenon as described by participants.' (Creswell, 2014:14). As a methodology and a method, the voice of the research participant illustrates the experience of a particular phenomenon. Phenomenology, as a descriptive methodology, seeks to focus on the participants' own words and terminology, negating any subjective positions the researcher may bring but, as Harper and Thompson (2012) state '...it is impossible to directly access someone else's lived experience, [therefore] phenomenological researchers rely upon descriptive accounts of experience.' (2012:120). This research is therefore influenced by Husserl's phenomenology to understand women's narratives regarding their experiences of help seeking.

Although Husserl's phenomenology provides a foundation for this overall methodology, the philosopher endorses reduction or 'bracketing off' as imperative in understanding the lived-world. Reduction involves the dispersing of all personal prejudice and opinion to achieve a 'single, essential and descriptive presentation of a phenomenon' (Kafle, 2011:186). This research holds a central focus on the role of experience in understanding the lived world of women. But, eliminating personal prejudice and opinion is not without its difficulties in research of this type. As this chapter has highlighted, women's experience and their telling of that experience is what gives this research its knowledge base. Bracketing their own opinions and prejudices to describe their experience of help-seeking (like they were describing their experiences of a table for example), may stilt conversation, invoke barriers to communication and perhaps even hinder the women from telling their stories in their own words. As such, only the basic assumptions of descriptive phenomenology are utilised in this research; the principals of learning through first person shared dialogue. Furthermore, transcendental phenomenology seeks to disregard the opinions and influences of the researcher within the research. Differing in its approach when compared to feminist research, Husserl's descriptive

phenomenology has no place for reflexivity ‘—it is [the] antithesis to the principle of bracketing out influences on the phenomena so that they can be seen as ‘the things themselves’’ (Sloan and Bowe, 2014:1297). The research question within this study was formulated based on my experience as a worker in the area of substance use and domestic abuse, therefore, reduction is impossible. Furthermore, the decision to conduct this research, to focus specifically on women, and to include feminist principals, is based on my interpretation of my lived world. Consequently, I cannot remove myself from the research process. This does not mean that my own subjectivities should be accounted for primarily throughout the research, but rather, I should adopt an open attitude to the various research stages and refrain from importing external frameworks and judgments that may take away from the carefully constructed overarching research question (Finlay, 2009). To overcome this within a phenomenological framework, hermeneutic phenomenology will be discussed as it allows for the use of descriptive phenomenology with the addition of reflexivity and interpretation (Cohen, Hahn and Steeves, 2000).

7.5 Using Hermeneutic Phenomenology

Hermeneutic phenomenology is ‘...grounded in the belief that knowledge making is possible through subjective experience and insights’ (Kafle, 2011’194). It is concerned with the meaning and processes attached to a particular experience (Harper and Thompson, 2012), and seeks to interpret the dialogue to create a deeper meaning and understanding of the phenomena. Hermeneutics interprets the expressions and objectifications of lived experiences to determine the meaning within them (Van Manen, 1990). Similar to feminist research, hermeneutic phenomenology views the individual as the centre of the research, i.e. they have the knowledge (Van Manen, 1990:19).

Following Husserl’s conception of phenomenology as transcendental, Heidegger, as interpreted by Smith, Flowers and Larkin (2009), argued against the role of reduction within phenomenological understanding, claiming the external world could not be separated from experiencing a phenomenon because ‘our observations are always made from somewhere’ (Harper and Thompson, 2012:102). He believed the subject

e.g. research participants, could not separate or disregard personal opinion and therefore he advocated for 'acceptance of endless interpretations' (Kafle, 2011:186), i.e. relativity. Harper and Thompson (2012) discuss Heidegger's phenomenology and explain our involvement in the world as shaping our perception of the world. The authors understand that although phenomenology may be descriptive initially, it can only ever be interpreted in its implementation (Harper and Thompson, 2012). Similarly, Kafle (2011) writes of Heidegger's phenomenology as focusing on interpretation because that is all individuals have, but description is part of the interpretive process. In relation to the research participants within this study, women may have shared similar experiences of substance use and domestic abuse initially but, they may interpret these experiences differently, this is described by Dean, Smith and Payne (2006) who explain:

The experience of the event, the immediate physical context, the social and cultural influences and past experiences of similar events all mean that people may experience a particular event or occurrence in different ways. (Smith and Payne, 2006:141).

Hermeneutic phenomenology therefore focuses on the subjective experience in '...an attempt to unveil the world as experienced by the subject through their life world stories' (Kafle, 2011:186).

The basic foundations of Husserl's phenomenology are key in utilising hermeneutic phenomenology. Sloan and Bowe (2014) cite phenomenology as being an asset in using hermeneutic phenomenology as a methodology. In their study examining lecturer experiences of curriculum study, they found phenomenology was best suited in eliciting the experiences of their research participants. The authors believe that using hermeneutic phenomenology gave voice to the experiences of the research participants under investigation. Similarly, Landgren and Hallström (2011) used hermeneutic phenomenology when they investigated parent's experiences of living with babies with infant colic. They highlight the role of the authors pre-understanding as an importance part to the interpretive process. Within hermeneutic

phenomenological research, Reiners (2012) discusses humans as being embedded in their world. The researcher should not remove themselves or their presuppositions with the subject under investigation but, use their previous understandings to avoid bias in analysis. This is explained by Finlay (2009) who states:

Researchers' subjectivity should, therefore, be placed in the foreground so as to begin the process of separating out what belongs to the researcher rather than the researched (Finlay, 2009:13).

As this research seeks to grasp the experiences of women who have been affected by substance use and domestic abuse, the philosophical underpinnings of hermeneutic phenomenology influence the methodological direction of this research. Hermeneutic phenomenology also aligns comfortably with feminist research theory. Both theories aim to understand the experience of a specific phenomenon, but feminist research theory seeks to do so within a gendered framework. However, both epistemic theories do not guide the researcher practically when conducting research. As such, the method of Interpretative Phenomenological Analysis (IPA) will be used to guide the researcher to conduct this research.

7.6 Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) will be used as a guide in conducting this study. IPA follows a phenomenological approach and,

...attempts to explore personal experience and is concerned with an individuals' personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object of event itself. (Smith and Osborn, 2007:53).

Aligning with Heidegger's hermeneutic phenomenology, IPA emphasis the role of the researcher within the research.

IPA, according to Larkin and Thompson (2012), should be used when there is a

homogenous group that can offer a valuable perspective on the topic under study. In relation to this research, the 'homogenous group' are the women who have experienced substance use and domestic abuse; however, differences do exist within this 'homogenous group'. This will be discussed in chapter 19.

IPA also aligns with feminist theory. This is highlighted by Baird and Mitchell (2014) in their study of domestic abuse experiences in pregnancy. The authors explain:

Feminist researchers intend to contribute to the improvement of the lives of women through the uncompromising tenet of feminist methods which are concerned with the importance of women's lives and their position in the social structure of society. (Baird and Mitchell, 2014:421).

The focus on exploring what's important to the research participants is a common thread running through feminist research theory and so, marries comfortably with hermeneutic phenomenology in this research.

IPA is also a fitting method because it offers a systematic guide for analysing research. The next chapter will, therefore, illustrate the steps in data collection and analysis using interpretive phenomenological analysis and highlight why IPA was favoured as a research method over grounded theory and free association narrative interviewing.

Chapter 8

Doing the Research

By reviewing the literature, the following research question was formed: What are the experiences of help-seeking and support among women who have been affected by co-occurring substance use and domestic abuse victimisation? After defining the research question and subsequent aims, outlined in chapter six, it was evident that a qualitative approach was necessary, because of the experiential focus of the research question. Having grappled with the epistemological literature it was apparent that a feminist position would be taken with a specific focus on experience as knowledge. Using a phenomenological and hermeneutical approach IPA naturally fit with this methodological position. However, a review of potentially 'best fitting' methods was considered based on the research question. With an overall focus on the experience of women affected by dual substance use and domestic abuse, the Free Association Narrative Interviewing approach and Grounded Theory were considered in detail.

8.1 Free Association Narrative Interviewing (FANI)

Hollway and Jefferson (2000) discuss Free Association Narrative Interviewing (FANI) methods as an adaption of the biographical interpretive method. In contrast to the belief that research participant's narrative should 'tell it like it is' (Hollway and Jefferson, 2008:298), the FANI method believes that research participants are the 'defended subjects' (2008:299). Hollway and Jefferson (2008) believe that in everyday interactions, we do not take people at face value but instead question, disagree and interpret. The authors state that a similar approach should be included in qualitative research. Using psychoanalytical theory, FANI regards the defended subjects as holding an unconscious conflict, which produces anxiety (Hollway and Jefferson, 2008). They therefore look for inconsistencies, contradictions, conflicts, changes in emotional tone and avoidances (Hollway and Jefferson, 2008). Using the principle of free association, the authors state that '...unconscious connections will be revealed through the links that people make if they are free to structure their own narratives' (Hollway and Jefferson, 2008:315), i.e. using an open question approach,

where the participant is free to direct the flow of their story, will lead to the uncovering of the unconscious.

As this research is focused on women's experience, the FANI method was briefly considered because of its dedication to a story-telling of experience through a qualitative, open ended interviewing method. Despite similarities to IPA in its position of reflexivity and questioning the researcher's position (Hollway and Jefferson, 2000), FANI was not considered appropriate. Its focus on psychoanalysis did not meet the overall aim of this research. This research does not wish to tap into the unconscious but rather, interpret narratives in relation to wider social and cultural dynamics. Furthermore, the FANI approach acknowledges that the research participants will potentially cover up their true feelings. The belief in searching for contradictions and inconsistencies contrasts to feminist epistemology, particularly standpoint theory, and so is not suited to this research.

8.2 Grounded Theory

Grounded Theory was also considered as a suitable research method for this research topic. This approach to research collection and analysis was originally designed to systematically proceed from a set of assumptions, a theory or general conclusion. Introduced by Glaser and Strauss in 1967 to refocus '...qualitative inquiry on methods of analysis...' (Charmaz, 2014:5), it bordered on an objective, positivist epistemology, negating the researcher's involvement. However, it has since been adopted and adapted by Charmaz (2014) who refers to it as Constructivist Grounded Theory which she says: '...adopts the inductive, comparative, emergent and open-ended approach...' (2014:12). According to Tweed and Charmaz (2012) the main goal of grounded theory is to develop an inductively driven theory. It is an approach to data analysis (Olesen, 2007) that seeks to '...conceptualise people's views, actions and life experiences...' (Tweed and Charmaz, 2012:131). Charmaz discusses constructivist grounded theory as an approach that focuses on the phenomenon rather than the methods of studying it. Like IPA, Charmaz (2005) believes interpretation is based on our own biographies and presuppositions and this must be accounted for in grounded

theory, she says: 'In short, we share in constructing what we define as data' (2005:509).

In conducting research, grounded theory has specific prescriptions. The main elements of grounded theory focus on coding, memo writing, comparative methods and theoretical sampling. Coding is a similar process to that in IPA and so too is memo-writing. However, in IPA, memo-writing takes place at the first open reading to understand the text as a whole and to remove any bias the researcher may have. Another difference between IPA and grounded theory is theoretical sampling. Because grounded theory seeks to build or create theory, theoretical sampling requires the researcher to analyse the initial data while questioning what is missing to further develop the emerging theory. This approach sees the researcher collecting further data to fill in the gaps and tighten the theory; memos help in this process, alerting the researcher to gaps. IPA also differs to grounded theory in its sampling approach as grounded theory aims to achieve saturation whereas the idiographic focus in IPA only requires a small number of participants. Although pragmatic factors such as time and budget can influence the ability to reach saturation in grounded theory, it is the end goal where possible. Unlike IPA, comparison occurs at all levels of analysis in grounded theory and this involves comparing data with data, codes with codes, and categories with relevant theory and literature. Although IPA themes can be compared and contrasted, this cannot be done until a detailed idiographic analysis has been conducted. Overall the differences between IPA and grounded theory can be easily understood by Starks and Trinidad (2012). In their article, the authors compare phenomenological research and grounded theory defining phenomenology as: 'Describe[ing] the meaning of the lived experience of a phenomenon' whereas grounded theory seeks to 'Develop an explanatory theory of basic social processes' (2012:1376). The authors highlight that the two approaches share analytical traits, however, it is in the methods where the two approaches differ.

IPA was chosen as the appropriate method for this research because of the strong focus on understanding and interpreting women's experiences to illustrate how it is for them. Combined with an idiographic focus, IPA appropriately fits with the

underlying argument in this research and provides an opportunity to illuminate the voices of the women in this study, so readers are able to understand their experience as it is.

8.3 Understanding Interpretative Phenomenological Analysis

Interpretative phenomenological analysis (IPA) is an interpretive (hermeneutical), phenomenological epistemology (Harper and Thomson, 2012) and a set of research guidelines offering a step-by-step approach to doing research (Smith, 2004a; Dean et al. 2006). The founders of IPA (Smith et al. 2009) believe individuals exist in a world of objects, relationships and language. This existence in the world of objects, relationships and language affects how individuals perceive and interpret various phenomena. Our being in the world is temporal and fluid and therefore impacts how individuals perceive, interpret and relate to their experiences of the world (Harper and Thompson, 2012; Smith et al. 2009). For example, how I currently relate to my PhD experience (phenomena) differs to how I experienced it 12 months ago; potentially because of the relationships (supervisors and networking) I have developed, and the objects (books, presentations) I have interacted with. Similarly, the role of objects, language and relationships may impact my PhD colleagues differently, despite sharing a similar experience. IPA is therefore used to give individuals a space to tell their own story of a particular experience and how they relate to it (Dean et al. 2006).

IPA can be understood in this research as social phenomenology. According to Willig (2013), 'Social phenomenology is concerned with understanding the social reality which is subjectively experienced by groups of people as they go about their daily life' (2013:59). IPA is used to answer questions which seek to explore in detail the personal lived experiences of research participants and the meaning attributed to such experiences (Smith et al. 2009; Larkin et al. 2006). Using the subject of 'love' as an example, Larkin et al. (2006) illustrates the primary focus in IPA research. The authors explain that it's not the nature of love that IPA researchers are concerned with but how the person in question experiences, is concerned with, and understands love. The subject is replaced with the person experiencing it. IPA is therefore centred

on exploring what matters to the research participants and what the experience means to them (Larkin and Thompson, 2012).

While being interpretive, IPA is influenced by idiography; a focus on a single individual and their experience, or 'the particular' according to Smith et al. (2009). The values of an idiographic focus offer a '...detailed, nuanced analyses of particular instances of lived experience.' (Smith et al. 2009:37). IPA's dedication to idiography therefore requires a thorough and systematic analysis of the phenomena from the individual's point of view. Doing IPA research sees researchers committing to '...exploring, describing, interpreting and situating the means by which our participants make sense of their experiences' (2009:40). As such, idiography first requires the researcher to focus on the participants on a case by case basis before any comparisons are made between other research participants.

8.4 Role of researcher

Whereas phenomenology as a methodology focuses specifically on the descriptive experience of the phenomena, IPA recognizes the interpretation of the researcher as an important tool, as Hollway and Jefferson (2008) explain: 'If we wish to do justice to the complexity of our subjects an interpretive approach is unavoidable' (2008: 3). While IPA seeks to understand how participants view and experience a phenomenon, it also accepts that it cannot gain direct access to the life world as experienced by the research participant. Therefore '...understanding requires interpretation.' (Willig, 2013:96). The research must explore what the research participant is saying about their experience and '...such an exploration must necessarily implicate the researcher's own view of the world as well as the nature of the interaction between researcher and participant.' (Willig, 2013:87). How the researcher does this, is based on their own conceptions and standpoints (Willig, 2013).

As the participant tries to make sense of their world, the researcher tries to make sense of the participant's world. Smith (2004a) calls this 'Double Hermeneutics'. The participants interpret a phenomenon that has already occurred by sharing it through language; the researcher then interprets this language (Dean et al. 2006).

Interpretation is an attempt to understand what the participant means by what they are communicating both verbally and non-verbally (Finlay, 2009). A participant blushing for example, can be interpreted by the researcher as a particular expression (e.g. embarrassment) in line with what they are describing (Van Manen, 1990). In making phenomenology hermeneutic and therefore interpretative, Finlay (2009) explains that the researcher goes beyond the surface descriptions offered and interprets the verbal and non-verbal communication that has occurred. This may involve drawing upon existing literature, theory or constructs (Willig, 2013). Smith et al. (2009) explain: 'In IPA research, our attempts to understand other people's relationship to the world are necessarily interpretative and will focus upon their attempts to make meanings out of their activities and to the things happening to them' (2009:21).

8.5 Conducting IPA

IPA is a relatively new approach to conducting research and offers a step by step guide to collecting and analysing qualitative data. Introduced by Smith in the 1990's, he says the reason it is so attractive to students is because of its accessibility and practicality (Smith, 2004a). However, the author also explains that IPA is not easy to conduct (Smith, 2013). With its initial attractiveness down to its accessibility, flexibility and applicability, Larkin et al. (2006) believes IPA is easy to do badly if there is poor engagement with phenomenological theory, i.e. by being simply descriptive. Because IPA is influenced by Husserl's phenomenology and Heidegger's hermeneutics (Smith, 2009), the aim is not to provide simply descriptive outcomes. The heart of IPA lies in the interpretation and analysis of the data collected (Smith et al. 2009). The quality of the overall research findings is attributed to the personal analytic work carried out by the researcher as Smith says: 'One cannot do good qualitative research by following a cookbook. The suggestions I make are only that-suggestions to be adapted and developed by researchers...' (2009:40). Using IPA as a method of collection and analysis is therefore open to interpretation; a potential weakness of the method that will be reflected on in chapter 11.

In phenomenological research the data being investigated is the human experience, so writing this experience down is the best way to investigate it according Van Manen (1990). Larkin et al. (2006) says it is important for the participant to tell their story in their own words and equally important that the researcher expresses, represents and contextualizes any concerns they share. Therefore, an IPA researcher must approach their data in a way that highlights the world the participant is explaining so the reader can understand 'what it is like' (Larkin et al. 2006:104) for that participant. Successful IPA captures both the empathy and questioning and draws a picture for the reader (Smith et al. 2009). This picture attempts to communicate to the reader what the participants are saying and what the researcher has interpreted from what they are saying (Smith et al. 2009). The IPA researcher therefore holds an important role. They must ensure the participant's voice shines through transparently in the researcher's interpretation. In doing this, the researcher must set aside their own theories or presuppositions that may influence that interpretation. In the context of this research for example, I must set aside my belief that all women have had negative experiences when seeking support, a theory I have, based on my experience working in domestic abuse services. If I am not aware of this presupposition, I will search, perhaps subconsciously, for only negative experiences in the analysis of interviews. Therefore, it is important to remember as a researcher when choosing IPA that '...we commit ourselves to exploring, describing, interpreting, and situating the means by which our participants make sense of their experiences.' (Larkin et al. 2006:110). How this is conducted practically, is illustrated by Smith et al. (2009) and Larkin and Thompson (2012) in their guide to analysis which will be described in following chapters. However, before I can explore, describe and interpret the dialogue shared from a research participant, a process of sample selection, recruitment and data collection must first be adhered to.

8.6 Establishing a Sample

Sampling in IPA research is purposive. Individuals are recruited to take part in the research because they have experienced a particular phenomenon. The aim in IPA sample recruitment is to attract individuals who have experienced the phenomenon under investigation because they hold a specific insight. These individuals generally

make up a homogenous group and they are perceived as the experts (Smith et al. 2009; Larkin and Thompson, 2012; Willig, 2013). Within this research, the sample is women who have experienced substance use and domestic abuse victimisation concurrently (either currently or historically). This criterion was outlined on flyers that advertised this research (Appendix 4).

Within IPA, participants are generally contacted and recruited via referral, snowballing and the use of gatekeepers (Smith et al. 2009). The size of the sample is debatable. Within IPA analysis, Smith (2004a) believes the idiographic focus on a case by case basis is only possible using a small sample size. However, the IPA founder does not specify what a small sample is in numeric form. He stipulates anything from three to six cases for student projects and six to 10 for PhD projects; enough to provide meaningful points of similarity and difference but not so many that it may be overwhelmed by the amount of data (Smith et al. 2009). But Smith also advocates for a deep-rooted analysis of a single case study if possible, a method used by Nelson et al. (2016). However, the IPA Yahoo Research Interest Group (2016), popular among IPA novices and enthusiasts, has highlighted a variation in the sample sizes used in various projects with some researchers reporting the use of seven participants while another reporting 83 interviews. Variety in numbers is also evident in journal articles. Dickson et al. (2008) accessed 14 research participants when using IPA to explore the experiences of individuals living with Chronic Fatigue Syndrome, while Landgren and Hallström (2011) followed a hermeneutic phenomenological approach when interviewing 23 people to understand the meaning of being a parent living with a baby with infantile colic. Brocki et al. (2006) identified 52 different studies claiming to use IPA or an IPA approach and sample sizes varied from one to over 30. Even Smith has conducted research with a sample of 21 individuals in Spiers et al. (2016). It seems, there is no correct answer when it comes to the number of individuals required in an IPA sample. Rather it depends on the commitment of the researcher to the depth of case study analysis and reporting, the richness of the cases, and the organisational constraints the researcher is operating under (Smith et al. 2009). IPA is primarily concerned with detailed accounts, therefore Smith et al. (2009) reports

the importance of quality not quantity, as he says it can be more problematic trying to reach too many individuals than not enough in IPA.

Following Smith and colleagues' guide to sampling, this research sought to collect 10-12 narratives from women. This number was decided because it would allow time to conduct a rich, detailed analysis of each individual case to arrive at an understanding and depiction of lived experience that is '...rich, detailed and reflective.' (Harper and Thompson, 2012:104); while also potentially illustrating variability in experience of a similar phenomenon. However, the final number of research participants was governed by the time constraints associated with the study (six months in total for recruitment and data collection).

8.7 Data Collection Method

The purpose of IPA is to give research participants a platform to tell their story and in doing this, the researcher must provide a space that allows the sharing of that narrative to take place (Harper and Thompson, 2012). IPA is best suited to a data collection method that offers the participant a chance to share '...a rich, detailed, first person account of their experiences.' (Smith et al. 2009:56). In-depth interviews and diary entries are two of the best methods of data collection of this type because '...they facilitate the elicitation of stories, thoughts, and feelings about the target phenomenon.' (2009: 56). Finlay (2009) favours research methods that have the most relevance and impact.

Open or semi-structured interviews are generally used in IPA research according to Smith et al. (2009) and are considered a strong method of data collection because they allow the researcher to follow up issues in real-time (Smith, 2004a). Indeed, similar to Landgren and Hallström (2011) and Dickson et al. (2008), this research will use interview methods in understanding women's experiences of substance use and domestic abuse help-seeking because it gives me, the researcher, the opportunity to probe and clarify throughout the interview process. Van Manen (1990) says in hermeneutic phenomenological research, it is important to stay as close to the lived experience as possible because it can be easy to stray off course. Using interviews

and an interview guide gives an element of control to the researcher to keep the topic on path, something that is harder to conduct when using diary entries.

Smith et al. (2009) believe one-to-one interviews are easy to manage and help build rapport with the researcher and participant while also allowing a ‘...space to think, speak and be heard.’ (2009:57) for the research participant. In data collection, IPA uses few open-ended and non-directive (Willig, 2013) questions to allow the participant to explain themselves in their own words: ‘The [data collection] journey is much determined by the interviewee as it is by the interviewer’ (Frith and Gleeson 2012: 59) but, it is the role and responsibility of the researcher to engage deeply with the participant, by listening and probing so as to learn about their lifeworld (Smith et al. 2009). It is therefore vital in IPA interviews to keep the research questions open and exploratory without being too vague. Because the overall research question is quite abstract and therefore unhelpful to ask outright to the participants, an interview guide is used to gather more specific data relating to the overall research question; it may also help set a ‘loose agenda’ (Smith et al. 2009:58) and help probe participants who are not forthcoming in sharing their story. Landgren and Hallström (2011) illustrate this in their study, ‘All interviews commenced: ‘Tell me about your experience of having a baby with colic.’ Further questions were asked, aiming at encouraging further narration, such as: ‘How did you feel then?’ or ‘What do you mean?’’ (2011:318). Although Smith et al. (2009) highlight that a guide is not a stipulation of conducting qualitative interviews, he also believes ‘A good interview is essential to IPA analysis’ (Smith et al. 2009:58). Therefore, to get the most out of the analysis and ensuring important points are covered, this research utilised a semi-structured interview guide (Appendix 2).

The interview guide was created based on my knowledge of the research evidence to date, accounting for the overarching research question and subsequent research aims. As the appendix demonstrates, the interview questions sought to explore the experiences of support and help-seeking in relation to substance use and domestic abuse. Initial questions also sought to ask the women about their decision to get involved in the research. This question was designed to ease the women into the

interview process, rather than starting with ‘tell me about your domestic abuse experiences?’. As the appendix also shows, closing questions sought to end the interview on a positive note. Although I created the interview guide based on my pre-defined set of research aims, when conducting IPA interviews, it is important to remember that the participant is the experiential expert on the topic and therefore they should be given much leeway in taking the interview to ‘the thing itself’ (2009: 58). Using an interview guide keeps focus on the phenomena in question, however, the interview guide is just that, a guide. It will not determine all research questions as themes may emerge during interviews that may add to the research aims.

8.8 The process of recruitment

Following ethical approval (see chapter nine for more information on ethics), recruitment began in January 2017 and the following steps were carried out:

1. A list of relevant services (women’s services, drug and alcohol services, and national charities) from the North West of England was compiled.
2. Emails (Appendix 3) were sent to all services on the list. The flyer (Appendix 4), proof of ethical approval (Appendix 5) and information sheet for gatekeepers (Appendix 6) were attached to the email.
3. Where contact numbers could be found on Google, follow up phone calls were made two-three weeks later.
4. I continued to call services in my area that were signposted to me through various networks.
5. By March 2017, two women were interviewed.
6. In March 2017, following further ethical approval, I used Facebook as a recruitment tool.
7. I set up a new Facebook page, which detailed the project and had a picture of me for authenticity.
8. I joined Facebook groups relating to substance use and domestic abuse.
9. I contacted the group administrators and asked for permission to advertise my research. The majority of administrators said yes, however, one group

administrator said no because she worried the research topic would upset some group members.

10. When permission was granted, I shared the research information with the groups.
11. Women were asked to contact me via email, Facebook private message or mobile (set up specifically for this research).
12. Data collection ended in June 2017.

8.9 Gatekeepers

It was surmised, prior to data collection, that gatekeepers would be an important asset in recruiting women to this study. As such, an information sheet was designed specifically for gatekeepers (Appendix 6). This was also emailed to services upon initial contact. However, with the exception of one service, gatekeepers did not provide direct access to women but rather, recommended venue's where I could approach women directly. These were primarily day centres for individuals in recovery and women's centres. As a result of these recommendations, a housing service for women proved to be invaluable in accessing my first two research participants. A practitioner within the service shared the information sheet for women (Appendix 7) with a number of women who accessed the service. Two women agreed to take part. The gatekeepers were happy for direct contact to be made between the women and myself. They had no more involvement from that point.

8.10 Piloting

To test whether the interview guide was accessible and to ensure there was a mutual understanding of the questions during the interviews, the first two interviews were classified as pilot interviews. Following the interviews both women were asked to give feedback on the questions. I asked if they were happy with the questions asked as well as the way that I asked the questions. Both women said they understood the questions and wished me luck with my research endeavours. As the interview questions were not altered following interviews one and two, the data was included in the overall analysis.

8.11 Interview Process

Prior to interview, each woman was given an information sheet (Appendix 7) which outlined the rationale for the research, the reason they were being invited to take part, the criteria for inclusion, information about recording the interview, and information regarding anonymity and confidentiality. The women received an information sheet either in person or via email. Following the distribution of the information sheets, I told the women I would contact them again in seven days if I did not hear from them before that time. All women made contact prior to the seven-day period explaining that they had read the information sheet and were happy to take part.

A suitable time and place were agreed to hold the interviews. The location of the interviews was as follows:

- a private room at a recovery day centre in the North West of England (2 different services).
- an office at a recovery service in the Midlands of England.
- at a recovery service where she worked in the North West of England.
- in a private room at my university.
- in the women's own home.

Upon meeting the women at the agreed location, I produced the same information sheet they were initially given. They were asked to read it again and invited to ask questions about the research process. All women were reminded that they could stop the interview at any time and have their recordings deleted. They were also told that should they become upset, I would pause the recording. They were told that I would remove any identifying information during transcription and delete their recording once transcription was complete. They were also told that their consent forms would be the only piece of paper with their names identifiable; however, they would be locked away in a locker in my office. Once the women said that they understood this, they were asked to sign a consent form (Appendix 8) which reiterated what I had verbally communicated. Once the consent form was signed, the interview began.

Interviews lasted between 30 minutes and two hours. None of the women asked to stop during the interviews, however, three women became upset when speaking about certain topics. They were asked if they wanted to pause or stop the interview but they said no and wished to continue. Following the interview, the women were thanked for their time. Each woman was asked if she had someone to talk to for support following the interview and they all said yes. I informed each woman that I had contact numbers for domestic abuse and substance use support if they wanted them, but they declined. They were then invited to ask any other questions. Some women asked about the research project overall and wished me luck with my endeavours. A number of the women thanked me for conducting this research explaining the importance of more services for women who use substances. Before separating, each woman was given a small box of chocolates as a thank you gift.

Following the interviews, the recordings were uploaded to a password-protected computer and transcribed as soon as possible. Upon return to my university office, consent forms were stored in a folder and locked away.

Chapter 9

Ethical Considerations and Reflection

Ethical approval was granted by the Ethics Board at Manchester Metropolitan University (Appendix 5) in February 2016. Because this research covers sensitive subject areas and can cause distress, adherence to ethics was paramount. The women who agreed to take part in this research experienced both problematic substance use and domestic abuse, topics that the women may not have spoken about before. As this thesis has demonstrated so far, substance use and domestic abuse is also associated with feelings of stigma and shame, so when interviewing the women, it was vital that I approached the topic with sensitivity and understanding. It was also important to remember that the women could become upset at any point of the interview, so I needed to be prepared to respond to this upset with understanding and patience.

This chapter will present the various elements of ethical consideration as stated by the ESRC Core Principals (2018) accounting for informed consent, anonymity and confidentiality, power-imbalance between the researcher and the research participants, responding to upset during the interviews and, ethical reflections following data collection.

9.1 Informed Consent

An information sheet (Appendix 7) was given to all women who expressed interest in taking part in this research. Although some women said they wanted to take part in the research within an hour of receiving the information sheet, I stressed the importance of reading the information sheet and reflecting on their participation before we moved forward. The information sheet outlined the aim of the study, how their information would be used, the role of confidentiality and anonymity and the interview process. It also highlighted the potential emotional impact the interview questions may have. The information sheet highlighted protocol if this did happen during the interview explaining:

This research is considered a vulnerable topic as it has the potential to cause upset to those being interviewed. Reliving memories of substance use and domestic abuse can evoke negative feelings. This is something I am fully aware of as researcher. Although I cannot guarantee you will not become upset during the interview process, I have gone to great lengths to ensure this risk is kept to a minimum. I have experience supporting women and children who have experienced domestic abuse and substance use and so, should you become upset at any stage of the interview I will pause the recording and we can have a chat about what you would like to do. You will be under no obligations to continue the interview. (Appendix seven).

The women were invited to ask questions at all stages of the recruitment and interview process. Prior to interview, I also gave a verbal explanation of the research and asked each woman if she was still happy to move forward with the interview. Contact information was also provided for myself and my director of studies should any woman wish to ask questions before or after the interview.

9.2 Anonymity and Confidentiality

All women in this study were reassured about anonymity before and after the interview. Their name only appeared on the consent form, which was locked away. However, the information sheet highlighted that their anonymity could be broken if they told me anything that posed a harm to themselves or to others.

As part of the 'check-in, check-out' system for home interviews, my supervisor was provided with the name and address of the woman prior to interview, permission was sought from the women to pass on this information.

Following recording, their interviews were transcribed, and pseudonyms were used to replace their real names. All identifying information was also removed and replaced with [name of son]/[hometown] if specific people or place names were mentioned.

Confidentiality was also discussed with the women and noted in the consent form and information sheet. The women were informed that their interviews would be used for the purpose of this research and potential publications and presentations.

9.3 Power Imbalance

Feminist research seeks to 'deduce power differentials between researchers and participants' (Burgess-Proctor, 2015: 126). This was something I was acutely aware of during the various interviews. To try and minimise the power differentials during the interviews, I avoided using academic language, I had a cup of tea with my participants if offered, I spoke about general day-to-day things while we were setting up and closing down the interview and I dressed casually. Although these actions may seem small, I wanted the women to feel comfortable with me. However, while trying to remedy the power differentials I realise there was also an imbalance of power between myself and the women because I created the research topic and the interview guide, which meant that I had control over the direction of the research. The women also shared deeply personal stories with me, and therefore had to trust that I would be morally and ethically responsible with these stories.

9.4 Upset

During the interviews three women became tearful. I offered to pause the recording, but they said no and wished to continue. The final question sought to end the interview on a positive note as I felt it was important not to end an interview with upset. When recording finished, I asked each woman how she was feeling. I asked if she had someone to talk to if she needed and highlighted that I had information on services should they require it. However, all of the women appeared happy, explained that they had a friend, partner, support worker or twelve-step peer they would speak to later that day.

9.5 Ethical Reflection

Although all of the women declined contact information for support services following the interviews, a few weeks after interview five, I received a text message from a woman. She had asked for the author of a journal article that we had spoken

about following the interview. In her text, she also explained that on reflection she felt I should have contacted each woman post interview because she felt 'exposed' following the interview. I was upset by this. By the time she had text me, I had completed all the interviews with the women and felt I had not considered the aftermath of the interviews. Although I offered contact numbers to all women immediately after recording the interview, they all declined the offer. I now feel I should have ensured every woman was left with information for support. I spoke to my supervisors about this, feeling conflicted. My supervisors agreed that it was best I did not make follow-up contact because I was not in the position to do anything with the information the women may have potentially shared with me. For most of the women I did not have information regarding next of kin, gatekeeper or an address as all personal information including phone numbers were deleted following the interviews. Although the text message stirred upset, I was also conflicted because they had declined further information regarding support. I did not leave the interview setting until I knew each woman was okay and I made sure to ask if they had someone to talk to following the interview should they wish. Although in the initial moments following interview they may not have felt upset, on reflection, I asked about very personal experiences that they may not have thought about or spoken about in years. While they had voluntarily agreed to take part in the interview and were given plenty of time to think about their participation, they, like myself, may not have been aware of the impact of the interviews until hours, days or weeks later. This was a primary learning point in my research career. Moving forward, I will provide de-brief information with support details as part of the interview protocol. This way, the women will have information either way.

9.6 Researcher Self-care

Because of my experience working in drug and alcohol services and domestic abuse services, as well as personal experience of parental substance use and domestic abuse, I felt emotionally equipped to do this research. I felt I could respond effectively to all of the women should they become upset during the interview and I felt I would treat their narrative with respect and care. However, following the pilot interviews I found myself becoming very angry at how these women had been treated by their

partners and by services. This feeling resonated with me for a couple of days following the interviews. On reflection, I should not have interviewed the first two women back to back and then gone straight to transcription the following day. However, this anger soon turned to motivation. Although I felt anger following each interview, I was also motivated to share their experiences through my research and subsequent research outputs.

Chapter 10

Analysing the Interviews

The aim of IPA analysis is to interpret the descriptions shared by the participants in order to show what it is like for the person themselves, therefore ‘...the essence of IPA lies in its analytic focus.’ (Smith et al. 2009:79). The focus of IPA analysis is on the participants as they make sense of their experience. To do this a verbatim transcript of the interviews conducted is required. Following the audio recording, dialogue should be transcribed but transcripts do not need a detailed ‘prosodic aspect’ (Smith et al. 2009) of the audio because IPA seeks to interpret the meanings of the content of the account not every ‘nuanced sigh, stutter or pause’ (Smith et al. 2009). However, IPA requires a semantic record of the interview, so all words expressed should be transcribed and spelt conventionally (Smith et al. 2009).

In conducting hermeneutic phenomenological analysis, Landgren and Hallström (2011) followed three methodological steps after transcription. Step one saw the authors both independently conducting a naïve reading of the transcripts to grasp the meaning as a whole. In step two, the first author divided the text into meaning units highlighting important words, phrases or sentences, which were condensed to sub-themes, themes and main themes. Re-reading the text, structural analysis was discussed. Finally, in step three the authors associated their findings with relevant literature to revise, widen and deepen the understanding of the text, and their participants lived experience. Both Finlay (2009) and Van Manen (1990) advocate a similar approach in hermeneutic research. IPA, a descendent of hermeneutic phenomenological research has a similar approach to conducting analysis. Smith et al. (2009) says IPA can be characterised as a set of processes, moving from the particular to the shared, and the descriptive to the interpreted, always maintaining the basic principle of IPA; a commitment to the voice of the research participant and their attributed interpreted meanings.

Larkin and Thompson (2012), Smith (2004a) and Smith et al. (2009) all propose a variety of the following steps when approaching IPA analysis but, in reviewing the steps below it is important to remember ‘...analysis is an iterative process of fluid description and engagement with the transcript’ (2009:81). Understanding the philosophical concepts and theories underlining IPA, Smith et al. (2009) offers a practical outline for conducting analysis. His guide is similar to thematic analysis, however, the epistemological basis of IPA and its commitment to idiography, separates it from thematic analysis. The initial stage of analysis is operated on a transcript-by-transcript basis. In doing this, the authors advise that the researcher:

1. Read and re-read the interview transcript to ensure ‘the participant becomes the focus of analysis’ (2009: 82).
2. Initial noting (similar to that of writing ‘memos’) should take the form of descriptive, linguistic and conceptual comments.
3. Shifting focus to these comments, emergent themes are identified by ‘mapping the interrelationships, connections and patterns between exploratory notes.’ (2009:91).
4. Connections are found across all themes and are subsequently reduced and rearranged until a list of overarching themes are identified within the transcript.
5. The researcher then moves onto the next case.
6. Following the analysis of the final transcript, themes are compared and contrasted across all cases and superordinate themes are established.

However, Smith et al. (2009) also explains that these points are ‘merely prescriptive and the analyst is encouraged to explore and innovate in terms of organising the analysis’ (2009:96). As such, I chose to involve myself with the data in a way that I was more comfortable with. Like IPA, I sought to immerse myself in each individual interview on a case by case basis. I initially began analysis using a pen and hardcopy transcripts, however, I had to move to NVivo, a computer package designed to support qualitative research analysis, because I was overwhelmed with the analysis. The steps to analysis were:

1. Transcription

The interviews were listened to while transcribing verbatim. In doing this, I included long pauses, laughs, or sounds that I felt impacted on the tone of the conversation. The recording was listened to a second time, ensuring there were no misinterpretations of words, or major typos. Although the real-life interview can never be fully accessed on paper, I wanted to ensure the recording represented real life as much as possible. The dual listening helped me become familiar with the text. Following transcription, I printed each transcript. As I had analysed ‘by hand’ in the past, I initially felt analysis with a pen and paper was better suited to my strengths in analysis.

2. Familiarisation

I listened to the recording a third time while reading the hard copy transcript. This engagement with the data helped me to familiarise myself further with each woman’s interview and ensured I did not misrepresent their experiences. While listening, I made initial comments in my research diary recalling memorable aspects of the interview including body language. This added to the tone of the interview. For example, I noted a difference in body language between participant one and two. This was reflected in their engagement with the interview as participant one was more open in her dialogue than participant two.

Stage one and two were conducted on all transcripts before stage three.

3. Initial Noting

Following stage one and two, I returned to transcript one and began a line-by-line re-read of the hard-copy transcript. At this point, initial notes were made on the right-hand column. These comments were descriptive, linguistic and conceptual as

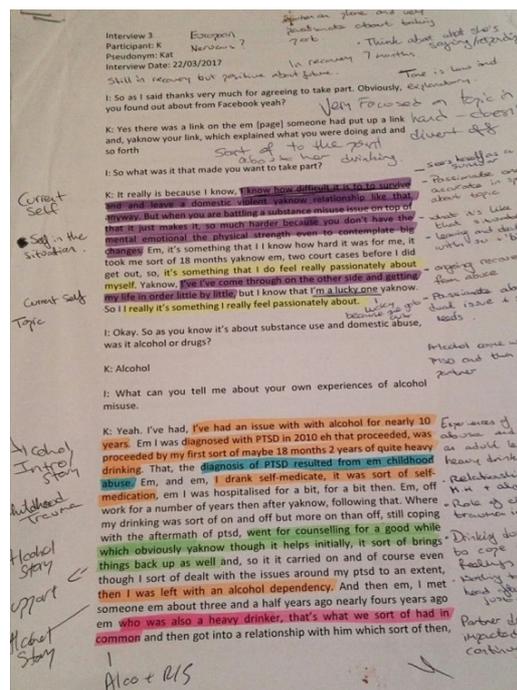


Figure 2. Initial pen and paper analysis

suggested by Smith et al. (2009). Descriptive experiences, the use of metaphors and questions in response to the participants comments were noted. Chunks of interview were also highlighted to represent these notes. Following this stage, the transcript was read a final time and the initial notes were given shorter codes on the left-hand column (see figure 2). This stage was conducted for the first three transcripts however, I soon realised that using pen and paper was not practical for IPA. As figure 1 shows, I was struggling for writing space on the transcripts. Although I enjoyed using pen and paper to analyse my data, I knew it was not the most efficient method of analysis. As such, thanks to the sound advice from my director of studies, I moved to NVivo to continue my analysis.

4. NVivo

Each transcript was uploaded to NVivo and a separate memo was created for each transcript. Beginning with transcript one, the initial hand-written notes from my research diary and the notes made at stage one and two were compiled and typed into the accompanying memo. The transcript was then read again, line-by-line where I began to code words, sentences and paragraphs that elicited meaning. While reading each line I was able to highlight and code chunks of text more than once. Something I was unable to do with a hard-copy. Commentary notes were also made and stored in the annotation system on NVivo (see figure 3). This process continued until all 12 transcripts had been coded in NVivo with accompanying memos and annotations.

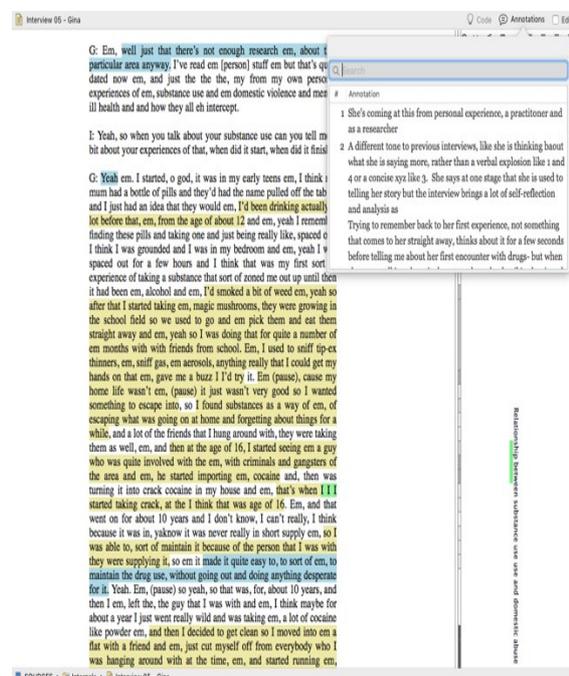


Figure 3. NVivo coding process with annotation box.

Coding each interview is time-consuming, but it is necessary in understanding the interview as a whole. Feeding into the concept of the hermeneutic circle (Smith et al.

2009), the codes represent the parts that make up the whole of the interview. Without the codes (the parts) I would not be able to make sense of the entire interview. And without reading and understanding the entire interview, I would not be able to make sense of the parts (the codes).

5. Reviewing

After coding the final transcript, all notes and annotations were compiled into the accompanying transcript memo and re-read to get an overall sense of the woman's interview and the themes that were apparent. This aided the familiarisation process before moving onto the codes. These notes were set aside until the final write-up.

A total of 573 codes were generated through the line-by-line reading of the 12 transcripts. Such a high number of codes demonstrates the inductive nature of the analytical process. Code-by-code reviewing then took place. Some codes were compiled to generate a new code because they shared similarity in overall theme. For example, codes that were initially titled 'childhood' or 'adolescence' were grouped together under a new code titled 'early life'. Other codes, such as 'role of father' for example, were grouped together in a theme titled 'not relevant to the research question'. The process of coding continued, with codes continually being compared and contrasted in light of the research aims, until I identified a final list of hierarchical codes. I identified the final list of codes based on my interpretation of the interviews. I felt this list responded to the overarching research question. Following this process, a total of five superordinate themes and 28 subthemes were identified (see table 1).

Each superordinate theme and associated sub-theme will be presented in part four of this thesis. Each theme is discussed and illustrated with verbatim quotations from the women who took part in this research. These quotations aim to enhance the understanding of the identified themes and highlight the experiences of help-seeking and support by women affected by co-occurring substance use and domestic abuse.

From Childhood to Adulthood	<ul style="list-style-type: none"> • Witnessing and Experiencing Abuse • The Impact of Abuse on Childhood • Living with Parental Substance Use • Early Substance Use
Effecting Change	<ul style="list-style-type: none"> • Motivation to Stop Using Substances <ul style="list-style-type: none"> • Previous Attempts to Stop Using • Fear • Health • Children • Self-determination to change • Tipping Point
Barriers to Support	<ul style="list-style-type: none"> • Fear • Disconnect Between Support and Need <ul style="list-style-type: none"> • Khloe • Holly • Kat • Prioritising Need
Experiences of support	<ul style="list-style-type: none"> • Accessing Support • Experience of Workers <ul style="list-style-type: none"> • Social Workers • Support Workers • Domestic Abuse Support • Family, Friends and Peer Support • Twelve-step Programmes • Friends and Peer Support
1. Impact of Support	<ul style="list-style-type: none"> • Volunteering • Ongoing Recovery • Improving Support <ul style="list-style-type: none"> • Understanding • Communication

Table 1. Finalised list of superordinate themes and sub-themes.

Chapter 11

Methodological Limitations and Personal Reflection

Part three of this thesis, 'methodology and methods' has presented a transparent and rigorous account of the steps taken to recruit research participants, to collect data, and to analyse data. However, despite the detailed account presented, this study is not without its methodological limitations.

In many research studies, the small sample size is often perceived as a limitation to the study because generalisations cannot be made, however, I do not believe the small sample size is a limitation of this study. Because this study was primarily about the experiences of women, a smaller sample size was necessary to be able to fully explore their narrative in detail. However, because of the small sample, this study may be considered to have less impact or influence on policy and practice, which is a limitation overall.

Following analysis using IPA, I feel conflicted in my feelings towards the method. IPA was initially appealing because of the systematic approach offered, its focus on idiography, as well as its accessibility through interactive group sessions and online forums. Upon reflection, the analysis of the interviews could also have produced similar themes using thematic analysis (Braun and Clarke, 2012). Comparing the two analytic methods, IPA is very similar in process to thematic analysis, however, it presents under the guise of hermeneutic phenomenology. In hindsight, I could have also used thematic analysis influenced epistemically by hermeneutic phenomenology. I also feel the focus on interpretation initially stilted my engagement with the data because I was worried I was not being interpretive enough. While wanting to ensure I interpreted my interviews, I also did not want to interpret to the point where I was over analysing the data and becoming psychoanalytical or critical. I started to question what interpretation was, while at the same time reminding myself that interpretation took place as soon as I began to engage with my transcripts and identify codes. Similar feelings were expressed by

colleagues who attend the IPA group sessions. Although we are all versed in the Smith, Larkin and Flowers (2009) approach to analysis, we continually questioned our analytical approach; which often meant that I left the sessions more confused than when I went in. I feel this is not helped by the authors themselves who say that their guidance is 'merely prescriptive and the analyst is encouraged to explore and innovate in terms of organising the analysis' (2009:96).

Because of the idiographic focus in IPA and my commitment as a feminist researcher to the voice of the research participants, I initially considered using Smith's guidelines in a way that I felt would illuminate each women's interview. Ideally, I would conduct steps one to four as outlined in Smith et al. (2009:82) and then write a section on each woman, presenting the identified themes. Following the twelfth interview, I hoped to dedicate a final section to the comparison and contrast of the presented themes, thereby addressing Smith's final point in his guide of analysis. I did attempt to carry out my research in this way, however, quite early on I realised my approach was not pragmatic for a PhD thesis, especially one with a limited word-count. This frustrated me because I felt I was not justifying the time and trust of my research participants.

I know most research involves a process of highlighting the most salient points grounded in participants' views that meet the aims. I have done this several times in previous research projects. I understand it has to be done because of the allocated word-count, the identified aims and objectives of the research and the potential role of stakeholders. However, during the analysis of this research, I was uncomfortable removing sections of dialogue that the women shared. Presenting a polished chapter of identified themes seemed to go against the foundation of this research. This research is about presenting women's experiences of substance use, domestic abuse and support. As such, I did not want to reduce their vast and varied experiences to four or five overarching themes.

All women willingly engaged in this research by agreeing to be interviewed. By telling me deeply personal accounts of their lives, they gave me their trust and their time. The detail of these varied experiences could form the basis of an entirely separate thesis. Their willingness to engage in the interview and their decision to share personal, often upsetting information about their life, is testament to who these women are now, and what their experiences mean to them. As a researcher, I am lucky to have been given access to something so personal. I did not think it was right or just to ignore the majority of the stories shared. It was important to me that their experiences were heard somewhere in this thesis. As such, I have included a pen portrait for each woman. All of the women who took part in the interviews, did so because they wanted to share their experience not just with me, but with other women. Using pen portraits is one way of doing this. Although the synopsis I have created will never fully grasp each woman's lived experience of substance use and domestic abuse (among other things), it provides a better insight into the women's lives.

An advantage of using IPA for a research topic like this, is the focus on the inductive analytical approach. Using this approach encouraged me to capture topics that could have been overlooked if I used a deductive methodological approach to data analysis. Using IPA, I encountered themes outside of the prescribed set of research aims. These themes were identified as having meaning for the women who participated in this research however, when presenting this qualitative research, I felt a constant conflict about what to include and exclude from the final piece. By using pen portraits, I was able to overcome my internal conflict somewhat. I also reminded myself that this research was centred on the women's experiences of support and help-seeking and I could revisit other themes in future publications.

Part Four

A Presentation of Findings

Chapter 12

Introducing the Findings

This research explores the experiences of help and support among women who have been affected by co-occurring substance use and domestic abuse. Following the recruitment procedure outlined in chapter eight, I contacted a total of 58 services via email and/or phone. Twenty-seven services responded to say they would share the information with clients/workers. The majority of these services were positive about the research. Four services said they did not have the time or resources to share the information. Twelve women were recruited to interview, however, more than 12 women showed interest in taking part. During recruitment, one woman agreed to take part but pulled out; she explained that she was emotionally vulnerable following the death of a friend. Another woman agreed to take part but also pulled out; she explained that she was worried about bringing up things she had moved on from. Two women agreed to take part following a Facebook chat however, they did not respond to my message after passing on the information sheet. In total seven women were recruited through Facebook, two were recruited through initial engagement with gatekeepers, two were recruited through a local service I volunteered at, and one woman was recruited through a colleague.

By the end of June 2017, 12 women shared their experiences with me through the interviews. I then transcribed and analysed the interviews using IPA. Adherence to the principals of feminist research theory and IPA means a dedication to the lived experiences of each individual woman. As such, their interviews were analysed inductively to capture their varied experiences of co-occurring substance use and domestic abuse.

Chapters 13 – 18 will now present the analysis in three forms:

1. The sample profile in chapter 13 is presented in table two, comprising basic demographic information about the 12 women in this study. The table

provides an overview of the women's age, ethnicity, the number of children they had, and the amount of time they were substance free, as well as a list of all services they had previously accessed.

2. Chapter 13 also presents pen portraits for each woman I interviewed. It was important to me, that the stories of the 12 women were shared in this thesis. As such, the pen portraits present the women's stories in a chronological order as shared with me during the interviews. The portraits highlight their experiences of childhood, domestic and sexual abuse, substance use, motherhood and recovery as shared by the women. By using pen portraits, the idiographic element of IPA is also captured, as the case by case experiences are presented individually.
3. Five superordinate themes as outlined in chapter ten, are presented in greater detail in chapters 14-18. The themes will be illustrated with verbatim quotations from the women. Each superordinate theme is accompanied by a number of sub-themes which add greater detail to the overarching superordinate theme. The themes seek to respond to the overall aims of this research and demonstrate how women who experience co-occurring substance use and domestic abuse, navigate support.

The analysis of interviews produced superordinate themes that could have formed the basis of another thesis. These themes included motherhood, experiences of abuse, complexity of multiple issues, the impact of the perpetrator on using substances, feelings of loneliness and isolation, and the role of father. These themes were not included as discussion points within this study but, wider dissemination of my findings will allow me to return to the analysis that was excluded from this thesis.

Chapter 13

Sample Profile and Pen Portraits

This research focuses on the voices and the experiences of women who have been affected by co-occurring substance use and domestic abuse. As such, I felt it was important to present as much information about each woman as possible given the pragmatic word-count limitations associated with writing a thesis. As my reflective piece also illustrated in chapter 11, I was not comfortable ignoring the women's experiences and simply presenting themes. The women generously gave me their time and their trust, sharing deeply personal experiences as such, I felt it was my responsibility to present their narratives in as much detail as possible, within the confines of this thesis. As such, this chapter will now present sample profiles and pen portraits. The sample profiles will provide key demographic information about the women as well as information about the services they engaged with and the amount of time they were in recovery at the time of the interview. Including this information is important because it creates context when moving forward. The pen portraits will give a descriptive overview of the women's experiences, as shared with me during the interviews. By illustrating the women's experiences in pen portraits, we have a greater sense of who each woman is moving forward.

Sample Profile

Pseudonym	Age	Ethnicity	Sexuality	Children	Substance Use	Recovery	Domestic Abuse	Service Engagement	Recruitment
Laura	65	White British	Heterosexual	Mother of 3 adopted/ fostered	Drug and Alcohol Use	2.5 years alcohol and 3 years drug free	All form of DV Prostitution	Psychiatric Hospital Drug and Alcohol Service Refuge Doctors Social Work Police Prison	Recovery Centre
Michelle	35	White British	Heterosexual	Mother of 5 children taken away	Alcohol Use	7 months	All forms of DV	Psychiatric Hospital Drug and Alcohol Service Residential Service Social Work Refuge Detox Unit Police Doctor	Recovery Centre
Kat	Unsure- late 40's?	White European	Heterosexual	Mother with two daughters from previous marriage, children always lived with father	Alcohol Use	7 months	All forms of DV	Refuge Drug and Alcohol Service Psychiatric Hospital Counselling Mental Health Charity Rape and sexual assault charity Other addiction service Doctor	Facebook

Khloe 45 White British Heterosexual 1 son Predominantly drugs with a bit of alcohol. Still drinks but not heavily. 5 years drug free but still drinks occasionally All forms of DV Prostitution Drug and Alcohol Service Detox Unit/rehab Hostel Police Doctor Prison Facebook

Gina 45 Black British Heterosexual Mother to three Drugs and a bit of alcohol but still drinks occasionally Nearly 3 years but still drinks occasionally All forms of DV NA & AA Domestic Abuse Project Social work Police Facebook

Kim 32 White British Heterosexual 1 daughter Drugs, alcohol and painkillers 2 years All forms of DV Rehab AA & NA Social Work Support Work Hospital Police Facebook

Lydia 28 White British Gay 0 Drugs and alcohol but predominantly drugs 5 days All forms of DV Drug and Alcohol service Day service for substance use NA/AA Social Work Police Snowball

Part 4

Sample Profile

Elaine	35	White British White British	Heterosexual	0	Drugs and alcohol	13 months	All forms of DV	AA & NA Counselling	Facebook
Holly	Unsur e- late 50's?	White British	Heterosexual	1 daughter	Alcohol Use	16 years	All forms of DV	Refuge 12-step Mental health service Hospital Drug and Alcohol service Police	Facebook
Lou	42	White British	Gay	0	Drugs and alcohol	6 years	All forms of DV	Rehab 12-step programme Counselling Police	Snowball
Jo	Unsur e- Late 50's?	White British	Heterosexual	5 children & 2 adopted	Alcohol Use	Ongoing	All forms of DV (mutual)	Counselling Alcohol counsellor Social Work AA Police	Facebook
Dani	Unsur e- late 50s?	White British	Heterosexual	6 children	Drugs and Alcohol	Drug free 7 years and alcohol free 6 years	All forms of DV Prostitution	Detox Unit Support Worker Social Work Police Prison	Snowball

Table 2. Sample Profile

Pen Portraits

Laura

Laura was 65 and nearly three years sober at the time of the interview. She began drinking at the age of 13 with a boyfriend from school. A year later, she had a daughter but was forced to give her up for adoption. It is from this point Laura explains her 'life just spiralled out of control'. Laura grew up with an alcoholic mother who was abusive towards her father, as such, she was raised by her gran and her father. Laura began entering mental health units at the age of 15. At this time, she also began experimenting with amphetamines. At 16 she entered into a relationship with a man who eventually became abusive, often pimping Laura out to make money. By 18 Laura was married, a rebellious act against her family she explains. Before her mid-twenties, she had two children. During this time, she was also in a number of abusive relationships, continued to self-harm, worked as a 'prostitute', and used drugs heavily. She did spend time in a refuge, but soon left and began a new relationship. When her children were eight and seven Laura decided to put them into foster care where they were later adopted. At this point she was sterilised, explaining that she should not have had children because of her lifestyle. For another 10 years, Laura continued a 'vicious circle' of drug use, abusive relationships and prostitution. She was also in and out of psychiatric units throughout and spent time in prison for crimes related to her drug use. Laura used heroin for 19 years. However, in a bid to stop using, her doctor advised that she move away. In her mid-thirties Laura moved to a new location but soon began using alcohol quite heavily. Although she continued to use drugs, she did not know where to find heroin in her new area. She was on a methadone script but continued to use cannabis. She describes her new home as a 'drinking place' explaining that she was not really a drinker before moving. For the next 30 years, Laura continued to drink heavily and use various drugs. She also spent more time in mental health units. When Laura was 62 she attempted suicide by cutting her throat. She was sectioned for six months in a mental health unit, during this time she was also detoxed. Her time in this facility offered her a new perspective

and she has not used substances since. Upon leaving the psychiatric facility, Laura was referred to a local drug and alcohol service. She has been attending this service for nearly three years. During the interview, she proudly explained that she was alcohol free for nearly two and a half years, and cannabis free for three years. Laura uses the service every-day and has made many friends who also use the service. She also volunteers for another addiction service, as a peer support worker.

Michelle

Michelle was 35 and seven months sober at the time of the interview. She was living in supported accommodation for individuals in recovery from substance use. Michelle explains that both of her parents were alcoholics, her mum still is, and her dad has died. She describes her childhood as one of neglect and abuse from her father especially. Michelle began drinking at a young age. She used to take alcohol from her mum and bring it into school, hoping she wouldn't be as drunk when she got home. At 13, Michelle was sexually abused and put into foster care when her mother refused to believe her. She says from here, her head 'went a bit mad'. She began drinking and getting into trouble with the police. Her drinking became problematic from the age of 17, when she met her partner who was not a drinker. He was controlling and coercive and Michelle was dependent on him, explaining that she was homeless when she met him. Throughout their relationship, Michelle drank heavily and experienced abuse. She also had three children. She reached out to a women's refuge for support, however, while in refuge she was referred to social work and put on a warning because she arranged for the children to see their dad. Two days before Christmas, Michelle returned to the refuge after consuming alcohol, following an argument with another woman Michelle was kicked out of refuge and her children were removed from her care. Following the removal of her children, she was 'strongly advised' to complete a seven-day detox. On the day of her release from detox she went to court to try gain custody of her children, however, she was denied access. From court, she went to the pub and Michelle says her life 'ended up going worse'. A couple of years later, she got pregnant with a new partner and was given a second chance by social work. It is understood that she reduced or stopped drinking. She soon had a second child. However, her new partner became abusive and she began drinking again. Social worker got involved and she lost custody of her fourth and fifth child. From there she continued to drink heavily, self-harm and tried to kill herself. She was admitted to a psychiatric hospital three years ago due to suicidal thoughts. She was detoxed in the hospital and was sober for 33 days. In hospital, she met Laura, a key person in Michelle's own recovery story. Michelle describes Laura

as a mother figure, explaining that Laura pulled her out of a pub one day and 'said some harsh things' that made Michelle think about her life. Although she had accessed the same recovery centre as Laura following her stay in hospital, she had fallen out of touch when she relapsed. Michelle's drinking soon began to impact her physical health especially her liver. She describes herself as 'a mess' towards the end of her drinking. Michelle's choice to stop drinking occurred through a combination of factors. She explains that Laura's influence, her physical health, and the thoughts of her children in the future, affected her choice to move out of her home and enter supported accommodation. At the time of the interview, Michelle was seven months sober and nearly six months living in supported accommodation. She was preparing to move out of the service but relayed her fears of living alone because she was in control. However, Michelle explained that she would try to focus on the positives and use the recovery centre where Laura is and where she feels comfortable.

Kat

Kat did not share her age but appeared to be in her early fifties at the time of the interview. She was seven months sober and living in a domestic abuse refuge when I met her. In 2007, she and her husband divorced. Although she only mentions her daughters once throughout the interview, it is understood that they stayed with Kat's ex-husband. Following her divorce Kat was diagnosed with depression. She began drinking heavily in 2008. In 2010, Kat was diagnosed with PTSD, this was due to extensive childhood trauma. She continued to drink and tried to kill herself. She was voluntarily admitted to psychiatric hospital where she stayed for four months. While in hospital, she was referred to a counsellor. She used the counsellor for nearly two years. Although the counselling sessions helped her deal with her trauma, she became alcohol dependent. She explains that she would often leave the counselling session, go home, and drink to cope with her feelings. Her alcohol use was never discussed in counselling although she feels her counsellor did know about her drinking. At this time, Kat was also accessing support from a mental health service and a sexual assault charity. Her psychiatrist referred Kat to an alcohol service; however, they did not support Kat because she was already accessing other support services. None of these services were alcohol specialists. As no intervention was offered, Kat continued to drink for many years. Four years ago, following counselling, Kat met her partner. He was also a heavy alcohol drinker. Both Kat and her partner kept to themselves and did not really socialise. His control and coerciveness slowly emerged and there were often times of light assault. The couple drank daily, and Kat explains that her ex-partner used to prefer Kat drinking because she was easier to control. In February 2015 Kat was physically assaulted by her ex-partner. She did not go to the police but went to the GP who recorded her injuries. In March, she was assaulted again, worse than the previous incident. She called the police and her partner was convicted for two counts of assault. A restraining order was put in place. Kat was offered refuge at that point; however, she was told she would have to stop drinking if she accepted a place. She was not offered any support, a referral or a number for a service to help with her substance use. She was not prepared to stop

drinking without a detox or support. As such, she moved in with a friend who was also a heavy drinker. She soon contacted her ex-partner and the relationship began again. At that point, Kat believed her partner would change. When the abuse began again, she lost hope in leaving because she felt she tried before and failed. However, Kat was in contact with domestic abuse services during this time because she was afraid for her life. She explained that her partner became more calculative in his abuse, which scared her more. In July 2016, he attacked her again and this motivated Kat to leave. She believed that in order to keep herself safe she would have to stop drinking. She accepted a place in refuge, and although there was an alcohol-free policy, she drank for the first two weeks, quickly reducing her consumption. She was not offered support for her substance use while in refuge. Kat's friend informed her about a local alcohol service. She engaged with them and was sober for seven months at the time of the interview. She is training to be a volunteer in the service and owes a great deal of her recovery to the peer support offered. She was still living in refuge at the time of the interview and continues to work on her experiences of abuse. Because of her experiences and the complexities associated with leaving an abusive partner when substance use is involved, Kat is passionate about multi-agency working and believes more needs to be done in the area.

Khloe

Khloe was 45 and five-years drug free at the point of interview. She began using drugs socially at the age of 15, enjoying the confidence it gave her. She also lived in a neighbourhood where drugs were used heavily. At 16, she moved out of her family home. Khloe grew up witnessing domestic abuse at home and had an understanding that abuse was normal in a relationship. At 16, she got into a relationship with a man who was physically abusive. She ended the relationship after six months. To earn some money, she worked as a prostitute, in her late teens, like many of her peers. She continued to use drugs and describes happy times of using with her friends. During the interview, she takes ownership of her drug use explaining that it was a choice she made for a long time. In her early 20s, Khloe met her son's father, a relationship she describes as good. She had a son with this man however, her partner died suddenly. After this trauma, Khloe changed her life and enrolled in a college. She continued to use drugs recreationally. Following college, she entered into a new relationship with a man who was involved in criminality and who also used drugs. They both used drugs together, particularly amphetamines, and Khloe believes he also encouraged her drug use. During their relationship, he went to prison several times. When he was in prison, Khloe began using heroin and crack cocaine, admitting that it was a conscious choice despite knowing what would happen to her life. When her son was five, soon after starting 'a career' with heroin and crack, Khloe realised she had a problem. She recalls ringing a doctor's surgery for help but was not offered any support. She also recalls feeling trapped, afraid she would lose her son if social services got involved. However, she explains that her involvement with heroin and crack helped her move away from her abusive partner. In her mid-20s Khloe was sent to prison for the first time. Her mother looked after her son. She spent years in and out of prison, removing herself from her family as a result. For another 15 years, she worked as a prostitute and continued to use drugs. She explains that she did not have a problem going to prison because she was homeless, and the prison service offered opioid medication. Her involvement with treatment started in 2006 when a drugs worker came into the hostel where she was living. At the same time, the court told her she had to get into treatment or she would go back into prison. She used both

methadone therapy and class A drugs simultaneously for many more years, slowly reducing her drug use. In 2009, following a missed methadone dose, Khloe went into withdrawal. The impact of her withdrawal motivated her to stop using methadone. She entered into a rehabilitation service for five weeks. From there she was heroin free but continued to use crack until she was forty. Following rehabilitation, Khloe developed an alcohol dependency, often drinking a couple of bottles of sherry a day. A year after her rehabilitation she relapsed onto heroin but refused to go on methadone and was prescribed Subutex, this medication proved successful for Khloe. Khloe's drinking reduced following another intense experience of withdrawal. She was still living in the hostel and was supported by her drugs worker to reduce her alcohol consumption. In 2012, Khloe began volunteering in a local drug and alcohol service. She says the responsibility she was given from her drugs worker motivated her to stop using crack. As a result, she stopped using drugs five years ago; however, she still drinks in a controlled manner. She does not believe in abstinence and feels there are positives to using substances as such, she says she will not stop drinking. Khloe does not access support for her substance use anymore, however, she is involved in a peer support group for people in the community. She works in the social care sector and talks about her journey to her work with pride. She believes her experiences show how far she has come in life.

Gina

Gina was 45 years old at the time of the interview. She was drug-free for nearly three years. She started using substances at the age of 12, beginning with alcohol and then moving onto drugs after taking her mothers' Valium as a young teenager. Gina grew up in a troubled house, with 'somebody who didn't like women'. She moved out of home at 16 and met a man who imported cocaine. She started using crack with this man. When this man cheated, Gina moved in with a new partner 'who was 10 times worse' but could also supply her with drugs. This man was more powerful than her previous partner and protected Gina from her ex-partner. After a series of violent episodes, she left this man and moved into a relationship with her brother's friend. This relationship lasted nearly nine years with violence and drugs intertwined. She had a child during this time. Gina eventually left this man and 'went really wild' for a year. She then decided to 'get clean' and began to look after herself. She separated from her drug using friends and soon met her husband. She had three children with her husband and did not use drugs during this 10-year relationship. Five years ago, Gina chose to separate from her husband and move back to her old neighbourhood. She contacted her old friends and began using drugs again. She met a man who sold drugs and began a relationship with him. This relationship lasted two years and again involved heavy drug use and domestic abuse. Gina had custody of three of her four children during this time. Social work was contacted following a domestic abuse incident, but they did not identify any problems with the children. Following a final domestic abuse incident, Gina left her partner and was contacted by a domestic abuse service. She was supported by a domestic abuse worker and took part in domestic abuse course. Although she stopped using crack at that stage, she was still using drugs recreationally. Three years ago, she went to her first NA meeting, a moment Gina describes as life changing. The opportunity to speak about her experiences positively influenced Gina's recovery. At the time of the interview, she was 'clean' for nearly three years and was attending university. She works with BME women affected by domestic abuse.

Kim

Kim was 31 years old at the time of the interview. She was substance free (alcohol, drugs, medication) for nearly two years. She grew up in an environment of parental addiction, domestic abuse, childhood abuse and neglect. In her early teens, she was put into foster care but it 'wasn't very good'. She refers to potential sexual abuse while in foster care from the sons of her foster parents. Kim began drinking while in foster care, owing it to the leniency she had there. At the age of 17, she left foster care and moved into supported housing. She continued drinking heavily and described herself as a party-animal. She began using drugs at 19 and soon started selling cocaine. Before the age of 21, she lost her home due to cocaine use. She met her ex-partner at this time. He found a house for Kim and soon moved in with her. They both used drugs and alcohol; however, he was a recreational user. Kim continued to drink and use drugs heavily. Her partner started taking control over her finances and substance use, limiting what she took. He also became physically abusive. At 22, Kim had a baby, she continued to use substances throughout the pregnancy and experienced ongoing physical abuse. Due to other health conditions, her substance use was never picked up on by midwives or doctors. Kim first accessed substance use support when she was 23; however, she was not ready to engage in treatment. She dipped in and out of AA for many years. She split from her partner when her daughter was four and continued to drink heavily. She neglected her daughter often passing out on her. After a violent experience with her ex-partner, police and social services got involved and her ex-partner was given temporary custody of their daughter. Following a positive experience with a social care worker, Kim got her daughter back; however, she continued to drink. Her daughter spent time between her house and her ex-partners. Kim's drinking and drug use worsened, and she tried to kill herself at the age of 29. Social services again gave her ex-partner custody of their daughter until Kim was sober and clean. Kim was ready for a change and agreed to enter treatment. However, she had to wait four months to get into detox and rehab, and during this time, she continued to use crack, cocaine and alcohol. She entered treatment in January 2015. Kim owes her recovery to her higher power and her involvement with 'the fellowship'. At the time of the interview, she

was seeking counselling for her childhood experiences and continued to go to AA and NA meetings. She works in an addiction centre and hopes to be an addictions counsellor in the future.

Lydia

Lydia was 28 at the time of the interview and living in residential support for men and women affected by problematic substance use. She was drug-free less than a week having relapsed five days prior to the interview. This was her second relapse since entering the service and her worst as she used heroin for the first time. Lydia spent most of her adolescence in foster care. She does not mention a father but talks about living in a home of domestic abuse from around the age of 10 or 11 from her mum's partner. She was also bullied by her friends. She refers to an incident, which saw her mum's partner trying to drown her in the bath one night. Lydia's mum did not believe her and after running away for four days, she was put into foster care. Lydia started drinking alcohol when she was 12 before quickly moving onto pills, ecstasy and amphetamines. She developed a 'cannabis habit' and at the age of 18 and she started using cocaine. She was in a good relationship during this time, describing her use as recreational. However, she decided she wanted to stop using and 'get away from it all'. She joined the army and was there for nearly two years before being discharged for medical reasons. This influenced Lydia's goals for the future and she began using drugs again. When she was discharged from the army Lydia says she 'pressed the fuck it button' and used various types of drugs; she became dependent on cocaine. Around this time, Lydia also got into a 'bad relationship'. She describes her girlfriend as having mental health issues and they were both heavy users. Her partner was abusive towards her, but Lydia says she also was violent towards her partner after a while. She was then introduced to crack cocaine 'and that's when it went downhill'. She used crack for about five years selling everything in her flat to pay for her addiction. She accessed a service in her hometown, however, she had to detox at home and go to groups at the centre during the week. Lydia explains she would go to group then go and pick up drugs. After selling all her possessions Lydia was sleeping on the floor of her flat. Her mother got in touch with a different addiction service and Lydia engaged with them, however, she left after a short while because she was too close to her home. Her knowledge of drug dealers in her hometown impacted on her use and she needed to move away to try and recover from drug use. At the time of the interview, Lydia was on a 28-day warning from the residential rehabilitation

service. She relapsed twice on drugs during her stay. Her relapse occurred when she visited her hometown, an hour away from the service. Lydia demonstrated a desire to get off drugs but also spoke about how hard it was not to use. It is my understanding that Lydia relapsed again following the interview and was forced to leave the service.

Elaine

Elaine was 35 and 13 months sober at the point of interview. She began using alcohol at the age of 13 to help fill a void and give her confidence. She was bullied as a young person and explains how alcohol gave her confidence to speak to people. She does not talk about her childhood during the interview but there is reference to potential childhood trauma as she explains her desire to forget things. She does not talk about her familial relationships at this time either, only referring to her parents as being supportive in her recovery. At the time of the interview, she was living with her parent's due to debt incurred during her drug use. Elaine's alcohol use continued throughout her teens, something she says she got away with until her mid-twenties because it was normal. She did notice a difference in her drinking behaviour compared to her friends as she broached 30. She began using cocaine to counter-act her drunken actions when out with friends. Her substance use moved from recreational weekend use to private at home use, as she explains a Monday night in front of the TV with 'three bags of cocaine and three bottles of wine'. She owned her own house at this time and was working as a senior nurse. Around this time, she realised she had a bad habit and went to AA but explains that it was not for her. Her friend introduced her to NA and although she preferred it to AA and identified with other NA users, she was not ready to stop using drugs or alcohol. A month after stopping NA she met her partner. Their relationship moved quickly. He also used substances and introduced Elaine to stronger cocaine. Slowly, her partner began taking control. Elaine experienced physical and sexual violence during their one-year relationship. After several incidents in work, Elaine lost her job and moved in with her partner. She moved away from her family and continued to use. After a violent episode one evening, Elaine left her partner, but she returned to him a couple of weeks later. Her friends pulled away from her. One friend stood by, this woman was previously in an abusive relationship. However, she told Elaine she could not be friends if she continued to stay in the relationship. At this point Elaine hit rock bottom. She felt 'really anxious and really frightened and really panicky all the time'. She left her partner and moved in with her parents. Knowing how NA worked she began to go to groups again. She now goes to NA three to four times a week and is

motivated in her recovery by the twelve-steps. Elaine is aware of the potential for relapse, seeing it through various NA members. As such, she is determined she will attend groups for the rest of her life to avoid the risk of relapsing. Elaine now works as a receptionist and does not think she will return to nursing. She has a qualification in recovery coaching but is not sure if she wants to pursue this as a career. At the time of the interview, Elaine was in a good place, commenting 'yeah, it's good, life's good'.

Holly

Holly was 13 years sober when I met her and appeared to be in her fifties, although this was not clarified. She does not go into great detail about her experiences during the interview and I struggled to probe further as her answers were quite short and closed off. However, interpretation of her interview indicates that Holly experienced extensive childhood abuse at the hands of her father. She does not talk about her mother in detail but refers to her as having no sympathy for her experiences of abuse as an adult. Holly met her partner around 1996. A year into their relationship he became physically abusive. Looking back, Holly realises he was emotionally abusive during their first year together but explains: 'he was me first boyfriend, so I didn't know what to expect.' During her six-year relationship with this partner, Holly experienced extensive physical abuse and threats of death. A year after the physical abuse began, Holly started drinking. Initially she was drinking a bottle of vodka every few days; however, she soon began to drink daily, some days drinking two bottles of vodka. Having not voted on the day of the 2001 general election, Holly realised she was an alcoholic. Her experiences of the DT's from alcohol impacted on her physical well-being and as such she contacted AA. She utilised AA for 13 years but stopped going recently because she believed it was too religious. She also believes she does not need support for alcoholism now. While accessing AA and still in a relationship with her first partner she tried to seek support from the community addiction team, however, they believed she was 'taking the piss' when highlighting her domestic abuse and discharged her. Holly has suffered from mental health issues including depression, anxiety and personality disorder for many years. She tried to access care through her local mental health service, but they could not support her because of her heavy alcohol use. She explained that she asked for police support for her domestic abuse, but her partner told the police she was making it up because of her alcohol use and because she was a 'mongoloid'. She explains that the police did not intervene. In 2001, Holly tried to kill herself by taking an overdose. Nobody called for help and when she came to, she went to a and e. She says she was discharged with no support. At some stage during her six-year relationship Holly had a daughter. Because of her drinking, social services were called but did not take any action. Holly

says they did not offer her support for her drinking or her domestic abuse. Holly's life changed for the better in 2002 when she was admitted to a domestic abuse refuge. She had to register as homeless before somebody listened to her story. She describes her one year in refuge as a time that changed her life. They supported her to set up a new life. The community addiction team also began supporting her again while she was in refuge. When she left refuge with her daughter, Holly was determined to complete her A levels. This motivation influenced Holly to stop drinking for good. She went to college and then to university. She now wants to be a writer but is currently on medical benefits because of her mental ill-health.

Lou

Lou was 42 and six years clean when I met her. She began using drugs at the age of 15, describing her initiation as normal for an adolescent. She grew up in an environment of drugs and alcohol, however, Lou was determined not to follow the path of many of her family members. Describing herself as a 'tomboy', she was passionate about athleticism and football and began training in a school of excellence at the age of 10. Her training at the school was focused on Olympic standards. At the age of 15, Lou got into a motorbike accident 'as a consequence of smoking cannabis'. Her career as an athlete ended and she began using drugs and alcohol quite heavily. Lou describes her use as an escape. Initially using sports to block out negative emotions, drugs were then substituted to help her cope. Her coping was related to her experiences of childhood trauma. Although she does not go into any detail about these experiences, she owed her continuous substance use to these experiences and refers to her brother as the person behind the trauma. She also talks about her experiences of fighting as a young person. She was often made fight other family members to help toughen her up. At the age of 19, Lou 'came out' to her family and had a series of relationships from this point. When she was 23, she cheated on her partner and began a relationship with a woman who also used drugs and alcohol quite heavily. She describes this relationship as 'co-dependent' and refers to psychological and physical abuse throughout. However, Lou also talks about her act of retaliation to the physical abuse after several physical incidents from her partner, explaining 'it ended up as her being a perpetrator and then both of us being yaknow'. This relationship lasted for five years, then Lou entered a loving relationship which lasted for seven years, she does not refer to any domestic abuse during this time. Lou continued to use drugs and alcohol throughout, describing herself as 'a functioning addict'. She also sold drugs during this time. When Lou was 35, her sister died from an alcohol related illness. This scared Lou into stopping, which lasted for 10 months. She accessed cocaine anonymous during this time after a friend reached out, however, she relapsed within the year. Lou continued to use substances for another two years, but she describes this time as 'a lot worse'. She became very isolated and lost her job. She moved in with her mum and only left the house when it was dark.

She was suicidal and describes her life as 'messy'. Lou believes she had the gift of desperation at this point and wanted to change. A friend reached out and took her to see an addiction worker. This woman changed Lou's perspective and gave her hope that she could change. With the help of the worker, Lou chose to go to rehab and decided a strict twelve-step service was the best fit for her. She spent eight months in a rehabilitation service and although she says it was not easy, she was lucky to get it first time around. When she came out of treatment she contacted a mental health service and engaged in deep psychological counselling for two years to help her cope with her trauma. She also began volunteering at various services related to homelessness, domestic abuse and substance use. She now works at a service that supports homeless substance users. She is still engaged in narcotics anonymous and continues to work through her trauma with the help of a sponsor.

Jo

Jo did not share her age but appeared to be in her early fifties. She identified as having a problem with alcohol at the time of the interview and admitted that she was still drinking, telling me that she drank every night for a month prior to the interview. As a child Jo grew up with parents who drank often, however, she explains that they were not dependent on alcohol. As she got older, her parents drank nearly every night. Her father was physically and psychologically abusive to her mother throughout Jo's childhood. Jo explains that she grew up with pressure from her parents to be perfect. Her father was also critical of her eating. As a teenager, Jo was bulimic. When she became pregnant in her early twenties her bulimia stopped because she did not want to harm the baby. By her mid-twenties, she had two sets of twins in less than two years. She started drinking frequently at this time due to unhappiness. Her partners drinking also increased and they both became violent. The first physical incident of abuse occurred when Jo threw her partner over the bonnet of a car following an argument. Up until that point, Jo's partner was verbally and emotionally abusive. Jo blames herself for the physical outburst because from then her partner became physically abusive. While her children were still young Jo went back to work, however, incidents of physical abuse continued. After a specific incident, Jo recalls how she put the children in the car one night and drove to the other side of the country. She was given a space in a guesthouse until she was moved to a women's refuge closer to home. She explains that she did not receive much domestic abuse support because she moved back with her partner after a short time period. She explained that her main reason for going back to her partner was her children. The couple went to see a counsellor who told Jo she should stop working because it was causing stress on her partner and that was why he was being physical. Jo never returned to the counsellor. The relationship went through periods of up's and downs. They realised that mutual drinking impacted on abuse and Jo explains that she would not drink if her partner decided to drink. Her partner attended anger management support and the physical abuse ceased. They still live together, and she describes their relationship as loving, however, she also says she would leave her husband if she had the money. Jo explains that she left the home nearly 30 times in

total because of abuse and arguments. During this time, Jo's drinking also increased and decreased. She went to see an alcohol counsellor at one stage, but she soon continued to drink. She also tried AA for four days but could not identify with the people that were there because she does not believe her problem with alcohol is as severe as those who attend AA. She believes she drinks because she is unhappy and uses alcohol as a coping strategy. A particular moment of sadness was the death of Jo's brother. Following the death, Jo and her partner adopted her brother's children. This adoption now has an impact on Jo's ability to seek support for her drinking. She drinks in secret at night, often finishing a bottle of wine in under an hour. She believes she has a problem with alcohol but cannot ask for help for risk of losing her adopted children. During the interview, Jo also talks a lot about other people's experiences of domestic abuse, such as her mother and her daughter. She shared detailed accounts of her daughter's experiences of abuse and explained that this was how she got into domestic abuse work. Jo currently runs an online group for women who are experiencing domestic abuse. She listens to them and offers support where necessary, sometimes putting herself in dangerous situations to support women. She is passionate about women's issues especially domestic abuse and hopes to create a network for women to get the right support.

Dani

Dani appeared to be in her mid-fifties at the time of the interview. She was drug free for seven years and alcohol free for six years, having previously used a combination of drugs and alcohol for nearly 30 years. She does not talk about her home life or refer to herself as a child. At 16 Dani started 'grafting' (prostitution). Although she smoked weed occasionally, the money she earned went towards holidays and nice things for herself. At 18 she started using crack cocaine heavily. She was introduced to the drug by a male acquaintance who was then sent to prison. Dani explains that this man went to prison having consumed hundreds of pounds worth of drugs, so she would go to the prison to score. However, when the drugs ran out she says, 'it all went to pot'. She met her 'kid's dad' in her early twenties and introduced him to crack. From there, Dani describes their relationship as 'Bonny and Clyde' as the two shoplifted and staged robberies to make some money. Dani continued to 'prostitute' to make money. She had five children with this man and a child with another man. She was in and out of prison several times. Her partner looked after the children while she was in prison. Dani's partner became physically abusive before her eldest son was born, over 25 years ago. The abuse lasted for nearly 20 years. She explains that she did call the police several times on her partner, but she never pressed charges. Dani was involved with social services for many years but never lost custody of her children because she could 'style it out' when they came to visit. However, she vocalises a hate for social workers during the interview. She also had several support workers throughout her experiences of drug use and domestic violence. She went into detox three times in total with encouragement from her various workers. However, her third time in detox had an impact on Dani's desire to change for the long term. She explained that leaving detox after three weeks was like taking off 'rose tinted glasses' because she realised her partner was no good. Her entry to detox was supported by her support worker, who Dani talks about as having a positive impact on her life and her children. In 2010, Dani stopped using drugs. She did not engage with addiction services after detox, instead focusing on motherhood, education and training. In 2016, she began volunteering in a service supporting people coming out of prison. She has an interest in care work and is working on a certificate in

counselling. She continues to engage in training and education believing 'you're never too old to learn'.

13.1 Summary of chapter 13

The sample profile and 12 pen portraits present a biographical overview of the women's lives. This presentation seeks to show the whole of their experiences rather than just the parts selected by me to fulfil the research aims. Although these condensed biographies cannot fully show how these experiences were for the women in this study, they do provide a context moving forward. As the pen portraits show, the twelve women who took part in this research have experienced multiple traumas and complexities outside of support seeking, that is why I wanted to use pen portraits. The following chapters will now examine their journey's to support using quotations to demonstrate the complex nature of support seeking when substance use and domestic abuse co-exist.

Chapter 14

Findings

From Childhood to Adulthood

As the pen portraits illustrate, childhood abuse, neglect, parental substance use and parental domestic abuse were common experiences for the majority of the women. Understanding the women's childhood and adult experiences helps us to understand how their substance use manifested, how their childhood relationships impacted on their adult relationships, and the complexities they brought with them when accessing support. The following chapter will, therefore, explore the experiences of childhood and adolescence as described by the 12 women in this study.

Phenomenological analysis can never fully illustrate how a specific experience was for the research participant, but by creating context and setting the scene with the use of verbatim quotations, we have a better understanding of the women presented in this research.

14.1 Witnessing and Experiencing Abuse

All 12 women experienced various forms of physical, sexual, emotional abuse and neglect as children and adolescence. Some also witnessed abuse as children. Michelle, Laura, Khloe, Kim, Lydia, Holly, and Jo all grew up witnessing domestic abuse as children. There is a suggestion that Gina also grew up witnessing domestic abuse as she referenced an unhappy childhood:

I believe that I was brought up by erm, somebody who didn't like women and that really impacted on me. (Gina)

For the majority of those who witnessed abuse growing up, it was perpetrated from father to mother as Jo illustrated:

...there was a lot of domestic abuse in the house, erm, me dad towards me mum...(Jo)

However, Laura highlighted that the abuse in her home was perpetrated by her mum towards her dad:

I seen it at home, but it was me mum who was the one who was violent, not me dad. (Laura)

Kim also witnessed and experienced domestic abuse at home:

...there was a lot of domestic violence as a child, erm, loads of neglect erm, quite a lot of abuse physical, mental, emotional erm, and I ended up living through that...(Kim)

Like Kim, Michelle also grew up with neglect, parental substance use, witnessing domestic abuse and experiencing physical abuse. Both women were also put into foster care. Kim was removed as a result of parental neglect and she stayed in care until she was 17. However, Michelle's experience of care was as a result of sexual abuse:

Eh I was about 13 and me mum had a lodger, and like he sexually abused me, and she didn't believe me, so I ended up going into foster care and that, and then me head went a bit mad. (Michelle)

Like Michelle, Lydia also went into foster care at a young age as a result of abuse:

Em, started from the age about,10 11 when me mum got with her partner erm, I used get battered off her [mum's partner] and I used to get bullied off me mates, erm, (pause). I got, she [mum's partner] tried drown me one night

in the bath and erm, me mum didn't believe me so that's why I ran away from home, I were missing for four days and that's why I got put into care, cause I went missing, and me mum didn't believe me and, (sigh)... (Lydia)

For the majority of the women, their experiences of abuse and neglect as children, impacted on their relationships as adults.

14.2 The Impact of Abuse on Adulthood

The various childhood and adolescent experiences impacted the majority of women as adults. For many, witnessing abuse, being abused and experiencing neglect impacted on their understanding of adult relationships as Khloe highlights:

...and I think, from my point of view, I think erm, being brought up, with the understanding that violence is kind of part of relationships as well, I say kind of definitely, definitely, not a good part of relationships but they go hand in hand, that was something, not really ever questioning that, erm, and leaving home at a young age, and almost immediately getting into a relationship...(Khloe)

Michelle was similarly impacted by her upbringing, particularly her experiences of neglect:

...and then some lad showed me affection and that, he was really nice like and I was, I thought I just wanted to be loved ya know what I mean, why can't I be like anybody else, and he showed me this love and I just and, and, it felt good. (Michelle)

Kim echoes Michelle's sentiment somewhat in her desire to be protected as a result of her childhood abuse:

...what I looked for in him was, he was able to provide for me... (Kim)

I used to go for older men eh, were secure so that they'd then make me secure and, yaknow... (Kim)

However, Lou specifically attributes her childhood experiences to her relationships as an adult:

Em, but looking, looking back now and doing some work around this stuff previously, I probably attracted that type of person because I thought that's all I was worth, if that makes any sense, yaknow. [...] because of my trauma, my childhood trauma and I felt worthless and dirty and it was my fault and you deserve this, it's kind of that's what that was what my belief system was like, that's what I fed myself, you believe it. You yaknow you're not worth it yaknow ya deserve this, it's your fault you shouldn't have done this and you're bad and you're dirty and you're naughty, all that kind of stuff, erm, so that's what I think yaknow, yeah. (Lou)

For Laura, the involuntary removal of her child at 14 saw the beginning of decades of substance use, domestic abuse, psychiatric incarceration and prostitution:

And I had to, it was from there, it all stemmed. Rebellion, they'll never tell me to do something yaknow... (Laura)

Holly's interview also suggests a relationship between her childhood experiences of abuse and her adult relationships. She grew up in an abusive household, experiencing physical abusive from her father. This abuse impacted on her first relationship which lasted for six years:

Well looking back, he was, emotionally abusive right from the start. But I didn't realise that because you don't. I mean he was me first boyfriend, so I didn't, I didn't know what to expect. (Holly)

For many of the women who witnessed and experienced abuse as children, they also lived with parents who were using substances.

14.3 Living with Parental Substance Use

Parental substance use was a common theme among many of the women as discussed by Laura, Michelle, Gina, Kim and Jo during their interviews. Reflecting back on her childhood Gina now believes her mum was an alcoholic:

Yeah, my mum was I think she was an alcoholic, if I think about it yeah, she was an alcoholic. (Gina)

However, Michelle understood her parent's substance use early on:

But me mum and me dad were alcoholic. Me mum still is and me dad's dead. (Michelle)

Laura also explains that her mother was an alcoholic and as such, she was raised predominately by her father and her gran:

...me mum died of alcohol abuse, and it was me gran and me dad who brought me up. (Laura)

Like Laura, Kim grew up in a home with substance using parents, explaining that they both still use:

...me mum and me dad are both erm alcoholics. (Kim)

Witnessing parental substance use also had an impact on Michelle's own use. In a bid to stop her mother drinking she explains:

So really, it started when I used to take some of me mums' beer into school thinking if I take these with me then she won't be as pissed when I get home, cause they was on me I thought well I'll drink them and it just escalated from there. (Michelle)

Michelle's substance use began as a teenager like the majority of the women who were interviewed.

14.4 Early Substance Use

Both Lydia and Michelle began using alcohol at a young age. Lydia started drinking when she was 12 with friends at the weekend. Social drinking with friends was a recurrent theme for many women, as Kim also talked about her enjoyment socially drinking at the age of 15. Michelle also began drinking with friends at 15, skipping school to go drinking with her mum's beer:

No when I was about 15 I just didn't bother going into the school I used to go to me friends and drink. And, me own mam never well, she weren't that arsed anyway cause she was always pissed herself, so I could get away with it, yaknow what I mean. (Michelle)

Many of the women in the study also began using drugs at a young age. At 15 Laura began using amphetamines but was drinking from the age of thirteen. Before the age of 18 Lydia also used pills, ecstasy, amphetamine and cannabis explaining that she had a 'cannabis habit'. Similarly, Gina used a range of drugs in her early teens but began drinking at the age of twelve:

...I'd been drinking actually a lot before that, from the age of about 12 [...] I'd smoked a bit of weed erm, yeah so after that I started taking magic mushrooms, they were growing in the school field so we used to go and pick them and eat them straight away and erm, yeah so I was doing that for quite a number of months with friends from school. I used to sniff tip-ex thinners,

erm, sniff gas, erm aerosols, anything really that I could get my hands on that erm, gave me a buzz I'd try... (Gina)

In comparison to these women, Lou's introduction to drugs was described as 'quite strange'. She began using drugs following an accident that stopped her progressing with her goal of being an Olympian:

I always had an ambition and a dream as a child of wanting to be some kind of athlete, [...] I was quite sporty little tomboy and I wanted to I knew I was going to be an athlete one day or a footballer [...]so by the age of 11 I was getting trained in a school of excellence to be an Olympian erm, so I was kinda like living my dream at a very young age and then the age of 14 15 I switched to football and I played for a numerous yaknow quite a few high-profile clubs, in terms of football. As a result of me smoking cannabis consequence for the second time when I were 15, erm, I got on the back of a motorbike that was unsafe and wasn't stable erm and it was stolen as well the bike the motorbike eh, my ankle got caught cause I was on the back of it, in the cog, I was rushed to hospital and I was operated on and I was lucky to still walk again. [...] Now, what happened for me there was, I was surrounded by drugs in the area where I grew up erm, but I was obsessed with my sports I stayed away from it because I knew what I wanted, and I was quite driven. But, I had a lot of issues, and I had a lot of childhood trauma, that was going on as well that I was tryna run away from and I was avoiding in sports so when I had my sports taken away from me cause they said you'll never run or play football at that level ever again I was stuck with all these difficult feelings because I was avoiding [the trauma] whilst I was in sports, so I couldn't cope with yaknow that, that was my introduction to, to drugs. (Lou)

Lou's ambition influenced her to avoid using substances however, a traumatic injury resulted in her engaging with drugs heavily. All of the women in this study eventually began using substances problematically, and the majority began using as children and

teenagers. They also experienced abuse as children and adolescents which eventually stemmed into adult experiences of domestic abuse. As the pen portraits illustrate, problematic substance use manifested in different ways and at different stages for all of the women in the study. Similarly, their experiences of domestic abuse varied. However, the common bond linking all of these women, is their adverse childhood and adolescent experiences.

Chapter 15

Findings

Effecting Change

During the interviews the women spoke in varied detail about their experiences of substance use, the drugs they used, the amount of alcohol they drank, the reasons they drank and the role of substances in their relationships. Many of the women also spoke in detail about their experiences of domestic abuse, often pointing to scars on their bodies to illustrate their experiences during the interview. This chapter moves beyond their lived experience of substance use and domestic abuse and instead will discuss how the women sought support for their substance use and domestic abuse.

This chapter will discuss how the 12 women in this study effected change in their lives. It seeks to explore their motivations for support seeking for their substance use and domestic abuse, the role of the self in seeking support, and significant moments that impacted upon their decision to make a change.

15.1 Motivation to Stop Using Substances

15.1.1 Previous Attempts to Stop Using

All of the women in this study tried to stop using substances at some point in their lives. For the majority, abstinence or a reduction in use was achieved. However, their most recent success with abstinence or reduction was not necessarily their first attempt at stopping. Some were not ready to stop using and some did not want to stop. However, the majority of women demonstrated a desire to stop using before they finally did stop. For some this desire to stop using substances was demonstrated years before becoming drug and alcohol free. For example, Khloe 'first got into treatment' six years before she was drug free. Whereas Laura wanted to stop using heroin when she was in her early thirties and actively sought to do this. However, it took another 30 years before she was completely substance free:

I was a heroin addict so then the doctors said to me 'well I think the best thing you can do is move out of [place]', so I said right, done what they said and moved to [place] but [place] was a drinking place, I didn't drink til I was 32, 33... (Laura)

Likewise, Lou demonstrated a desire to change at several points, but it took years before she became abstinent:

I tried to stop many many times, I could stop but I couldn't stay stopped... (Lou)

Like Lou, other women encountered support early into their substance use however, they all relapsed because they felt they were not ready to change their substance use. Laura explained how she was 'dried out' many times in hospital but never had any intention to stop using.

Elaine engaged with NA early on in her substance use however, she said that she was not ready to stop using drugs at that point:

...but I, I couldn't bring myself to be able to stop at that time, erm, so I kind of stepped away from that [NA] [...] but again I just couldn't, I couldn't imagine a life without drink and drugs at that point so erm, so I stopped going. (Elaine)

Similarly, Kim explained that she engaged in support but not because she wanted to:

I'd first [...] contact with erm, [recovery centre] years ago, and I went and tried to get some help because it was just becoming a problem and causing that much trouble at home, and I didn't wanna,[...] [at] first [I] didn't really want to stop but I knew that I needed to in a way erm, that didn't last. (Kim)

Dani also shared similar sentiments:

...I done it [detox] twice before in the past, but I wasn't, I just didn't do it, d'ya know what I mean... (Dani)

Unlike all of the women in this study, Jo was still actively using alcohol at the time of the interview to a level she deemed problematic. However, she previously engaged with an alcohol counsellor and twelve-step programme:

I don't want to be a drinker, like I say probably in the last month, I've probably drank every single night, I had a drink last night, a bottle of wine last night, and the night before and the night before, every night. (Jo)

Like Jo, Lydia was still struggling with her substance use at the time of the interview despite being engaged with a residential treatment service. At the time of the interview she was on a 28 notice for relapsing. Her relapse occurred 5 days before the interview. Her interview highlighted a conflict in her motivation to change as she focused on other people finding out:

I do want it, I do want recovery yeah, it's just fucking hard not picking up, it's so hard, I can't explain how hard it is. (Lydia)

... I think o yeah I can get away with using one more time but, you can't, someone always finds out... (Lydia)

Like the majority of the women, Lydia appeared to be conflicted with her substance use. She displayed a desire to stop using by engaging with support however, her recent relapse and focus on other people finding out also suggests that she is not ready to stop using. She also did not mention any motivations for stopping substance use or engaging with support unlike the majority of the women.

15.1.2 Fear

Although not discussed in great detail by many of the women, fear proved to be a motivating factor to change for Kat. Her motivation to leave her partner and stop drinking was impacted by her fear of dying. Because this was such an emotive topic for Kat during the interview, her dialogue on the topic is presented in parts:

...it [the abuse] got worse, I don't think that I was maybe even not as badly hurt as the year before, but the things that he was doing were getting like, yaknow, strangling and yaknow things that are more, you feel like your life is more in danger... (Kat)

I was more scared that time than any of the other times before. And that's why I erm, (pause) I just, I just knew, that I had no options left...(Kat)

I really, yaknow, I really believed that it either he would kill me or the drink [would kill her], and it would only be a matter of time [upset]... (Kat)

And I was convinced, that I wouldn't, yaknow, I wouldn't get out alive if I went back again [slight upset] (pause)... (Kat)

Like Kat, fear motivated Lou to make a change in her drug use. She spoke about a particular ten-month period of abstinence inspired by the fear she felt following her sister's death:

I lost my sister, erm when I were 37 no I was 35 my sister were 37, she was an alcoholic she got pneumonia erm and she was rushed to hospital erm and she spent three weeks fighting for her life in intensive care. [...] erm, that kind of frightened me a lot yaknow so I got clean first erm, before I went into the rehab I got clean for 10 months em... (Lou)

However, she began using within the year. She continued to use drugs for several years until her health and well-being was negatively impacted. She explains that this period of her life was scary and motivated her to re-engage with support:

yaknow I used to wake up and just as soon as I opened my eyes it'd just be fear, fear of just being [alive]... (Lou)

The fear Lou felt was in part, impacted by the deterioration of her health. A factor that influenced many women to stop using substances.

15.1.3 Health

Physical health was identified as a factor influencing some women's desire to change. Both Dani and Michelle spoke about the impact substance use had on their physical health towards the end of their using period:

...I says I'm ready I wanna go in detox now, I need to go in detox and that, I said I'm sick of being ill, I'm sick of being sick when I haven't got a drink yaknow throwing up in mornings and all that and, sick of it...(Dani)

...I was living here there and everywhere, just drinking anything. Just started deteriorating, my body, me health...(Michelle)

Although Khloe was already engaged in support and using methadone, missing a dose had an impact on her physical health also. The physical bodily withdrawal partly motivated her to become completely drug free:

...I picked up, but it was at the weekend and I hadn't drank it, and it was next to me next to me bed, so I woke up, in pain, and this is pain I'd only had described to me. [...] I spoke to the doctor about it and he said 'yeah this is common, so what did you do?' and I said 'well I reached over and I had my meds but if this is now going to happen to me it's almost like I've just doubled

the intensity (laughs) of my addiction', so I really really wanted to do something about it, I wanted to stop using methadone, more than I'd ever stopped wanted to stop using heroin. (Khloe)

For other women, their mental ill-health played a role in the motivation to seek support as Laura and Kat explained:

But eh, it's me mental it was me health what went this time, not me liver.
(Laura)

I was getting just sick and tired of the drinking myself, I was feeling, yaknow just really affecting my mental health in terms of, I was just feeling really really down, I was fed up of it. (Kat)

Six of the women in the study spoke about their mental ill-health and the impact it had on their lives. Laura, Michelle, Kat, Kim and Lou specifically talked about their mental ill-health diminishing prior to accessing support. Feelings of, and suicidal attempts were common among these feelings. Laura explains that she never intended to stop using alcohol but her attempted suicide and subsequent stay in hospital impacted on her motivation to change:

But 2 years ago, eh I went too far, and that's when I cut all me throat. And eh, they put me to [a psychiatric hospital] and sectioned me. I, at the time with me being so poorly, I didn't know in me head, erm I was being dried out. I didn't know, I was on eh, I went in as an alcoholic, but eh while I was in there with all this medication what they were doing to me, they were drying me out as well. I mean I've been dried out lots of times, but I never wanted, it never entered me head I was going to stop. It was just part of how, the cycle of with me going in hospitals, I mean this has been happening to me since I was 15 in and out of institutions for me health. Anyway eh, the last time when I went

in, like I said I'd been dried out and everything and that but eh, it was different, me mind had gone flipped different... (Laura)

Like Laura, Michelle entered psychiatric hospital due to suicidal feelings, in fact, she met Laura in the same hospital. However, unlike Laura, Michelle continued to drink after leaving hospital, despite being offered the same care and access to services as Laura. Instead, Michelle's motivation to change was impacted in part, by her children.

15.1.4 Children

Motherhood and the role of children had an impact on all of the mothers in this study in different ways. As the sample breakdown illustrates, Laura, Michelle, Kat, Khloe, Gina, Kim, Holly, Jo and Dani were mothers. Motherhood and the role of children was not discussed by Kat, as she only spoke about her children once in the whole interview. Similarly, Gina spoke about her children, but they were not a central part of her interview like some of the other women. The value placed on motherhood varied between the women. For some women, children were a central theme in their motivation to change and for others, children did not appear to influence their motivation to change. Laura, for example, identified a personal problem with drugs in her early twenties when she had two young children however, she realised she could not be a good mum and made the decision to put her children into care:

Me kids went to foster parents, but I put them there, because I weren't a good mum. [...] And then I got sterilised then. Because, me mind I shouldn't have had kids really, d'ya understand, as much as I love em and then when they got to 8 and 7, the heroin was so so bad, so, I eh, put them to foster parents. (Laura)

Similarly, Khloe left her son in the care of her parents during her years of substance use, domestic abuse and prostitution. She does not talk about her son as influencing her motivation to stop using but does talk about rebuilding a relationship with him since ceasing drug use.

For others, motherhood did influence their motivation to change. Michelle's desire to be a mother impacted on her reduction of alcohol in her first pregnancy:

...then I found out I was pregnant ehh, so I stopped drinking, but I was still drinking at the weekends... (Michelle)

Similarly, Jo's desire to be a good mother had an impact on her decision to leave and return to her partner several times:

Cause me mam never left so I would leave, I think, [...] I don't want my kids to grow up like this, so I'd leave, start afresh, leave all my furniture and everything that I had, I'd spend all me money doing up our house and then, and he would never leave, and then, I'd leave and then I'd end up going back anyway, for the kids. (Jo)

For many of the mothers, children did not initially influence their motivation to change. Both Michelle and Dani were prompted by social work to leave their partners for the sake of her children, but they did not see a problem:

...I'd be like, don't tell me I gotta get out of this relationship because I'm alright, the kids are alright the kids are getting fed...(Dani)

However, their children eventually became a motivating factor in their recovery from drugs and alcohol. For example, Michelle's recent attempt to be abstinent was prompted by the thoughts of her children in the future despite losing custody of them years previous:

...what someone said to me, when your kids get older [own name] do ya want them to see, see ya up there yaknow doing well, or yaknow in a grave, and that's always stuck to me that since... (Michelle)

Similar to Michelle, Kim temporarily lost custody of her daughter twice (to her abusive partner) however, upon losing her daughter for a second time Kim was motivated to change:

...but, it was to be a mum, for sure, it was to be a mum, it was to do what I was always meant to do, I wasn't meant to be that addict... (Kim)

I knew what I was, I was an addict and I had to go and do some kind of intervention and I had to stop for me to get her back, I understood it all... (Kim)

...she was the only thing that kept me alive. (Kim)

As Kim, Michelle and Jo illustrate, children were a big influence on their motivation to change, on their desire to stop using substances and on their decision to leave their abusive partner. However, Dani disagrees with the belief that children are the central influencer on a woman's decision to make a change:

...like you see it on Jeremy Kyle well if you don't [change] do it for your kids, it's bullshit, you will not do it for your kids or anyone, ya gotta do it for yourself d'yaknow what I mean. (Dani)

Dani firmly believes that recovery and change has to be about the individual woman, a belief shared by other woman in the study and also illustrated by the acts of many women in this study.

15.2 Self-determination to change

Although all of the women were impacted by a variety of motivators such as fear, health and children, the final act leading to change in their substance use and/or domestic abuse was inspired by each individual woman's strength. Like Dani, Kim shared the belief that change had to be about the individual woman:

I think any woman you'll ask who has had substance misuse will say, they, you have to be ready, and you have to be doing it for you, when you try and do it for someone else, it's not solely in your heart, it's in that person's heart it's in that person's best interest, not yours... (Kim)

For all of the women, there was a relationship between their motivation to change their lives, and a sense of self-determination. For some, this self-determination was sparked early on in their substance use as Khloe explains:

I'd always wanted from, from that moment that I'd realised when [son] was quite small, that I had a problem it had to be about stopping using, it couldn't be, even though I was continuing to use for a long time, treatment had to be about stopping using. (Khloe)

And for others, their self-determination impacted several periods of abstinence as Michelle's experiences in and out of detox demonstrate:

...I did a third detox and then, in [place] and when I come out in July I thought right I'm sick of trying and nothing, you've got to want this, so I was just thinking of all the good things that, yaknow what have happened and all that. (Michelle)

Michelle's determination to remain abstinent was so strong however, she decided to move out of the flat where she once lived with her children:

So I thought right this time I felt great when I come out of detox, so, and you gotta want it hadn't ya so that's why I just said right look where I live over there, too many drinkers, so. Yeah, within a week I moved and yeah just put me flat up, put something in the paper to come and get a man with a van and just bugged off. A lot of people now still don't can't believe that I've done it. (Michelle)

Overall the women illustrated a belief that change was about the self:

I mean ya gotta do it want to do it yourself...(Laura)

And then, I just thought right, yaknow what, I'm going in detox...(Michelle)

I wanted to do it for myself primarily...(Kim)

...it's, ya have to do it yourself, ya have to want it yourself not what other people can do for you, that's what I have learnt...(Lydia)

I think it was determination to change...(Lou)

This sense of self in the decision to change, led to the majority of women accessing support. As the pen portraits illustrate, this support varied for all women. The majority sought support specifically for their substance use by engaging in detox facilities, rehabs and twelve-step programmes. Only Kat and Gina engaged with domestic abuse support, however, Gina was recommended to attend by a social worker whereas Kat wanted to engage of her own free will.

However, their engagement with support did not necessarily stem from a sudden sense of empowerment and self-determination. For many women, a significant moment or, tipping point led to their engagement with support.

15.3 Tipping Point

As the pen portraits illustrate, for most women, a tipping point was reached prior to engagement in support. For Laura, her health, particularly her mental ill-health, led to her hospitalisation and subsequent detox. While in psychiatric hospital, she describes a lightbulb moment that impacted on her decision to engage and stop using alcohol:

And as she's talking, I'm looking at all these people and God help, they can't help it, but it was, 'o my god' I must have lost it this time because, awh, all ages men and women and everything it's, it's really bad yaknow really bad, and eh, it was that. (Laura)

However, Laura's journey to psychiatric hospital was influenced by a point she calls 'rock bottom'. This point was noted by many women. For example, Elaine explains that she needed to reach a point of desperation before she was able to make a change and access support:

I think for me the pain, of stopping, had to [...] get to a stage where that wasn't as bad as the pain of carrying on as I was. (Elaine)

I think I had to reach my own personal rock bottom. (Elaine)

Elaine's words about pain mirror Lou's lived experience too. Lou described a low point in her substance use that saw her health and well-being affected. However, unlike Laura and Elaine's view of "rock bottom", Lou believes she was given 'the gift of desperation' at that point. She viewed this tipping point as a gift, something positive that helped her to make a change.

The majority of women described a particular moment that led to a change in their thought process and eventual engagement with support. These moments are important to present because they illustrate the variety of women's experiences in seeking support:

It was the day of the general election in 2001 and, I didn't vote which I never do I always vote and, because I was too ill to get out of bed with the DT's and, that's the day that I realised that I was an alcoholic... (Holly)

...but before I went in to detox I were in the pub, I were in the pub up there (points up the road) and, this one walked past and seen me having a fag and come and told Laura cause I look at Laura like as a mum she's really nice, and she looks after me and that and, I was in my pyjamas pissed, so Laura come up and dragged me out of the pub, brought me back here [day-service], had a chat with me were firm with me, eh, made me a sandwich, brew, I still went back and got me pint though (laugh), and really, she said some harsh words

which was good eh, and just made me think yaknow if Laura can do it, yaknow what's stopping me from being I, it's like inspirational with Laura and me. (Michelle)

I had a raging habit to crack cocaine, cocaine, drink, I was drinking a bottle of straight vodka a day, yaknow I turned into that, that woman, my mum, I turned into her completely turned into her. Bar the physical abuse, I'd done everything that me mum done, there were no food in, there was just, it was just horrendous the neglect [of her daughter] and the levels of my drinking and using was, through the roof and, it was kind of like, I was suicidal, I thought I'm not, I'm you're not a good mum and I just kept, I lived in this absolute squalor and erm, she [her daughter] was staying at her dads and I tried to kill myself while she was at her dads, and I did mean business when I done it ...(Kim)

...and I think because, because of the fear I had been living with, and knowing how my drinking would be putting me at such high risk of going back, I just knew I had to do something [...] So this time when they offered me a place in a refuge I accepted it. Cause I just felt that it was my only chance of, yaknow of life, of any sort of a life. (Kat)

...we went to church and, it was quite incredible, quite an amazing experience and, one of the guys is there in tears and, it's just, it just really erm, moved me. (Gina)

It felt like, everything was crumbling around me erm, yaknow the job had gone the money, I didn't know where it was gonna come from, yaknow my house was gonna go and, all my friends and family had gone, it felt like I was on a like a big rock that was crumbling all around me and I was stood on a bit like that and that was all that was left yaknow, I didn't I didn't have any fight left in me to carry on. (Elaine)

At this chapter highlights, the women were motivated to access support for a number of reasons including fear, health and children. However, their motivation to seek support did not always result in receiving the right support to meet their needs. As the following chapter highlights, many women were met with barriers to support despite a desire to engage.

Chapter 16

Findings

Barriers to Support

As the pen portraits show, all of the women engaged with some type of support in their lives. This engagement was motivated by a desire to stop using substances and an innate self-determination to change their lives. At the time of the interview, all of the women (with the exception of Jo) were either currently, or recently engaged in support to change their substance use. None of the women were receiving support for their domestic abuse with the exception of Kat, who was still living in a refuge.

However, many of the women encountered various barriers to support despite a desire to engage. As highlighted in chapter 15, factors including fear, children and self-determination motivated them to access support however, the role of fear and children were also identified as barriers to accessing support despite a desire to engage. As such, this section will explore the various barriers to support as discussed by the 12 women in this study.

16.1 Fear

As all the women in this study experienced substance use and domestic abuse, fear was a common theme among the interviews. For some, fear was a motivator for support seeking while for others, fear was a barrier to accessing support. Lou was the only woman to identify fear as a motivator and a barrier. As the previous section highlights, she was motivated to seek support because of the fear she felt following the death of her sister. However, she was less inclined to seek support for domestic abuse because of her fear:

I wish I'd have been a bit braver in coming forward and getting myself some help sooner, cause had I done that I probably wouldn't have [stayed in an abusive relationship], d'yaknow... (Lou)

Like Lou, Gina's experiences of domestic abuse impacted on her ability to access support. Her fears were heightened because of the criminal nature of her partners. When asked if she ever spoke about her domestic abuse she explained:

Never. Never ever because of the types of guys that I was with, it just wasn't like, no. (Gina)

Just the being scared of the repercussions really because the, the guys that I was involved with were like serious criminals... (Gina)

Gina also spoke about the complexity of reporting the domestic abuse in relation to her drug use:

...if I report this person for domestic abuse then I'm losing my supply of drugs, d'yaknow what I mean, it's erm, and the perpetrator often, often knows that. (Gina)

The fear she experienced, silenced Gina from speaking out earlier and getting help despite the physical impact the abuse was having on her. Kim also spoke about how fear impacted on her ability to speak to services honestly:

...and they [police] could see it, they come the day after and they could see it and I'm like 'no this was I did this myself', because it's just fear, it's not knowing what's going to happen after it, what are the, what's gonna happen what's gonna be the results of this. Is it gonna get worse he's probably gonna kill me after it, d'yaknow what I mean. And you've gotta stick together cause you've got a child yaknow, you best had stick together. (Kim)

The fear Kim and Gina felt, was influenced by their experiences of domestic abuse. They were afraid of the repercussions from their partners if they asked for help but,

they were also afraid to speak out because they were using drugs. Their drug use inhibited them from seeking support, especially from the police. Elaine explained how she was afraid to go to the police because of her drug use:

I think maybe part of the reason also why I shied away from erm, sort of getting more support through the police was I didn't want to expose my own drug use. (Elaine)

Khloe mirrors Elaine's experiences. She explained that reaching out to the police for domestic abuse support was not an option because she was using drugs and working as a prostitute, acts that were illegal:

And when you're in those situations where you can't go to the police for any sort of support or help, you're always wanted for something, everything you do is illicit or illegal to a certain extent cause you're a drug addict (laughs) em... (Khloe)

Khloe and Elaine's fear of the police positioned them as a barrier rather than an enabler to support. Fear of statutory services was also a barrier to support for Gina, Kim and Khloe. Their use of substances played a significant role in intensifying this fear because they were mothers. As mothers, their substance use stopped them seeking support because they were afraid of losing their children.

For the women using substances, particularly drugs, the fear of losing their children was a barrier to support as Gina shared:

I always think I thought if I'd ask for help then for, erm, the drugs, social services would get involved and they'd take my kids, so that was like a barrier for me to, to actually doing anything erm, about it. (Pause). (Gina)

Khloe also mirrors Gina's fears, explaining that she wasn't sure who to turn to because she was afraid she would lose her son:

...I wasn't really sure what to do, or who to go to, because, my, yaknow, they could have taken [son] away from me (laughs) and probably would have done.
(Khloe)

However, the fears these women faced is now historical unlike Jo, who still drinks heavily, and fears support, particularly because of the complexity surrounding her adopted children:

I can't access any kind of support because, (pause) I've got two children that I've got custody of, whose mother is an alcohol and a drug addict. And everything goes on your record and social services go through everything and fine toothcomb. (Jo)

I cannot risk losing them children... (Jo)

Jo's current experiences with alcohol is a secret because of the importance she places on family. She adopted two children and wants to protect them, as such she feels she cannot seek support.

Fear has been identified as both an influencer and inhibitor to accessing support. For some women, fear motivated them to speak out and access support however for others, fear of their partner, fear of statutory services and fear of losing children prolonged their experiences of substance use and domestic abuse. Their own fears were a barrier to support however for some women, another barrier existed.

16.2 Disconnect between support and need

Throughout the interviews Khloe, Holly and Kat described situations that identified a disconnect between support and need. These gaps appeared at various stages; from initial contact early in their substance use and domestic abuse experiences, to their

most recent engagement with services and support leading to their abstinence. For some, the lack of support resulted in continuous substance use and domestic abuse and for others, gaps appeared despite engagement with support. Each woman's experience will be presented individually to give the reader an understanding of the gaps, missed opportunities and subsequent barriers that they were met with.

16.2.1 Khloe

Khloe encountered gaps in support during her 'career' with drugs. She explained that her multiple encounters with the police never resulted in support for domestic abuse, despite her willingness to press charges:

Em, he was arrested several times and, yaknow I was covered in blood, on certain occasions, with black eyes and (pause) I remember on one particular occasion being, being told by the police that if I didn't tell them where he was getting his money from, erm, they'd let him out because they wouldn't be able to hold him. Even though it was very obvious that that there'd been a domestic assault, erm, and I was willing to press charges about that as well. (Khloe)

I can't say hand on heart, that no one ever offered me any support around domestic violence I can genuinely say hand on heart that I don't recall that ever happening, erm, despite the fact that I have been arrested with black eyes, I've given statements to the police erm about domestic violence incidents impacting on why I was committing the crimes. (Khloe)

Domestic abuse support was also lacking in Khloe's substance use support. Despite being engaged with a drugs service for six years, and despite an awareness that Khloe had experienced domestic abuse during this time, little intervention was offered to her:

I think it would have been nice for it to be mentioned to know that there were organisations there and also maybe to discuss the fact that it could be very helpful for me...(Khloe)

Like many of the women, Khloe's substance use support was available to her when she wanted it. However, her involvement with this service does demonstrate a failing to support her in other aspects of her life.

Her experiences of assault, including sexual assault also identify significant gaps in support and subsequent failings by the police. During the interview Khloe referred to an incident of rape while working on the streets one night. The rapist was wanted by the police and as such, Khloe was invited to give a statement. Following the intervention, Khloe was not offered any support:

...but I left that meeting feeling very good about the intervention that had gone on and yet there still wasn't any phone numbers or support given to me and that's not that long ago yaknow, we're talking about between, god would that have been 2010...[...]...you'd, they'd got so much in place to protect or apparently protect people who were giving statements, and yet just that for that, for the sake of going one step further and giving you a little bit more and that wasn't domestic violence that was rape, but it still, quite yaknow, a vital service, so I think, despite all of the complications with that and the extra training and the extra effort that people might need to go to, erm, it could be condensed on a bit of paper and handed to you. It could em. (Khloe)

16.2.2 Holly

Aware of her alcohol use, Holly tried to access support. She contacted the community alcohol team and was offered a home detox despite informing the service she was living with an abusive partner:

...well before I left him I got involved with, the community alcohol team, because, I realised that I was an alcoholic, so I asked them for help and they gave me a, they thought that the best thing for someone trapped in domestic violence to recover from alcohol is, to have a home detox...(Holly)

...when I was with [partner] the community alcohol team came around one day, and then, this, because I couldn't stop drinking I was finding it difficult, cause of the domestic violence, and, I wrote that, we had to write things on some piece of paper for something or other, and I wrote that, if you drink it's like, anaesthetic, they used to use it when they chopped your legs off in the olden days. Cause I used to drink so that when he came through the door and battered the shit out of me it didn't hurt so much. And the alcohol team man said you're taking the piss I'm discharging you. (Holly)

Holly was not offered support for her domestic abuse. She explained that she tried to seek help for her domestic abuse and substance use multiple times, but she was not given the support she needed:

I tried, I asked everyone I could for help and, they wouldn't help me...(Holly)

The gap in support led to a point where she thought she was going to die at the hands of her partner.

I just switched off and thought well I'm gonna die of this, one of these days he's gonna kill me. Cause he used to get his shotgun and he used to threaten me with it. And he threatened to pour petrol on me and set me on fire and all sorts. And I thought, one of these days he's gonna do it. (Holly)

Holly's experiences demonstrate multiple gaps in support, which led to ongoing substance use and domestic abuse. Holly was ready to change and willing to access support however, barriers were in place stopping her from progressing. Her experiences illustrate feelings of hopelessness when support is not in place. Like

Holly, Kat's experiences with services demonstrated failings that resulted in prolonged substance use and domestic abuse. As chapter 15 illustrated, Kat's final decision to change was motivated by fear however, she was ready to change and engage in support years before her most recent engagement with services. Her failed attempts to engage with services, resulted in continuous substance use and domestic abuse.

16.2.3 Kat

As her pen portrait illustrates, Kat engaged with a counsellor following her PTSD diagnosis. Despite the support she received at this point, multiple gaps in support were also identified, the first appeared when she was referred to counselling for her PTSD:

...went for counselling for a good while which obviously yaknow, though it helps initially, it sort of brings things back up as well and, so it carried on and of course even though I sort of dealt with the issues around my ptsd to an extent, then I was left with an alcohol dependency. (Kat)

Although she was receiving support for her PTSD, there was no plan in place to help her cope with the aftermath of the sessions, as such she developed an alcohol dependency. Lydia also shared similar experiences, explaining that she attended day groups but struggled with her feelings afterwards. While Khloe said she went to rehab for her heroin use but upon leaving treatment, started drinking heavily.

Following her self-identified alcohol dependency, Kat actively sought support from a drug and alcohol service in her community. However, her engagement with other services (not substance use related) led to a barrier accessing substance use support:

But because, I went there a couple of times, because I was going for counselling with [place] which is a rape and sexual abuse centre, and then I

was involved with [name] which is yaknow mental health charity, I was basically told that there wasn't anything more that they could do for me. (Kat)

...he [alcohol worker] said to me, because you have these other people involved he felt that he couldn't give, he couldn't, there wasn't any sort of additional support that he could give me. (Kat)

This was one of many barriers Kat faced when wanting to access support. As her pen portrait shows, failure to access substance use support resulted in her continuous drinking. She met a man who soon became abusive. Because of the abuse, she sought support from a domestic abuse service however, her drinking inhibited her ability to access support:

I was offered erm, a place in a refuge at that point, but then they said to me that I'd have to stop drinking I couldn't go if I was drinking. I was drink dependent, I couldn't, I felt, probably medically it wouldn't have been safe for me to stop the way I was drinking in anyway, erm, I would have needed, because I was drinking every day, I would have needed a detox or something, erm but all they [name of refuge] they said to me, if you come you can't drink. I thought I can't stop...(Kat)

At this point, Kat was not offered support for her substance use, nor was she given a number to call. The gap in support and lack of referral resulted in ongoing substance use and eventual reengagement with her abusive partner. She tried to access refuge support months later, but was again faced with a new barrier, this time related to her financial situation:

...but at some point I yaknow, I spoke to them and, when they said, offered me a place in in their one of their refuge places, houses erm, then my problem was that I was working so I would have had to pay, but I wasn't doing enough

hours to be able to pay, so you come up with, you just, again it was like well what do I do...(Kat)

Kat eventually moved into a refuge and stopped drinking however, gaps still exist with her current support in refuge. While in refuge at the time of the interview, the support between her domestic abuse worker and her addiction worker has been separate. She describes an encounter with her domestic abuse support worker:

...even when I started in recovery, when I said to my support worker and don't get me wrong they've saved my life, I'm not criticising them in that sense, I think it's just lack of training, I don't know what it is, I said to her that I started in recovery and she said 'what are you recovering from'. I mean I couldn't believe it (laughs) yaknow. (Kat)

She describes the support as 'separate' between the refuge and the drug and alcohol service and wishes for more coordinated and joined up working between her support workers. Her experience of separate support has motivated Kat to take part in this research. During her interview she vocalised her frustrations about the lack of coordinated working between services:

...yaknow a lot these erm organisations they work with women who are still living in those circumstances not quite ready yet to maybe leave but, but desperate enough to want some support. Yaknow for the care of to be more coordinated between the substance misuse services and the domestic violence yaknow charities, because, even making sometimes even getting away to make one appointment a week, can be, nearly impossible. If you have to go to this one place for your substance misuse another place for, to see someone about the violence, it can be impossible, and when you feel like you're not being you're just told, well yeah we can offer you a place but you have to stop drinking, that in itself, you've hit a brick wall. And you do feel like

there's nowhere left to go, so there needs to be more understanding, definitely. (Kat)

The experiences of Kat, Holly, and Khloe demonstrate a multiplicity of barriers, impacting access to support when substance use and domestic abuse are co-occurring. The experiences of those who have encountered barriers, illustrate the siloed nature of support and the lack of co-ordinated care for women with multiple needs. The women's various experiences show that accessing support is complex, despite a desire to engage. Jo vocalised this as a frustration during her interview:

And it's the same with the services it's not a lot of, erm where they can cross over, they kind of, will only deal with because they're not trained, a drugs and alcohol worker are not fully trained in dealing with domestic abuse so therefore they're not comfortable dealing with it so ya either deal with one or the other, they're not dealing with it together so. (Jo)

Kat further vocalised this complexity when describing her own experiences:

I know how difficult it is to survive and leave a domestic violent yaknow relationship like that anyway. But when you are battling a substance misuse issue on top of that it just makes it, so much harder because you don't have the mental, emotional, the physical strength, even to contemplate big changes...(Kat)

And I think that's where it makes it so difficult, to leave because, it's not you have these different needs it's you have, you need support obviously to leave the relationship, but you desperately need help with your substance misuse. (Kat)

Kat talks about the complexity of having 'different needs' and how these needs

impact support access. Some women described being unaware of what to do or where to go for support for either or both needs:

...it's only in the last few years that I've, even been aware that there were at that time, organisations set up to address that. (Khloe)

... and then not knowing really who, or, or where to ask yaknow em.... (Gina)

For other women, one need was prioritised over another.

16.3 Prioritising Need

For the majority of the women, getting support to deal with their experiences of domestic abuse was not a priority. Although Laura and Michelle both accessed refuges at some point of their lives, this access was short lived, and both women explained they were not in refuge long enough to benefit from support. Only Kat and Holly accessed refuge and stayed until they were ready to move on. However, Kat explains that she had to deal with her substance use before she could fully engage in refuge:

I mean I didn't, I felt that I had no option, but to stay until I was ready to give up the drink myself and that's when I was able to stay, because even now, if I hadn't been ready to give up drinking, I don't know where I'd be now...(Kat)

Because of the lack of support for her substance use, Kat stayed in an abusive relationship until she was ready to give up alcohol. She had to prioritise her substance use needs and reach a point of desperation before she could get the support she wanted. Like Kat, Holly reached a point of desperation. As Holly's experience shows, she was not listened to by services for years. Her tipping point came when she prioritised her safety and her domestic abuse needs over everything else, including her daughter:

Well, one time, someone said to me, you should get in touch with [service] cause I had mental health problems, and so I did I contacted them and they said, well if you can't live with your partner because of your mental health issues, not domestic violence, because of you mental health issues, then if you go to the town hall they'll put you in [name of flats] which is this notorious block of flats in [location] where they put all the druggies and people like that, and they said well you can't take you daughter with you, no children no pets, and I thought well if going to [name of flats] gets me out of domestic violence I'll go. (Holly)

Holly's experience shows the level of desperation she had to reach before she was able to access support. However, this support did not meet all of her needs, so she had to prioritise. This lack of service was common among the majority of women, as such, they had to prioritise one need over another, a choice that didn't always come easy as Gina explains:

...yaknow it's that sort of chicken and egg erm, scenario for me... (Gina)

Kat also said that it wasn't a choice she wanted to make, but had to make for the sake of her safety:

I think particularly in the early days, my focus really had to be stopping drinking even more than, getting over [ex-partner] and what he had done because I knew that if my abstinence from alcohol didn't come first, I would end up very possibly drifting back again because it had happened before. So, I had to sort of almost in the first weeks, I had to prioritise that over dealing with the hurt and the pain, yaknow. (Kat)

However, unlike Kat, Gina and Holly, some women prioritised their substance use needs by choice. Although they recognised their experiences of domestic abuse, the

absence of the abusive partner was enough for Elaine and Khloe to focus on abstinence and recovery:

My objective was to get off drugs, that was that was the primary focus for me.
(Elaine)

Focus always on the drugs em...(Khloe)

Lydia similarly chooses to focus on her substance use however, she also shares that she is not ready to deal with her experiences of abuse yet:

I will do when I'm ready, I'm just not ready yet I've got my, I've got enough shit (chuckles) to deal with apart from that... (Lydia)

The experiences of the majority of the women in this study highlights a definite disconnect between the support that is available and their actual need. Despite the disconnect and the barriers the women were met with they did engage with various services. The next section will highlight the women's experiences with various support types illustrating what worked and didn't work in their recovery journey.

Chapter 17

Findings

Experiences of Support and Service Provision

17.1 Accessing Support

Despite the barriers to engagement with support, all of the women in this study have engaged in at least one type of support; either in the past or, they were in the process of receiving support at the time of the interview. This support appeared in different forms, from formal service engagement with substance use services and domestic abuse agencies, to statutory support such as social work involvement and police, to more informal support such as friends, family and peers. The various support options were not siloed either. For many women, peer-support proved to be an invaluable part of the overall support they received in the various drug and alcohol services. Engagement with more than one support type was also common as each woman accessed between two and eight support types (not including peer support, family or friends) up to the point of interview. A total of 66 support types were mentioned by the 12 women over the course of the interviews.

For some women, a desire to engage led to them accessing support without any barriers, as Kim and Laura explain:

I kind of avoided services until I really needed the help, and then I had opened me arms to them...(Kim)

Everything. They got me in touch with all these, in [place] for the drug and alcohol which I went to. (Laura)

Similarly, Khloe had continuous access to support during her six-year cycle of engagement and disengagement:

...living in that hostel you always had access to the drug workers because there were always people in there in treatment, so it wasn't as if and she left the door open yaknow... (Khloe)

...it hadn't been difficult for me to get back into treatment... (Khloe)

Like Khloe, Lydia has constantly had access to support when she wanted it. At her current service, Lydia admitted that support is available to her, but she struggles to fully engage:

...there is a lot of support here though they do, they do support you a lot, if you need it, but you have to ask... (Lydia)

All of the women accessed at least two support types up to the point of interview. For some, support had a positive impact on the women's substance use and domestic abuse and for others, accessing support was a revolving door of engagement and disengagement. However, a fundamental part of their access to support was the role of a worker.

17.2 Experience of Workers

As the pen portraits illustrate, nearly all of the women were engaged with a social worker and/or a support worker at some stage of their lives. The majority of the women were engaged with both social work and support work and identified a distinct difference between the two. Support workers were favoured among the women because of the non-judgemental approach the support workers took with the women. Social workers however, were spoken about with mistrust due to the role they played.

17.2.1 Social Workers

Fear of losing children played a role in women's access to support. As such, social workers were not trusted by the women who were engaged with them. Eight women

were engaged with social workers at some point of their lives. Social workers were in some of the women's lives from a young age, due to their adverse childhood experiences, however, this involvement subsided when they turned eighteen. The majority of the women had a social worker as children and reengaged with them as adults because they were mothers with complex needs. As Laura explains:

...with having mental health problems as well yaknow, they're [social work] on ya like a tonne of shit, I tell ya honestly... (Laura)

There were mixed feelings about social workers too. For example, Lydia was engaged with social workers as a child while she was in and out of foster care. She said that they did not give her enough support when she left foster care. Similarly, Kim viewed social workers as a threat when she was a young person:

Some [children] may go down the right path, others, are more damaged then they'd let on, because they see social workers as a threat, so why am I gonna tell you what really going on in my head. (Kim)

Other women demonstrated a major dislike for social workers because of their experiences as adults. Dani had constant involvement with social workers during her substance use, but was unhappy with the support she received because of the individualistic approach to support:

...yaknow like you get social workers that'd come in to help the kids to like say the kids got issues at school right, and then, that social worker will come in and probably work with that kid for like so many week, not even say to the mum 'do you need help, what's going on in your life' d'yaknow, because it's well, it usually is true d'yaknow what I mean what's going on in the whole household or like, like you'll have one kid that's like really really quiet that don't speak or anything, d'yaknow just get involved in the whole family, not just one person. (Dani)

Although Dani did not lose custody of her children during her experiences of substance use, domestic abuse, prostitution or imprisonment, she expressed hate towards the profession because she felt stigmatised by them:

I think social workers are full of shit. I really fucking don't like them. Ya might, ya might get the odd genuine one right, and then when you do they're probably in that job for about four week d'yaknow what I mean, and you're lucky to, they don't answer the phone, they don't turn, they don't, say like people are waiting here for an appointment with the social worker, they don't turn up, and they don't let you know they're not turning up, now if it were the other way around it'd cause murder wouldn't it and that but erm, they're so judgemental as well, they judge ya social workers I think. (Dani)

Negative judgement from social workers was a feeling shared by Kim. Both women believe that the approach of their social workers took, and the negative judgement they felt, impacted on their willingness to engage fully:

...the way social services come into your life, get involved, I think they could change that slightly. I think if they go in with that erm I'm better than you and I'm the boss and this is what's gonna happen attitude, we're people with an addiction, they're gonna close off to that, they're not gonna let you in. [...] They need to, kind of, not just barge in and go, this is what's happened and this is what's going to happen because of it, d'yaknow what I mean... (Kim)

...and that's why women won't go to, yaknow when they say right ring up, and when they do ring up and say right I've got this and that going on and all that, they end up then getting put on a care order or sommit slapped on them. (Dani)

The age of the social worker also had an impact on how Kim and Michelle engaged

with their social workers. The judgement Kim felt was partly because her social worker was young:

...and I had one social worker who I really didn't have a good experience with, she was just, she was about, at this time I was 26, she was about 20, she must have just qualified, and she's looking down her nose at me like I am the absolute hulk or the, just a horrid person... (Kim)

I don't I think the younger woman, she had no idea, she was very judgemental, she came in with that professional head on her, like you're very wrong, you're in the wrong [...], this is what's happening, telling, dictating. (Kim)

Whereas the age of a social work trainee negatively impacted on Michelle's willingness to engage at her current residential service:

...the fact that, there's a couple of students that work there [residential support for substance use], who are younger than me, who think they're something, eh [...] I thinking they better not put me with one of them students yaknow, I thought I'm older than them yaknow what I mean I don't want the social worker not a chance. (Michelle)

The approach of the social workers, as perceived by Kim, Dani and Michelle impacted on their willingness to fully engage with support. The women felt judged, particularly because of the age difference, and the judgement they felt impacted on the trust they had with their social workers.

However, for Michelle, hindsight has had an impact on her understanding of the social work role. This hindsight also coincides with her abstinence:

...a lot of things what stopped me from [keeping her children] was me past because it's happened, I'd already lost 3 children, so they thought I was

vulnerable, and I'll just fall into another failed relationship yaknow cause of all me past, which made sense looking at it now, cause it was just like that circle weren't it, d'ya know what I mean they give me that second chance and, I fucked up worse or, it was like for the best d'ya know what I mean. Eh, but I've only started thinking that now while I was sober cause when I was drinking it was like they're all wankers all social services yaknow they've done this, they've done that and just, I don't wanna be here tryna kill myself yaknow just, I wanted to be dead and everything. (Michelle)

Both Michelle and Kim speak about their experiences with social workers in detail unlike Laura, Gina and Holly who were also involved with social workers at some point in their adult lives. Compared to Michelle and Kim, the experiences of social work practice for Gina and Holly were minimal. Gina believes this is because she kept her substance use quiet whereas Holly believes social workers were not interested in supporting her.

For the eight women engaged with social workers, their experiences differed. Some women had a negative view because of their childhood experiences with specific social workers, and some women were unhappy with the social work profession because of their experiences as adults. Despite their negative experiences expressed towards social workers, hindsight and abstinence impacted Kim and Michelle's opinions, as they explained that they now understand why social workers got involved in their lives and took away their children.

Because of the negative experiences of social workers, the profession was compared by most of the women to support workers as Dani illustrates:

They got a lot of stigma social workers haven't they, like erm, that's why a lot of people don't like them cause they're hard work, they are hard work and they take that many caseloads on, they don't know who they're dealing with d'yaknow what I mean, it's like, so they'll come in and it's like, women with

kids and that are scared to talk to them, if you get now, if you get a support worker that's a different ballgame, brilliant and you get a good one that's genuine and is like, don't just do the yaknow do the talk. (Dani)

The comparison between the two support types highlighted support workers as a favourite because of the approach they took with the women.

17.2.2 Support Workers

Six of the women specifically spoke about a support worker who had a positive effect on their overall support. Support workers were those who supported women engaged in a service such as Khloe's drug and alcohol service, Michelle and Lydia's various residential services, Gina's domestic abuse outreach service, Kat's substance use service and separate refuge service and, Kim and Dani's different family support services.

The women had various experiences with their workers and they were engaged for different reasons however, they all spoke about their engagement with positivity. For example, Khloe speaks about her support worker as being the central part of her treatment:

I can only really describe treatment as [name of worker]. (Khloe)

...so yeah it was pretty much [name of worker] on her own...(Khloe)

Like Khloe, a number of women talk about the impact a specific worker had on their motivation to change. Although the women were already engaged with support, the role of the worker empowered them even more. Gina explained how her support worker helped her to speak out about her substance use and domestic abuse experiences:

I think I'd gone for some counselling with an (D.V) worker, and had to disclose my drug use then erm, so I did, and she was like just really cool about it...(Gina)

Em, the support worker that I had, at the time erm, she was quite wise I think she herself had experience [of substance use or domestic abuse] em. [...] Because she just nailed me, she was like, she was like, she was yaknow you're using and erm, yaknow she knows, and she said that 'I know you just want this guy to change and if he stops doing what he was doing than everything would be alright em', so yeah. But erm, (pause) but yeah, she was like, she was really cool em... (Gina)

Similarly, the encouragement from Kim's support worker to speak out about her domestic abuse, helped Kim get access to her daughter again:

...and she said to me, she said 'I think you're lying', she said 'for some reason, I think you're lying' she said 'is that what really happened?' and she kept on at me, kept on at me and I thought I can't tell her cause they will take her [daughter] off us both, this is what he'd [partner] drilled in me, because that's what he was about, he got his own way and that's the way it was em. And she ended up finding out and she said, 'I know you're lying' she said, 'tell me the truth and things will change I promise ya' so I told her the truth... (Kim)

...she kind of took over the one [support worker] who was lovely, and I loved it, I've never forget her, the experience I had with her. (Kim)

Lou's support worker also helped her to access a residential rehabilitation service, which paved the way for Lou's abstinence:

...I couldn't decide so she helped me pick one erm, yaknow she knew about my attitudes and behaviour...(Lou)

For Dani, it was the practical elements of support that helped her make a change thanks to her support worker. She also appreciated the whole family approach the worker used:

...she done some work with every one of my kids as well, and it made a massive difference, just to do that, I mean she took me to the detox and all that and it was about me, but she was a family [worker]...(Dani)

The role of the support workers had an impact on each woman in varying ways. For some women, their support worker helped them achieve abstinence. For others, their support worker also helped them speak out and use their voice. The support worker was the catalyst for women to take the next step and make a change in their substance use and domestic abuse. The impact the support workers had, was influenced by the approach they used with the women. Unlike the descriptions of social work, the women described their various support workers with fondness because they were non-judgemental as Khloe explained:

I liked her as well, I liked her, she was a nice woman, and she clearly, well, again, knowing now what I didn't really know then, erm, she just there wasn't any judgement there, it was about, look this is how it is, there is treatment available, you don't have to, you'll have to come in to see the doctor at some point, but we can be flexible... (Khloe)

The down to earth attitude of the support worker also impacted on Kim's engagement with services. She explained that she got on with her support worker because she felt listened to:

...yaknow that woman [support worker] was just very natural, very congruent with me and she was just, I got a real sense of, she is being real with me, she's not bothered she's not got this erm, I'm a professional head on, you're a minor like alcoholic, ya mean nothing, ya don't have a say, she wasn't like

that, she listened to me, erm, and she made me feel like, important as well, that I, that I did matter yaknow and that erm, she was there to help and to do the best for my daughter... (Kim)

Lou was also influenced by the faith her support worker had on her:

She [support worker] got me, she believed in me. She really gave me hope, that there was a way out of this, erm, and yeah, I felt like she was, there was, some part of her that understood, erm, and I just felt for such a long time that it'd be through relationships or friendships that I'd just been totally misunderstood, yaknow. (Lou)

As their experiences with support workers show, the women had very different experiences between social workers and support workers because of the perceived differing approaches the professions took. The approaches appeared to have an impact on the women's willingness to engage further with support. The impact that domestic abuse support workers had on some of the women, was also spoken about throughout the interviews.

17.3 Domestic Abuse Support

Half of the women sought support for domestic abuse at some point in their lives. As Michelle and Laura's experiences show, their engagement with domestic abuse support was short-lived. For Laura, her involvement with refuge had an impact on her first engagement with recovery:

And it was through the domestic violence, they got me in touch with like alcoholics anonymous and yaknow for heroin for the methadone, and sleepers, barbiturates, I got addicted to as well...(Laura)

Eh yeah, they put me, that's how I got to be put on methadone, it was through them. (Laura)

Although Laura's engagement with refuge was over 30 years ago, it was the catalyst that began her abstinence from heroin. Holly's placement with refuge also helped with her engagement in substance use support:

...so, I went to the refuge, and, automatically overnight everything changed, their attitude towards me. I got the community alcohol team being sympathetic and being nice to me... (Holly)

Like Holly, Gina's involvement with a domestic abuse course had a massive impact on her life and her understanding of domestic abuse:

...it was recommended that I do [a domestic abuse course], so I went and erm, I did the programme in a children's centre and the first session I was like wow, I need to like, I need to do this and tell other women about it and erm, so I asked, I got in touch with the, the founder of the course, and they said well you've not done it yet so come back to me in 12 weeks-time so the erm, so I did and erm, I trained like I did there training course and then I started delivering it... (Gina)

Like Gina, Kat also speaks positively about the support she has received from her domestic abuse service, describing the refuge as lifesaving:

I mean of course the refuge erm, yaknow they gave me somewhere safe and they, and you can't put a price on that when you come from somewhere where you're so scared all the time just to be feel safe, is just so so precious. (Kat)

Jo's experience of domestic abuse support differs to the other women however:

...and I said 'I've left my husband domestic violence' and erm, they were having none of it, even though like the kids, we sat in there all day and

eventually they put us in a guest house and they, they put us in the guesthouse but we had to leave we weren't allowed to eat there, we had to leave after a certain time and had to be in before a certain time so that the other guests in this guesthouse didn't see us, em... (Jo)

Domestic abuse support was not a priority among most of the women. Their choice to engage with drug and alcohol services is connected to their specific needs at the time of engagement. For most women, their need to recover from substance use was greater than their domestic abuse needs. One way some of the women chose to get help for their substance use, was through twelve-step programmes.

17.4 Twelve-step Programmes

During the interviews, eight women spoke about their involvement with twelve-step programmes, specifically alcoholics anonymous, narcotics anonymous and cocaine anonymous. Four of the women (Gina, Kim, Elaine and Lou) spoke positively about their experiences, owing their recovery and the role of peer support, to the twelve-step movement. However, Khloe, Holly and Jo did not agree with the movement and highlighted flaws in the twelve-step programme. Lydia explained that she had to attend meetings as part of her house contract, particularly since she relapsed, however, her interview suggested she was not fully committed to the twelve-step programme.

Gina's involvement with narcotics anonymous was accidental. She explained that she went to a meeting by sheer fluke, however, this accidental involvement was identified as a significant moment for Gina because it helped her speak out about her drug use for the first time:

I just started sharing and it was like, before I knew it I was just like telling erm, getting a lot off my chest and it was like, wow, and then I ended up going to the meetings then quite regularly. (Gina)

Being able to use her voice and speak out about her drug use had a powerful impact on Gina, especially because she has never attended any drug services. Her NA/AA involvement was the main support she had in her recovery from drug use and was bolstered by the feeling of acceptance she felt at the meetings:

And I found that erm, quite powerful in terms of like the AA and NA meetings just being able to say yeah, I am doing drugs, or I do do them or I have done them... (Gina)

If there could sort of be like a model of like acceptance erm, then that would be it em. Of how accepted I felt after divulging that information, erm, then yeah em. That would be it. (Gina)

The feelings of acceptance shared by Gina, were also identified by Kim. Although she 'bobbed in and out of AA' for many years, Kim's prior experiences of the programme aided her decision to access support permanently. She chose a residential rehabilitation service that utilised the twelve-step programme because of the shared identity of those within the group:

...when I went into treatment and they introduced me to NA, I'd really found where I lived, I lived there d'yaknow what I mean, I was, they're addicts, addicts not alcoholics, and I'm an addict. (Kim)

Like Gina, Kim's ability to speak openly and honestly about her experiences in a non-judgemental environment, impacted on her continuous involvement with NA and AA:

Who, when I tell them anything about my past they're not shocked one bit, because they've done it, they've been there and done it, it might be slightly different, but they've done it. (Kim)

Kim's experiences with the twelve-steps also mirror Elaine's experiences. Her initial encounter with the programme, highlighted a shared identity with the other group members:

I was kind of resistant for a couple of weeks but then I went along with him [a friend] erm, and I identified loads with everybody so I've, I had full acceptance then that I was an addict. (Elaine)

Despite disengaging with the programme and reengaging with drug use, Elaine was motivated to return to the programme when she was at a point of readiness. Like Gina and Kim, Elaine's identification with the other programme users, impacted on her returning to the group weekly. However, unlike Elaine and Gina, Jo could not identify with those in AA and so decided not to engage further, despite a desire to change her drinking:

So I went and I did that for four days and on the fourth day I thought, these are all nutters and I am definitely not an alcoholic... (Jo)

Jo's ability to identify with other group members, was impacted by the extreme cases she found when she attended AA. She felt she was not like the other members because her alcohol use did not impact her day-to-day activities:

I am an alcoholic because I'm drinking every[day], and I've got a problem with alcohol so that is an alcoholic, but I'm not as severe as them [AA members] [...] and some of the things that yaknow the stories that ya hear at these AA's, it's just think makes ya think, it's a bit similar to erm, domestic violence erm, this is, me issue with domestic violence is, you read these stories you see these stories and they're all the, extremes. (Jo)

Elaine also spoke about the benefits of NA more broadly and believes that NA is not just about abstinence, but about an overall lifestyle change:

Em, it's not, a misconception that people have is that it's there to help you get off drugs, that's a tiny tiny part of it, it's to help you become a better person. (Elaine)

Lou also spoke about the twelve-steps as being more than abstinence:

Well the fact is the twelve-steps helps ya work on yourself so, yaknow... (Lou)

Lou's involvement with NA and CA had an impact on her mental well-being also, as she explained how the twelve-step tools help her in her day to day life:

I've got a head that when I wake up of a morning tells me I'm shit and I'm worthless, excuse my language, but that's what my head does, d'yaknow. And the, yaknow I can get resentful really quick and things can manifest inside really quick yaknow. I just believe that's me as an addict yaknow erm, I can start avoiding it in sex and whether it be porn and buying clothes and [...] trying to fix the outside rather than fix the inside, the twelve-steps of narcotics anonymous erm, give me tools to help me be rid of them resentments, yaknow, erm, making amends, with people yaknow because that type of stuff keeps ya sick. (Lou)

Kim also said that the twelve-step programme helped her day to day. However, a key tool for Kim, is her 'higher power':

I think yaknow for me my higher power, cause I have a higher power that helps me on my journey, helped me along the way and yaknow I had real faith and inspiration and just thought yaknow I'm gonna do it, yaknow and I did it... (Kim)

Kim was the only woman engaged in the fellowship to discuss the concept of a higher power. Gina, Elaine and Lou, although positive about the role of the twelve-step

programme in their lives, did not refer to a higher power once during their interviews. However, Kim was vocal about the place her higher power had in her day to day life:

It is an energy, it's an energy of certain things. It's a positive energy, it's the, it's the good wolf that speaks on my shoulder not the bad wolf, yaknow I've got an addiction in my head that wants me dead, it wants me dead, and it will have me dead if I allow it, erm, the good part of me is that kindness, and yaknow it's, I look at it as it is a thing, it's a, it's a thing, it's bigger it's powerful, it's more, it's something bigger than me, it's that stuff that makes miracles happen erm, it's yeah it's god, it's god but I don't know what god is consisted of, it's an energy and it's, it can speak through people, it can give you intuition and inspiration and I could hear my higher power speak through someone else and think, o my god I needed to hear that, right now, so, it's just, it's a thing, it's a thing that really looks after me, and everybody's got one, they just don't know they've got one, the ones that know that, and believe in that stuff, they've, they are aware of it the ones that don't are the ones that are closed off from themselves a little bit, d'yaknow what I mean. (Kim)

Kim's faith in a higher power, feeds into the role of control and agency in recovery. Kim was self-motivated and ready engage in support for her drug use however, she appears to owe her ongoing recovery and abstinence to her higher power. This is a concept that Khloe fundamentally disagrees with and was the reason she did not continue to engage with a twelve-step programme:

...what I understood was there was only ever erm, it was all about NA and AA and CA it was like yeah yeah you need to go to this group [own name] because people succeed and it's all about abstinence and I went, to lots and lots of meetings and, I I'm not powerless, I'm not powerless, erm I have to make choices that protect myself, my family erm, so to say that I am powerless and more importantly to trust some other fucker, or thing with my recovery and my life isn't an option for me, it isn't, em... (Khloe)

Khloe takes complete control over her recovery and the choices she made to recover. Being in control was a consistent theme within Khloe's interviews, as she takes responsibility for the choices she made in using substances also. Khloe's experiences of recovery were also influenced by her independence. Although she speaks about her drugs worker and her eventual engagement in peer support, she does not speak about the impact family or friends had on her recovery unlike the majority of the women.

17.5 Friends and Peer Support

During the interviews the majority of the women spoke about the impact friends and peer support had on their overall support and recovery. For Lou and Elaine, friendship appeared to have an impact on their engagement with support. Lou explains that her friend instigated her support by taking her to a support worker:

...the night before I went, I reached out, the night before my friend came and said to me 'I'm gonna take ya to see this key worker yaknow, she said 'look do ya want some help' and I said 'yeah, I'm really desperate'. (Lou)

Kat also owes her engagement with substance use support to her friend:

If I, if I hadn't had support from say my friend and that, I don't know what would have happened. (Kat)

Elaine's friend gave her an ultimatum that pushed Elaine to make a change and engage in support:

...and then it was when my very last friend said, 'if you don't leave him now, you and me are done', and I don't know, I think that was kinda like the straw that broke the camel's back and I thought 'this is it I've gotta go now'. (Elaine)

Whereas Kim speaks about her friend as supporting her all the way through treatment:

I used quite heavily with her erm, but, she can stop I can't, and when I went into treatment she was with me til the end that one that girl, and she helped me so much erm, and when I got clean she knew what I was going for, she understands me addiction. (Kim)

Friendship through treatment and, as a result of treatment was a significant topic for Michelle. As the pen portraits highlight, Michelle and Laura met in hospital and Laura influenced Michelle to engage with substance use support after some 'harsh words'. But even in treatment Laura has motivated and supported Michelle through her recovery. During the interview Michelle spoke about Laura with love:

Believe it or not, Laura. Yeah. She's just one of them people that you can warm to d'ya know what I mean. And she doesn't judge ya and, yaknow like, say if I had a problem with, a good problem which I know it could get me into trouble or I've done someit wrong and I wanna, I want to tell staff but they might be mad or blame me, I know that if I tell Laura she'll just tell me straight, d'ya know what I mean. (Michelle)

Laura also talks about the importance of friendship in recovery, however she does not speak about Michelle specifically but rather, her friendship group as a whole:

I feel safe. Nobody cares whether you got 2 heads 3 heads or no head at all. Honestly, d'ya know what I mean, they accept you for who you are. We've all got troubles, cause otherwise we wouldn't be here, right. And I know what true friendship is now yaknow what I mean and. So that's it, and I love it. (Laura)

Before Michelle and Laura were friends, they were peers in hospital. Peer support was an important topic for many of the women, because peer support had a positive impact on their recovery. For some women, peer support was about a shared identity with others. Khloe speaks about this shared identity when explaining why she still organises a weekly walk for people in recovery despite no longer being engaged in formal support herself:

I'll never move completely away because of my heart is always with the people who are either still struggling or, trying to find some way whatever it is, to overcome whatever it is they think they can't, erm and that's yaknow, I am with those people cause I'm one of them, and I think we all are actually, I think we all are. It's just that we don't really see the similarities, it's not all about drugs, it can be so many different things that we need to recover from...
(Khloe)

Kat's shared identity with those in her drug and alcohol service has also impacted on her engagement with the service:

...when you come off alcohol from the way I was drinking, [...] the early sort of physical withdrawals can be quite bad, you don't [...] always feel comfortable being around people who don't understand how you are feeling either. So, to me being around recovery people in recovery sort of seemed, I felt I had more, could relate to people in recovery more than the women in the refuge in a way. (Kat)

Kat was passionate about the role peer support has in recovery. She believes, peer support is an important part of the recovery process and thinks it is just as beneficial as professional support:

...but through the peer support the sort of the community-based peer support the groups, friends, yaknow human contact just, connecting with people. erm,

sharing yes, I've been able to share my experiences I've felt supported, it's not always even that you need 1-1 sort of work from a professional, a trained counsellor or someone, it's just connecting with people who, and yes of course you do come across with other women who've had similar experiences. So, to me that has been the key, that yaknow has changed has, has changed things for me I think. (Kat)

Laura's involvement with the recovery centre and the impact of peer support has also impacted on her continuous engagement with support:

I've just changed, yaknow what I mean I like the people here, eh I do, I come every day and, it just went from that. (Laura)

Peer support has had an impact on many of the women in this study. The shared identity with those accessing twelve-step programmes or drug and alcohol services has impacted on their continuous engagement with support and recovery. As Michelle demonstrated, the role of friendship and peer support had an impact on her decision to engage fully with drug and alcohol support, while Laura continues to return to the service because of the acceptance she feels.

As this chapter demonstrates so far, the women engaged with multiple support types throughout their experiences of substance use, domestic abuse and recovery. Their support engagement extended beyond domestic abuse agencies and drug and alcohol services. And the people they encountered in support, including social workers, support workers and peers, had an impact on their continuous engagement and recovery. For 10 of the 12 women, their most recent engagement with support resulted in a positive outcome. Nearly all of the women were substance free (Gina and Kim were drug-free but occasionally drank) and no longer living with domestic abuse. However, despite the positive outcomes, the impact of support varied for all women.

Chapter 18

Findings

Impact of Support and Service Provision

Engaging in support highlighted a variety of experiences among the 12 women in this study. Their interviews demonstrated gaps in support, barriers to support, and the effectiveness of support. As Kat and Holly have already explained, engagement with domestic abuse agencies saved them. While, Dani and Khloe spoke about the impact their support workers had on their engagement with drug services. And the support of peers was found to have a positive impact for many of the women, including Laura and Michelle. The support of peers was also impacted by the feelings of acceptance and understanding as demonstrated by Elaine, Lou and Kim, through their involvement with twelve-step programmes. The woman's varied experiences with support effected a multitude of outcomes.

Because of their engagement with support and subsequent recovery, many of the women spoke positively about their current sense of self. Laura explains that her recovery for drug and alcohol use as well as her engagement with her recovery service has given her piece of mind:

Yaknow, erm, got piece of mind now. Eh, with this place [Recovery centre] yaknow I have got... (Laura)

...that's what I've done. I've changed everything I've come every day and every day I love it... (Laura)

Michelle also speaks about the same recovery centre and the impact it has had on her life since becoming abstinent:

I feel comfortable here, so I'd rather catch two buses rather than none... (Michelle)

The support both Laura and Michelle have received at their recovery centre, as well as the support they receive from each other, has impacted on their recovery and prompted them to return to the service daily. However, Michelle also speaks about the impact breathalysing has at her residential service:

...I'll go in and say can I have a breath test, just even yaknow cause I don't have a drink I just want to see that naught. That motivates me in my recovery that. (Michelle)

Like Michelle, Lydia was also engaged with a residential service at the time of the interview, however both women were at different stages of their recovery. Despite Lydia's recent relapse and the conflict in her desire to change, she explained that the service has had a positive impact on her sense of self:

...I'm more confident and, I've, I have grown a lot, I've grown up a lot as well, cause my temper used to get the better of me and I've been in that many situations past few month where, me tempers not got the better of me. (Lydia)

Confidence was a common theme for many of the women following support. Holly explained that her twelve-month stay at a domestic abuse refuge had a big impact on her confidence:

Well I'm a lot a lot more confident and, I don't put up with shit anymore (laughs). (Holly)

Dani describes how her three-week stay in detox, encouraged by her family support worker, impacted on her view of life. Referring to her sense of self following detox she said:

...and when I come out erm, fucking hell I must have taken my rose-tinted glasses off cause, I've like thought, what the fuck... (Dani)

The women's involvement in support has demonstrated a more comfortable and confident sense of self. This confidence also motivated many women to volunteer as Dani shares:

I started doing voluntary here for [service] in January and erm, it's like I've changed again, d'yaknow what I mean... (Dani)

18.1 Volunteering

Following support, eight of the women began volunteering. The majority began volunteering with the same drug and alcohol service that supported them in their recovery. Many of the women spoke about the impact volunteering continued to have on their recovery and on their sense of self. For Khloe, being invited to volunteer and being trusted with responsibility had a big impact on her sense of self:

Em, so, that was partly what changed things for me being given some responsibility but it all feeds into the politics of this place [recovery service] as well... (Khloe)

Now, it is [possible to get a job], cause it has been and, and not only in drug treatment either, it was kind of, I got it there because there's an expectation that if you believe people can recover surely you should be investing to a certain extent in, in people's long term recovery, employ them, give them a job, so I kind of thought 'O well yeah but they kind of have to do that', but moving from drug treatment into another support service where I work [...] it's a really big thing for me to understand that actually you can overcome all that stuff and then you can stand up on your own two feet with your references, your qualifications, and your background and the work that you've put in and people accept you. (Khloe)

Like Khloe, Kat's involvement as a volunteer continues to help her in her recovery. She believes volunteering has helped her self-esteem and given her some purpose for the future:

Yeah and it's of course it's the desire to help but it's rebuilding yourself as well and it gives, it's a sense of purpose, that it gives you, yaknow I'm not just looking back of years of yaknow abuse and drinking, I'm looking forward to contributing and feeling erm valued and, yaknow, it's just your self-esteem it's just a huge huge issue. (Kat)

Volunteering has also impacted on Laura's day-to-day abstinence. She explains that although she is a group leader, she is still learning about herself through other group members:

And listening to different stories how they cope with it and how they do, ya might not think you know but it's just steps and learning cause you're never too old to learn yaknow what I mean... (Laura)

Laura's philosophy was also shared by Dani, who has decided to continue to volunteer and engage with a counselling course:

...I'm just going to stay as I am, keep training, keep getting an education, cause you're never too old to learn yaknow what I mean and that so. Fucking hell, if I knew all this d'yaknow what I mean, but it doesn't work like that does it, so. (Dani)

Volunteering as a domestic abuse group facilitator has also had a big impact on Gina. Gina's voice helped her to access recovery however, she explained that continuing to speak about her experiences as a volunteer helps her ongoing sense of self while also helping other women:

I'm finding that talking yaknow, just talking about it and me being, cause I was like quite well known in my community like through my family and through, I was just wild, I was just partying all the time, erm, making it okay for other women to talk about it and [...] removing that sort of shame...[...]...because I think that's what, what needs to be done to sort of like, make it alright for other women erm to talk about it yaknow just me putting myself out there and saying well look this is what, what's occurred to me...[...]... so all that embarrassment and shame that I felt of being like someone who used, misused substances and erm, been through dv it's, I just gotta push through that uncomfortability yeah... (Gina)

Gina speaks about volunteering as a way of using her experiences to help other women. A reason many women also decided to take part in this research. Elaine's faith in the twelve-steps motivated her to engage with the interview because she wanted her experiences to help other women:

...so obviously I see this as a way of helping other women... (Elaine)

Holly also wanted to use her story to help others affected by domestic abuse and substance use:

Because I've had some very horrid horrible experiences over the years and I want to make sure it doesn't happen again, to people. (Holly)

Along with volunteering, Kim has used her experiences of substance use and domestic abuse to inform the police:

And I ended up going doing a speech erm for the commissioners of the police through that course, they asked me to go and do a chat because I was domestic violence and substance misuse... (Kim)

She has also travelled with her fellowship to talk about her experiences of substance use.

Laura continues to volunteer in her local drug and alcohol service because she believes she has an experience that is unique to those who work in the service:

...they try to blag me all the stories and it's like it won't work because, [worker] and then they think, ah they're belting it but, they've only learnt from books, they don't know all the cons and the (chuckles) yaknow, I've been the other side yaknow where I know, when they're pulling the leg saying I've not used today and they're sat there and their eyes are pinged out yaknow what I mean like (chuckles) yaknow. (Laura)

However, despite the positive impact support has had on the women and the role volunteering had played on their confidence and sense of self, a number of the women do not believe they have recovered.

18.2. Ongoing Recovery

None of the women spoke about being at an endpoint in their recovery. Despite expressions of positivity from nearly all of the women, a conflict was also identified as many of the women spoke about their ongoing recovery. With the exception of Lydia, who had recently engaged with a substance use service, and Jo, who was still drinking problematically; the remaining 10 women all spoke about their current sense of self in a way that identified they were not fully 'recovered'.

Many of the women spoke about their learning as an important process in their ongoing recovery. Laura's engagement with support has had an impact on her substance use and mental ill-health however, she explains that she is still learning how to cope with her feelings:

Because but I'm learning now, when I'm depressed, because the first thing I want to do is cut, so I have got to the doctors, I have cut I've done it, then gone for help. [...] So, I'm just trying to learn. (Laura)

Gina also talks about her current self as trying to learn and understand her experiences:

...I suppose I'm just attempting to understand it more really because it's like, I realise [...] how it really impacted my life...(Gina)

...cause sometimes it is still uncomfortable yaknow the stuff that I remember and so on... (Gina)

Like Gina, Kim also talked about the continuous learning process she is currently experiencing in the early part of her recovery:

I'm only earlyish in recovery I think so myself em... (Kim)

I'm in the process of dealing with my consequences continuously with my sponsor and I have a counsellor, I'm having therapy on it at the moment, quite deep therapy. I'm having some TA so it's kind of, it's a continuous learning and progression for me erm, so I grieve that time on my own yaknow... (Kim)

Still living in refuge Kat explains that she is still in the process of rebuilding herself following her experiences:

Again, with both domestic violence and substance misuse, no one comes yaknow breezing in brimming of confidence in one of those situations, yaknow you sort of scrape yourself off the floor you know. So, it's all that rebuilding of yourself... (Kat)

Elaine and Lou also viewed their recovery as an ongoing process of understanding and learning:

...which is what I'm getting from it yaknow ya do a lot of work on yourself, cause I didn't know myself at all, let alone like myself erm, so it's helped me sort of erm, get to know myself a bit better I suppose and it's a long ongoing process em...(Elaine)

I've been doing a bit of work with it [her trauma] outside here lately... [...] ... erm, yeah, I'm still working on it and it's kind of, it's just around my brother erm, it's around my step work and my programme erm, so yeah. It's around resentments and yaknow, writing my resentments down yaknow and getting them out. (Lou)

Like these women, Michelle also demonstrated that she was still dealing with her experiences of domestic abuse and substance use, particularly the effects of losing her children. Although she describes this learning with a positive tone during the interview, she also appeared to be vulnerable in her learning:

Just cause I'm still suffering after the aftermath yaknow what I mean. (Michelle)

And now I think why, d'ya know what I mean. Cause obviously I cry every night when I'm at home and what have ya, and things like that then go through my head. But I can't turn the clock back. (Michelle)

Michelle was also at a point of change in her accommodation at the time of the interview. She expressed her fear in leaving this accommodation and looked forward with worry:

But I'm scared, I tell ya what I'm scared of, I'm scared of when I move out of [residential service]. (Michelle)

The impact of support demonstrated a variety of experiences as illustrated by all of the women in this study. For the majority, despite recovery from substance use, they identified their recovery journey as ongoing and were comfortable with this feeling. Volunteering further amplified their learning and their sense of self. Finding their voice played an important role in their journey through recovery and subsequently impacted on their engagement with the interview.

18.3 Improving Support

Towards the end of the interviews, the women were asked ‘was there anything that could have been done to support you sooner?’ The conversation varied based on each woman’s experience. Some felt there was nothing that services could have done for them sooner because, as previously highlighted, they had to be ready to engage with support. However, some women also gave tips about how services could better be improved to meet their own needs. Their recommendations were:

18.3.1 Understanding

Some of the women discussed the need for staff and service providers to have a better understanding of co-occurring substance use and domestic abuse and Kat says:

I think it’s absolutely essential that organisations who work with women, in violent relationships, have, a much better and deeper understanding what it is like to live with a substance misuse problem, erm, and how best to support women, (pause). (Kat)

Jo felt that people judged her and did not understand domestic abuse:

...the weirdest thing is when I tell people that I run a domestic violence group and I do all this campaigning that I’m still living with me husband and they go, why. And I think, don’t ask me why, don’t make me feel, bad. (Jo)

While Dani felt that understanding the complexity was important however, it was essential that those working in services showed compassion too:

So, I think it's just like being passionate, well compassionate and stuff like that. (Dani)

Michelle spoke about a lack of understanding from the from the council:

Eh. No just the council. Yeah cause they could have put me eh. Cause they knew what was going on with domestic violence, so they could have put me some extra locks on, yaknow on my windows and that. Eh. And, yeah. [...]. It's just the council yaknow what I mean, nosing in my business and just, they knew how scared I, how scared I were and it was like they didn't give a shit. And then when the windows had got put through, off their dad and they're bloody charging me for it, even though they know bloody dam well. (Michelle)

18.3.2 Communication

Some of the women also spoke about the need for better communication. Khloe explained how more could be done to communicate service availability:

...we talk an awful lot about how, there are professional organisations there to approach, there are support services there for people, but it tends only to be in retrospect, that you understand that, erm [...] That's not to say they're going to act on it but yeah. (Khloe)

Kim felt social workers would benefit from some training in counselling to improve their communication skills:

...they [social workers] should do counselling skills, they should I think every social worker should do some form of counselling skills to see that body

language and that, what they, yaknow openness about them, they need to be there. (Kim)

While Dani and Laura spoke about the importance of listening and showing empathy in services:

...if you got someone [social worker] to just like give them that bit more guidance and that and show some yaknow like empathy and that. (Dani)

Listen. Listen. When people talk to ya and they say they're alright look deeper and listen. (Laura)

And listen, that's massive, listen. (Dani)

18.4 Summary of the Findings

The deconstruction of each woman's interview sought to identify themes concurrent with the aims of this research. By conducting an inductive line-by-line read of each individual interview, multiple themes and sub-themes were identified. Using the overall research question as a guide, I interpreted the themes presented in chapters 14-18 as the best fit in responding to the overarching research question. An alternative researcher may have identified a different set of themes using the same transcripts, however, IPA justifies individual interpretation, because of the position of the researcher and the role of their own experiences.

The overall research question sought to explore women's experiences of substance use, domestic abuse and support. In doing this, five superordinate themes were identified. Superordinate theme one, 'From Childhood to Adulthood' presented in chapter 14, described the experiences of the women before their adult engagement with substance use and domestic abuse. Although the research question does not seek to understand the lived experiences of children and adolescents, by describing their childhood abuse, parental relationships and introduction to substance use, the women located their experiences as adults within the context of their abusive experiences as children and adolescents. Furthermore, by using concepts drawn from the hermeneutic circle such as the part and the whole, the women's childhood experiences (the part) helps set a context for their adult life and subsequent experiences as adults (the whole). To understand their adult life, we need an understanding of their childhood. As such, I felt it was important to include the women's varied, yet similar childhood experiences.

By examining their childhood, we understood the women's various trajectories into substance use and domestic abuse. Although their lived experiences of substance use and domestic abuse has been described, the details of their experiences of domestic abuse and substance use have not been discussed. The various stories the women shared about their experiences, including the embodied experiences of substance use and domestic abuse, could form the basis of an entirely separate research study.

The pen portraits aim to give some insight into these experiences. Understanding their journey into substance use and domestic abuse also helps understand their journey out of substance use and domestic abuse, because there is an idea of who the women are and what their experiences have been leading up to the point of assessing support.

Identifying the motivations leading to change was a sub-theme discussed in chapter 15 'Effecting Change'. Within this theme, the motivations that impacted women to engage with support were presented. The women's own self-determination proved to be the most powerful motivator effecting their motivation to change. Sub-themes such as fear, and children were also identified as motivators for some of the women. However, they were also identified as a barrier to support for other women. Because of the barriers identified throughout the interviews, a third superordinate theme was presented.

'Barriers to Support' presented in chapter 16, examined the barriers that prohibited women from accessing support but also while in support. The most prolific of these barriers was the identified gaps in support e.g. the gap in provision for Kat. The experiences of Khloe, Holly and Kat in particular, highlight significant gaps in support hindering their engagement and recovery from both substance use and domestic abuse. The gaps in support as identified in the majority of the women's stories, impacted on the women accessing the support they needed and as such, for many women, one need was prioritised over another. However, by prioritising their needs, the women did engage in support of some kind.

As such, superordinate theme four, 'Experiences in Support', presented in chapter 17, sought to explore the support that the women had encountered. Within this chapter, the various support types were examined, and attention was placed on the role of social workers and support workers. As the women demonstrated, support workers were favoured because of their open and non-judgemental attitude, and this support impacted on women's engagement with domestic abuse and substance use

support. However, the support of friends and in particular, peers, was described as the most effective support for women, alongside more formal engagement with drug and alcohol services and twelve-step programmes. The value of peer support and friendship was identified as a motivator for ongoing recovery and this value was also found in twelve-step programmes. Although three women vocalised a dislike for AA and NA, four of the women had faith in the support because of the feelings of acceptance and a shared identity they encountered among their peers.

The feelings of acceptance and the shared identity had an impact on many of the women and led to the creation of superordinate theme five, 'Impact of Support' presented in chapter 18. For the majority of the women, the confidence and acceptance they felt following support engagement motivated them to volunteer in their drug and alcohol service. However, volunteering also continued to impact on their sense of self and bolstered their learning about their own life and their own experiences. This learning fed into the sub-theme 'Ongoing recovery' which identified that the women were not recovered from their experiences of substance use and domestic abuse but were on a continuous journey of self-discovery and learning.

Finally, their overall impact of support led some of the women to share their views on improving support provision for substance use and domestic abuse. The final sub-theme 'Improving Support' demonstrated the need for better understanding, more systematic improvements and better communication between workers and women who access support.

Chapters 14-18 presented in part 4, have illustrated the barriers, enablers and impact of engaging with support for women who are affected by substance use and domestic abuse. However, it is important to remember that the 12 women in this study were not just affected by substance use and domestic abuse. Mental ill-health, physical health, motherhood, prostitution and socioeconomic status were also identified as themes that could have been discussed in more detail. The women's interviews

demonstrated complexity in their lives and in their experiences, something that cannot be fixed with one specific approach or support type as this chapter has identified. As such, part five of this thesis, will present a further discussion on some of the themes outlined so far. Focusing on the overarching research question, the following discussion in part five, will discuss the complex journeys to support as experienced by the 12 women who took part in this research. In discussing their journeys to support, wider literature and research will be drawn upon to demonstrate the need for more effective practice for women who experience co-occurring substance use and domestic abuse.

Part Five

A Discussion of the Findings

Chapter 19

Introducing the Discussion

The experiences of substance use among women, is a topic that is widely overlooked in UK based research, policy and service provision, particularly in relation to other complex issues such as domestic abuse. This research is, therefore, original and important because it focuses on the voices of women who have experienced co-occurring substance use and domestic abuse. This research offers an in-depth perspective of women's experiences. It is the first qualitative study from the UK to specifically explore help-seeking and support, focusing on the complex journeys to support and the experiences of support among women affected by co-occurring substance use and domestic abuse. This research also provides an opportunity to understand the lived realities of accessing support in a climate where support is reducing, and it highlights the impact siloed working has on women who need the support the most.

This research fills a gap in current knowledge and understanding regarding women and substance use and provides an opportunity '...to move on to a real meeting of women substance users' needs.' (Ettorre, 1992:126). By fully listening to the experiences of women, this new knowledge has the potential to impact local and national practice and policy in both the substance use sector and the domestic abuse field.

As chapter six explained, this research aimed to identify women's motivations for support seeking. It sought to explore the barriers and/or enablers to accessing support. It wanted to determine the wider influences on women's decision to seek help and, it also sought to identify the practice of substance use services and domestic abuse agencies in supporting women with dual needs. By exploring these aims this research has demonstrated that women who experience substance use and co-occurring domestic abuse also experience deep complexity in their journey to problematic substance use and, in their journey to support. This complexity was

presented through the pen portraits and five superordinate themes described in part four and will be highlighted further in this overarching discussion, where four key themes will be discussed in the context of wider literature and research evidence.

By exploring the direct experiences of women, this research has created new knowledge surrounding women and substance use. The key messages presented are, therefore, important because they offer an in-depth way of understanding women's experience of co-occurring substance use and domestic abuse, something we have not seen previously in research on the topic. The chosen key themes (outlined below) have been chosen as integral discussion points because they illuminate the complexity of help-seeking and support access for the 12 women in this study. The key themes that will be discussed are:

1. More than substance use and domestic abuse – Understanding the complex histories of women who use substances.
1. The complex journey to support – exploring the motivators and barriers
2. Experiences of support and service provision – systemic barriers
3. What works? Using women's voices to inform policy and practice

19.1 Defining support

When conducting this research, the concept of support was not specifically defined but rather, was open to interpretation by the women. Although this research did not seek to define support in any particular context, when designing the interview guide I was particularly interested in formal support such as drug and alcohol services, domestic abuse agencies, women's services and social work. However, the interviews contextualised the meaning of support to mean different things for different women. During the interviews, the women spoke about their involvement with formal services (see the sample profile in chapter 13), but also focused on peer support through the twelve-step movement, friendship and activities such as volunteering. Their interviews showed that there are a multitude of support types that can impact recovery and change. For example, many of the women favoured the twelve-step movement as a support type however, within their twelve-step engagement, they

also spoke about the impact of shared identity and peer support. Among those who did not attend twelve-step programmes, peer support was also discussed as having a positive impact on their recovery. This research therefore shows that support is not a specific 'one-sized fits all' approach but rather, encapsulates a number of formal and informal ways of achieving recovery. An individual examination of each support type reported throughout this research will not be conducted, but future research should explore the impact of the varying support types on women's experiences of engagement and retention, as well as substance use and domestic abuse outcomes.

19.2 A note on intersectionality

Although the sample of women all experienced co-occurring substance use and domestic abuse, as the sample profile in chapter 13 shows, they are by no means a homogenous group. As Ettorre (1997) writes,

It is important for the reader to be aware that if one is a lesbian, a woman of colour or a disabled woman, for example, having an alcohol problem is experienced in a different way both personally and socially than it is by women who are less marginalised. (Ettorre, 1997:19).

This sample of 12 women represented differences in age, ethnicity, race, sexuality and socioeconomic status. As the sample profile in chapter 13 illustrated, the women were aged between 27-63 at the time of the interview, they were white British, white European, black British, heterosexual, homosexual, working class and middle class. It is important that these differences are highlighted because as Ettorre explained, their experiences of substances are impacted by their positions in society. This positionality also impacts their engagement with support and services; for example, Gina's experience growing up and recovering in a black community had an impact on her desire to speak out about her substance use and domestic abuse. Her ongoing recovery at the time of the interview influenced her to create a space for Black women in her community, to speak out about their own experiences of domestic abuse and substance use. Engagement with support also impacted Kat who was living in a refuge space for BAME (Black, Asian and Minority Ethnic) women at the time of

the interview. Unfortunately, this study did not explore intersectionality in detail, but further research should be conducted to explore how sex, race, ethnicity and socioeconomic status impacts support and help-seeking for women affected by substance use and domestic abuse.

The following chapters will now discuss the key themes further.

Chapter 20

Discussion

More than Substance Use and Domestic Abuse

Understanding and Naming the Multiple Experiences of Women Who Use Substances

The pen portraits and findings chapters in part four, have shown that substance use and domestic abuse are not experienced in isolation. Multi-layered histories can exist prior to, and alongside substance use and domestic abuse. This is not to say that all women who use substances and experience domestic abuse have traumatic histories. However, the 12 women interviewed did share their experiences of childhood physical and sexual abuse, intergenerational substance use and domestic abuse, mental ill-health, prostitution, imprisonment and losing children; experiences that are traumatic in isolation. These experiences cannot be ignored when exploring substance use and domestic abuse because they impact how and why women use substances and experience abuse, but also, how women engage with support and how support engages with them. Therefore, to understand how the 12 women engaged with services and to understand how they perceived service engagement, it is necessary to first explore the various experiences that led them to wanting support. As such, cycles of abuse and substance use will be demonstrated to reinforce the multi-layered histories that have impacted the women in their substance use and domestic abuse experiences. Intergenerational cycles of substance use and domestic abuse will also be discussed to illustrate the relationship between witnessing substance use and domestic abuse in childhood and experiencing use and abuse in adulthood. The experiences of prostitution, imprisonment, losing custody of children and the impact of mental ill-health will also be discussed to demonstrate the impact of re-traumatisation. As such, this chapter will be presented in two sections, 'the experiences of childhood trauma' and 'the experiences of adult trauma'.

The depth with which some of the women spoke about their lifetime experiences led me to realise that this research was about a multitude of experiences that impact substance use, domestic abuse and subsequent support and help-seeking. In discussing these histories, I also feel it is important that we name the specific experiences as shared by the women, instead of using a blanket term such as trauma or post-traumatic stress disorder (PTSD). By naming the specific experiences that have impacted the 12 women in this research, we are given an opportunity to understand the complexities of their journey to recovery but also, we move away from the silencing of women. Women's voices are an integral part of this research, so when they say they have been raped, or they have been abused, it is important that we name these experiences and help reduce the shame that has been imposed on them by a society that has told them for years, it is their problem.

20.1 The experiences of childhood trauma¹.

The first superordinate theme in chapter 14 focuses on the experiences of childhood. As basic psychological developmental theory (McLeod, 2013) describes, the experiences of childhood impact our adult experiences, particularly the bonds we have as children. This relationship was demonstrated by Felitti et al.'s (1998) ACE (adverse childhood experience) study. The ACE study, conducted in the USA, found that individuals with adverse childhood experiences, including living in a home with parental substance use, experiencing physical and/or sexual abuse as a child, witnessing domestic abuse, and experiencing neglect, were more likely to experience substance use, domestic abuse, mental ill-health and many other health-related issues as adults. In the UK, Bellis et al. (2014) reported similar results to Felitti and colleagues. Conducting a national representative survey in England, the authors surveyed nearly four thousand residents (aged 18-69) and found a history of childhood physical, sexual and verbal abuse to be prevalent between 6-18% of the

¹ The definition of trauma comes from the American Psychology Association (APA) who state, 'Trauma is an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea. (APA, 2018, online).

respondents. Bellis et al. (2014) also reported that females reported childhood physical, sexual and verbal abuse more than males. Jarvis (2018) explains the relationship between childhood ACE's and adult outcomes as follows:

People with significant ACE loads, having experienced toxic stress in childhood, enter adulthood with a stress 'thermostat' that is chronically set at too high a level, in the same manner as a central heating system that has been set at maximum heat, which puts constant pressure on the boiler, so that when the thermostat is advanced even further by stressors in the day-to-day environment, the system becomes increasingly likely to 'blow'. (Jarvis, 2018, online).

Although I did not specifically ask about childhood experiences during the interviews, I was aware that some of the women might bring up childhood experience. However, I did not anticipate the number of women who would speak about their childhood experiences in detail. For all of the women, experiences of childhood abuse and neglect were discussed, as well as intergenerational cycles of substance use and domestic abuse. These experiences are being discussed within this chapter because they go some way to explain how problematic substance use and domestic abuse victimisation eventually occurred in lives of the 12 women in this study.

20.1.1 Impact of Childhood Abuse on later Domestic Abuse and Substance Use

The women in this study referenced at least one adverse childhood experience (ACE) (Felitti et al. 1998). For the majority, more than one ACE was identified as the interviews also highlighted various cycles of physical and sexual abuse from childhood to adulthood (chapter 14). All of the women in this study have experienced domestic abuse in their adult lives but Michelle, Kat, Kim, Lydia, Holly and Lou, also experienced physical and sexual abuse as children. The experiences of childhood physical and sexual abuse correlate with findings by Barnes et al. (2009) who explored revictimisation from childhood to adulthood. Using comparative longitudinal research, the researchers conducted an 18-year study beginning in childhood

(average age of 11) to early adulthood (average age of 24). Their findings highlighted that those who experienced childhood abuse were twice as likely to experience physical and sexual revictimisation as adolescents and adults, when compared to those who did not experience childhood abuse. Similar results were identified in the British Crime Survey for England and Wales (ONS, 2017). Defining child abuse as 'psychological and physical abuse, sexual assault, and witnessing domestic abuse' (ONS, 2017), the survey found that 1 in 5 adults between the age of 16-59 had previous experience of child abuse. Of those who experienced all aspects of child abuse, 77% experienced domestic abuse after the age of 16. Understanding why childhood abuse may lead to adult experiences of domestic abuse is complex. However, in chapter 14 Lou sheds light on her experiences when she says, 'because of my trauma, my childhood trauma, I felt worthless and dirty and it was my fault and you deserve this' (Chapter 14).

The childhood experiences of abuse among Michelle, Kat, Kim, Lydia, Holly and Lou also impacted their adolescent experiences of substance use. Multiple studies have attributed childhood experiences of abuse to adolescent's substance use including a seminal study by Kilpatrick et al, (2000). Conducting a national study of over 4000 adolescents aged between 12-17, 7% (n=276) met DSM (diagnostic and statistical manual) criteria for substance abuse or dependence. Their findings highlighted that participants who experienced or witnessed physical or sexual abuse in the home were more likely to have past-year problem substance use. Shin et al. (2010) reported similar results from their study which found that experiences of childhood sexual abuse increased the risk of heavy and poly substance use in girls during adolescence. Further studies relating to adverse childhood experiences have continued to find a relationship between childhood abuse and adult substance use. For example, Merrick et al. (2017) found that emotional abuse, sexual abuse, physical abuse, household substance abuse and household mental illness were associated with drug use and heavy drinking in adulthood. Stein et al. (2017) reported similar results in their study of childhood abuse among 457 adults entering detox for opioid use. Although only

one-third of the participants were female, findings highlighted that women were more likely to experience past sexual abuse when compared to men.

Understanding the relationship between childhood experiences of physical and sexual abuse and later adult substance use, can be better understood in light of the self-medication hypothesis (Khantzian, 1997). This theory argues that those who use substances problematically do so to alleviate feelings associated with traumatic experiences. Using alcohol to self-medicate was highlighted by Michelle and Holly when they spoke about their adult experiences of domestic abuse. Although none of the women directly related their substance use to their childhood experiences of abuse, their narratives do suggest a relationship between their childhood experiences of abuse, and their adult experiences of substance use and domestic abuse (see figure 4 for a visual demonstration of this relationship).

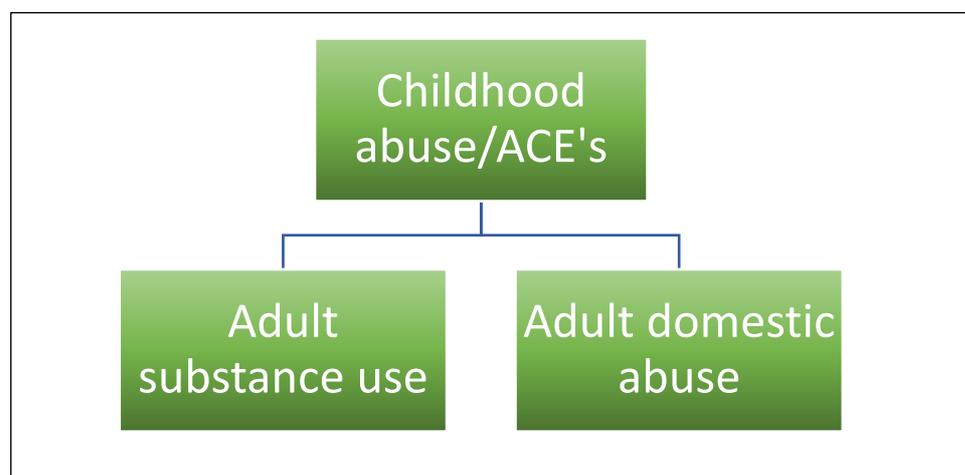


Figure 4. Relationship between childhood abuse and adult

The self-medication hypothesis as discussed above does create an understanding of the relationship between childhood physical and sexual abuse and later substance use, but it does not account for substance use when adverse childhood experiences are not present, nor does it explain the cohort of individuals who do not use substances problematically despite experiencing childhood abuse. As such, multiple factors including the role of parents, peers and other life stressors must be

considered when examining the self-medication hypothesis (Hall and Queener, 2007). A consideration for adult life stressors, must also be considered, this will be discussed further in section three 'experiences of adult trauma'.

20.1.2 Intergenerational Cycles of Substance Use

As chapter 14 highlighted, Laura, Michelle, Kim and Gina spoke about one or both parents using substances problematically while they were children. The women then began using substances at a young age and this use eventually became problematic. Their cycle of substance use, in particular, their early initiation, is not uncommon as research by Vermeulen-Smit et al. (2012) found in their survey of 2319 parent-child dyads over a three-year period. Their findings showed that adolescents from families with two heavily drinking parents were at a higher risk of early initiation into drinking and, at a higher risk of increasing their drinking. Similarly, a study by McCutcheon et al. (2017) also found that participants with two parents who used substances problematically were at greater risk of early initiation of alcohol use before the age of 16, and cannabis by age 12. Parental binge drinking also predicted young adults binge drinking in a 13-year longitudinal study by Pedersen and Soest (2013) when they surveyed 2000 participants. Similar results were also identified in a 25-year, longitudinal study by Fergusson et al. (2008), who found that parental substance use predicted substance use in their children aged 16-25. These findings are relevant for most of the women in this study because their parents used substances problematically while they were children, and most of the women began to use alcohol in their early teens. The role of parental monitoring may be understood to impact this early initiation. Exploring parental monitoring, Ewing et al. (2015) examined how changes in parental monitoring and family values between baseline and 180-day follow-up impacted adolescent substance use. Surveying 193 adolescents between the age of 14-18, analysis found that poor parental monitoring, poor family values and perceived adult marijuana use, were associated with greater alcohol use and heavy drinking among adolescents. Similar results were identified by Rusby et al. (2018), who found that poorer parent-youth relationship quality and lower parental monitoring was associated with substance use onset in adolescents

aged 13-14. As adolescence is already a time of risk-taking (Gore et al. 2011), a lack of parental monitoring may be understood to heighten risky behaviour common in adolescence and may go some way to explain why some of the women in this study used alcohol from a young age.

From adolescence Laura, Michelle, Kim and Gina continued to use substances heavily, and eventually became mothers. Their own adult experiences of substance use mirrored their parent's substance use, therefore creating an intergenerational cycle of substance use. This echoes Thornberry et al.'s (2006) work, which sought to explore whether substance use in a prior generation increased the risk of substance use in subsequent generations. Findings by Thornberry et al. (2006), illustrated a relationship between a mother's substance use and her daughter's substance use, which is particularly relevant to Laura, Michelle, Kim and Gina who reported maternal substance use. The relationship between parental drinking and later adult drinking was explored by Dube et al. (2002) who analysed data from over 17,000 participants as part of the adverse childhood experiences (ACE) study and found that having at least one parent with problematic alcohol use increased the risk of heavy drinking, self-reported alcohol problems, self-reported alcoholism and marrying someone who drinks heavily in adulthood. However, it is important to remember, not all women who experience or witness substance use and domestic abuse, go on to experience these adversities as adults. Factors such as socioeconomic security, education and relationships with family and friends, may impact a person's resilience, serving as a protective factor from later adult adversities.

20.1.3 Intergenerational Cycles of Domestic Abuse

Similar to substance use, an intergenerational cycle of domestic abuse was also found when analysing the interviews. Laura, Michelle, Khloe, Kim, Lydia, Holly and Jo shared how they grew up witnessing domestic abuse as children and how they experienced domestic abuse as adults (Chapter 14). Their experiences correlate with findings from the British Crime Survey (ONS, 2017) which highlighted that adults who witness domestic abuse as children are more likely to be victims of domestic abuse as adults.

The adult experiences of abuse were normalised by many of the women during the interviews. This sense of normalisation correlates with the social learning theory (Bandura, 1971) which posits that children can learn from their parents by observing their behaviour. As Khloe said, she grew up witnessing abuse from her father towards her mother and so, she believed this was a normal part of relationships; Holly likewise alluded to this normalisation in chapter 14. Anderson and Kras (2007) argue that domestic abuse should be understood in relation to social learning theory because of the influence witnessing abuse can have on childhood understandings of relationships. As Holly and Khloe's dialogue demonstrates, this learnt behaviour goes some way in explaining the intergenerational cycle of domestic abuse as well as the intergenerational cycle of substance use discussed in the previous section.

The intergenerational cycle of domestic abuse was also found between the mothers (Laura, Michelle, Khloe, Kim, Holly and Jo) and their children. This was especially prevalent in Jo's narrative. During the interviews, Jo spoke about her daughter's extensive experiences of domestic abuse, which reinforces the intergenerational relationship between witnessing abuse in childhood, and later adult experiences of domestic abuse. In Jo's case, she experienced abuse, which mirrored her mother's experiences; however, Jo's daughter also experienced abuse, mirroring Jo's experiences. Jo's daughter is also a mother and her daughter has witnessed abuse, which puts her at a higher risk of experiencing abuse in the future, as findings from the ACE study has demonstrated (Dube et al. 2002). Again, it is important to point out, that the ACE study demonstrates correlation, not causality and cannot assume that Jo's granddaughter will definitely experience abuse in the future. External resources, including protective factors outlined in section two above, must be considered in the examination of intergenerational cycles of domestic abuse.

The two intergenerational cycles demonstrate the relationship between childhood experiences and adult experiences, however, these cycles do not exist independent of each other. Analysis of the interviews also described how Laura, Michelle, Gina and Kim witnessed both substance use and domestic abuse as children, thereby

creating a third intergenerational cycle (figure five visually demonstrates this relationship).

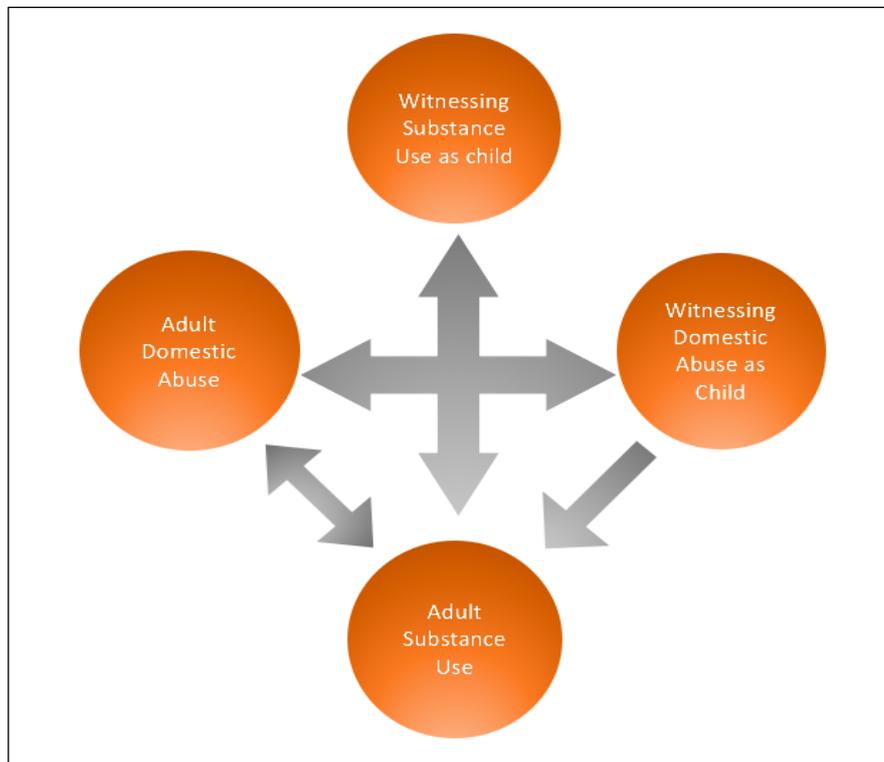


Figure 5. Combined intergenerational cycle of substance use and domestic abuse.

20.2 Analysing the ACE Study and Intergenerational Cycles

Although the ACE study serves to create an understanding of the relationship between childhood adversity and later adult experiences, it is important to consider the findings with caution. The ACE study was conducted in the USA, with an initial aim of exploring the impact of seven childhood experiences on physical health. Although heterogenous in its sample (79% white and nearly half college educated), studies conducted since Felitti's seminal piece of research, do produce similar findings (Bellis et al. 2014; Couper and Mackie 2016). However, a systematic review and meta-analysis by Hughes et al. (2017) found that ACE's varied in their effect. Overall, the study found a strong association between problematic substance use and domestic abuse among those who experienced four ACE's or more. However, weak to moderate associations were found when physical health outcomes, smoking and

heavy alcohol use were analysed. It is also important to remember that the ACE study was conducted in the USA, so generalisations within a UK context must be made with caution, as the countries social and health care systems differ. As the UK has not conducted much research in the area of ACE's (Bellis et al. 2014), further research is recommended. Overall, the ACE study is beneficial in understanding the relationship between childhood experiences and later adult experiences, and correlates with various developmental psychological theory, however, the ACE studies 'can only demonstrate associations' (Felitti et al. 1998:251) between childhood experiences and adult outcomes, and so should not be viewed as a definite causation.

Like the ACE study, the intergenerational cycles of substance use and domestic abuse, as well as the social learning theory, do go some way to explain the relationship between witnessing domestic abuse and substance use as children, and experiencing domestic abuse and substance use as adults. The theories are therefore helpful in understanding how the women in this study experienced adversities as adults, however, the theories do not account for the women who did not experience childhood adversities, but did experience them as adults

A meta-analysis by Smith-Marek et al. (2015) found weak effect sizes to determine a definite relationship between witnessing domestic abuse and experiencing domestic abuse in adulthood. Similar results were reported by Haselschwerdt et al. (2017) in their methodological review of intergenerational studies. However, Smith-Marek et al. (2015) reports, 'there are other risk markers interacting over the course of an individual's life that contribute to the outcome of adult IPV' (2015:509). The authors advocate that researchers consider a developmental-interactional perspective as part of social learning theory. The developmental-interactional perspective considers the role of social learning, but also considers other risk and protective factors such as relationships. The researchers therefore advocate for a holistic approach to understanding a person's trajectory to domestic abuse. Jarvis (2018) also writes about this when she says, 'human beings are the sum of all their experiences, which makes isolating cause and effect extremely difficult' (Jarvis, 2018, online).

The ACE study, intergenerational theory and the social learning theory, are individual theories, placing the onus of responsibility on the women, therefore negating the wider socio-cultural factors that may impact later adult substance use and domestic abuse. In trying to understand how the women in this study reached a point of problematic substance use and domestic abuse victimisation, it is necessary to consider the impact of their wider environment. As Heise's (1998) ecological model of partner abuse (derived from Bronfenbrenner's (1977) ecological framework) demonstrates, domestic abuse is impacted by both the wider community with which women are situated, as well as society more broadly. Although not discussed in this research, the role of poverty, socioeconomic status and unemployment, impact a women's ability to leave a violent relationship. The normalisation of domestic abuse and the cultural mantra of 'what happens behind close doors', further impacts the continuation of domestic abuse which can have an impact on a woman's use of substances.

The theories presented, also project elements of 'learned helplessness', a concept that originated from experiments by Seligman (Ali and Naylor, 2013; Seligman and Peterson, 2001), who theorised that repeated exposure to trauma, resulted in an acceptance that a situation cannot be changed. It 'refers to the maladaptive passivity shown by animals and people following experience with uncontrollable events' (Seligman and Peterson, 2001, online). This concept mirrors the social learning theory insofar that it focuses on the cognitive impact repeated exposure of abuse has on the normalisation and acceptance of abuse. However, the normalisation of abuse in the context of learned helplessness or social learning theory situates women as passive agents and therefore fails to account for their own agency. As this study has shown, agency was demonstrated by all of the women, because they used substances as a coping mechanism. This was evident in Michelle and Holly's narrative when they explained that they drank alcohol before their partner returned home because they knew the abuse would not hurt as much. Other women also used substances as a way of taking control of their lives; Lou spoke about substances as a way of taking control of her trauma, Laura said she drank as a form of rebellion against her parents, and

Khloe said she drank because she wanted to. The women therefore demonstrate agency over their abusive experiences by using substances.

Many of the women also spoke about their early use of substances as pleasurable, a conversation that is rarely discussed in literature. The concept of women choosing to use substances or, enjoying substances, goes against society's pre-defined role of women as caregivers. Understanding the role of pleasure among women who use substance 'appears as a subverted or hidden reality' (1989:599). I am not advocating for problematic substance use, however, as Ettorre (Ettorre, 1989) also explains, it is important to consider the pleasurable effects of substance use among women, and how their desire to gain pleasure from substances, feeds into their wider need for empowerment in an otherwise subjugated position; both within the context of domestic abuse, and the wider social constraints of patriarchy. Further research should be conducted to understand this concept more.

This section has demonstrated how the women engaged in substance use and domestic abuse from a young age. The following section will now explore why the women continued to engage in substance use and domestic abuse for many years.

20.3 Adult Trauma

From childhood, the women experienced substance use and domestic abuse for years; however, their trauma was not solely limited to domestic abuse. As the pen portraits highlight, many of the women were also impacted by mental ill-health, prostitution, criminal justice, and child custody involvement as adults. A process of revictimization in some ways, particularly by losing children, prostitution and incarceration. Although the women did not state outright that they were revictimised or retraumatised, their experiences, and reactions to these experiences demonstrates levels of revictimization. To understand their experiences of support and how support engaged with the women, it is important to again explore their history prior to engagement with support. Naming and illustrating their experiences, highlights the complexity that women bring with them when accessing support.

20.3.1 Prostitution

Laura, Khloe and Dani spoke about their experiences of prostitution as being violent and abusive. This revictimization can be understood to add to their experiences of trauma. For many women who experience prostitution, physical and sexual abuse is not uncommon as research by Holly and Lousley (2014) and Mellor and Lovell (2011) both highlighted in their studies with female sex-workers in the UK. Khloe also described an incident of rape while working on the street (chapter 15). The three women also spoke about their long histories of prostitution as a way of funding their substance use. This is a common theme among research relating to prostitution, as Sallmann (2010) found in her qualitative study exploring women's experiences of prostitution. The researcher found that all of the research participants identified problematic substance use with many of them explaining that prostitution and substance use was 'a means to an end' (2010:123) and went 'hand in hand' (2010:122).

Understanding the women's history, such as their experiences of prostitution, is important when we move forward to explore service provision, because for Khloe for example, her gateway into drug services began at a hostel for drug using 'prostitutes'. Prison was also a place of initial service engagement for Khloe as she engaged with a methadone programme while there.

20.3.2 Incarceration

Laura, Khloe and Dani also experienced imprisonment and were arrested several times, often in relation to prostitution. Again, this experience can be seen as having a traumatising effect on some women. Harner and Riley (2013) identified re-traumatisation in their study exploring how incarcerated women perceived their mental health while in prison. Although findings from the 445 surveys and 12 focus groups found that the mental health conditions among the participants improved, worsened or stayed the same, the study also highlighted how some women were re-traumatised in prison because they were scared for their lives. Covington (2008) also discusses the impact of incarceration on trauma explaining 'it can be

retraumatising when a battered woman is yelled at or cursed at by a staff person' (2008:382). However, both studies are from the USA, where prison systems are different from those in the UK. Nonetheless, the role of control within a prison setting can have a retraumatising effect on women who have histories of domestic abuse and coercive control (Moloney and Moller, 2009; MacDonald, 2013).

20.3.3 Losing Custody of Children

An element of adult trauma experienced by Laura, Michelle and Kim is the (temporary and permanent) loss of their children. Laura said she chose to put her children into care when she was in her twenties (chapter 14). As the pen portraits show, when Laura was 14 she was forced to give her first child up for adoption, which she says, was the start of her substance use. Both Michelle and Kim also lost custody of their children, which impacted on their mental ill-health. Their experiences echo research by Wall-Wieler et al. (2017) who found an increased rate of anxiety and substance use disorder diagnosis among women, in the two years after their children were taken into care. The effect of losing children can be viewed as re-traumatising for Laura, Michelle and Kim. Their increased drug and alcohol use following the removal of their children highlights this trauma. Their experiences are mirrored in a study by Harp and Oser (2018) whose longitudinal research with women who lost custody of their children informally and officially (with and without service involvement), found that loss predicted an increase in drug use.

20.3.4 Impact on Mental Ill-health

The identified experiences as shared by the 12 women in this study are understood to impact on their adult experiences of mental ill-health. Numerous studies have found a relationship between each individual experience highlighted so far, and adult mental health outcomes. For example, the experiences of childhood abuse, witnessing abuse as children and witnessing parental substance use is associated with later adult mental ill-health outcomes (Felitti et al. 1998). Experiencing domestic abuse victimisation is associated with more emotional distress, suicidal thoughts and suicidal attempts (Ellsberg et al. 2008; Rees et al. 2011), and problematic drug and

alcohol use has been found to have an impact on negative mental health outcomes (NIDA, 2017). Furthermore, engaging in prostitution has been identified as having an effect on depressive symptoms (Carlson et al. 2017) and being incarcerated is associated with psychosis and depression (Fazel and Seewald, 2012; Constantino et al. 2016). Finally, losing custody of children has also been found to negatively impact mental health outcomes (Kenny et al. 2015; Nixon et al. 2013). When exploring co-occurring substance use and domestic abuse, the role of mental ill-health cannot be ignored. Studies have shown consistently that there is a relationship between substance use and mental ill-health, domestic abuse and mental ill-health and traumatic experiences and mental ill-health. The women in this study have also highlighted their battles with mental ill-health, some demonstrating the embodied experiences, as Laura demonstrated when she pointed to the scar on her neck indicating an attempted suicide.

20.4 Concluding Comments

The women in this research have histories that include, witnessing parental substance use and domestic abuse, direct experiences of childhood abuse and, experiences of mental ill-health, motherhood, incarceration and prostitution. This is not a new finding regarding women and substance use, but rather, reinforces the fact that women who experience problematic substance use, often experience other multiple complex issues (Covington, 2008; McNeish and Scott, 2014; Herman, 1997; and Frem et al. 2017). By examining the various childhood and adult experiences as shared by the women in this study, this research has highlighted multiple relationships between the substance use and traumatic experiences. This chapter has shown that the women in this study experienced trauma at multiple points in their lives, often as a cycle. However, as the following chapters will demonstrate, services have not responded to the whole of the experiences presented in this chapter. Moving forward, it is important to remember that when women chose to access support, substance use or domestic abuse may appear to be the most obvious issues that need support, however, beneath these issues lie a history of complex trauma and experience. This multi-layered history is represented in figure six as an onion type

diagram to demonstrate the many layers that exist beneath the outwardly presenting issue. How these histories are responded to in service, will be discussed in chapter 23.

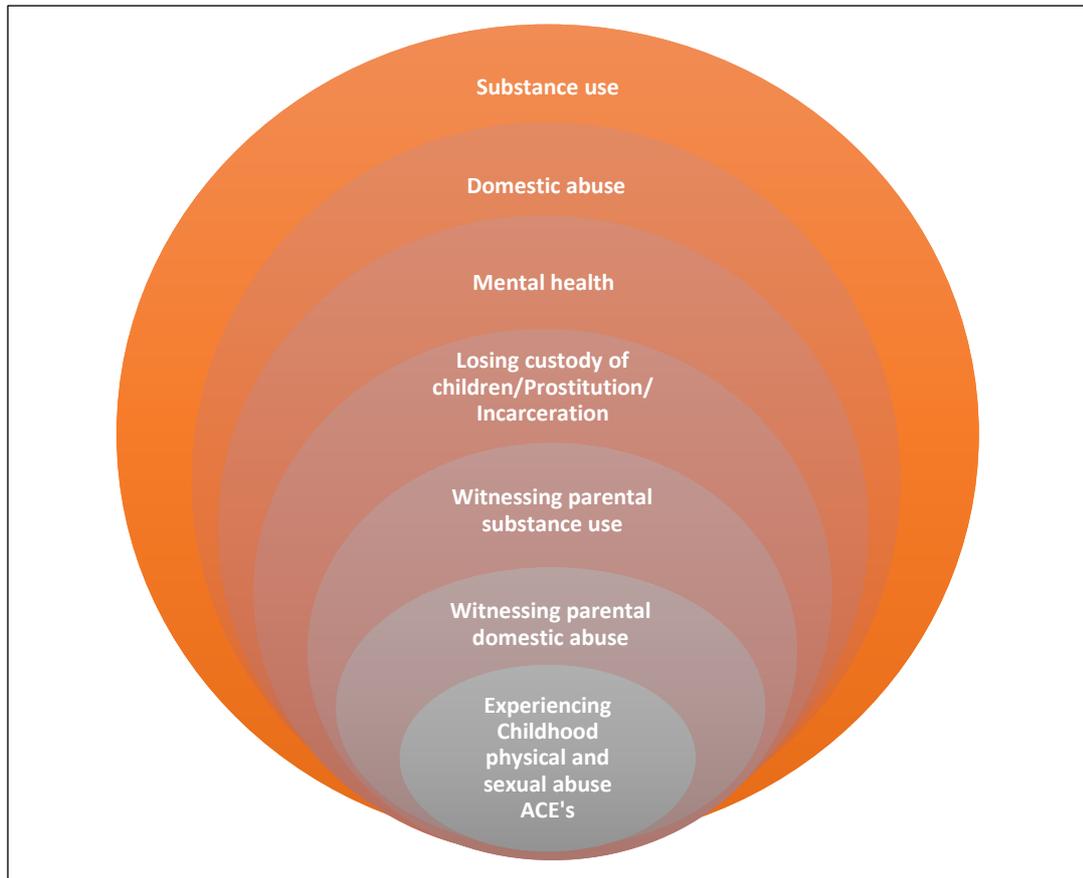


Figure 6. Layered history beneath substance use and domestic abuse

Chapter 21

Discussion

The Complex Journey to Support – Exploring the Motivators and Barriers

As chapter 15 and 16 illustrated, accessing support was not based on one simple decision but rather, was affected by both barriers and motivators. Some women demonstrated a motivation to access support for their substance use and domestic abuse based on factors including fear, children and health. Similar factors were also highlighted as potential barriers to support seeking by other women. For the context of this research, these motivations and barriers are considered personal motivators and barriers, because as chapter 22 will explore, there are also multiple wider systematic barriers that impact women from accessing the necessary support. I feel it is important that I explore the personal barriers and motivators because they provide an opportunity to understand why women may be reluctant to access support, as well as what pushes them internally to access support. However, the following chapter does not aim to place blame on the women themselves. Rather, it aims to understand the reason why the women felt they could not access support sooner.

As I demonstrated in the literature review, there is a lack of research on this topic in the UK despite the anecdotal conversations that take place in practice and research. As such, research evidence from the USA is continually cited as a way of gleaming understanding on the topic, but such research cannot be generalised to UK populations. By focusing on the reasons why women may or may not want to access support, this research provides an opportunity to learn how to engage women in support sooner. The following discussion regarding barriers and motivators is therefore necessary, because it creates a new knowledge regarding women's access to support. As such, this chapter will now discuss both the personal barriers and the motivators to accessing support as perceived by the women in this study.

21.1 Barriers to Accessing Support

The two predominant factors identified as barriers to support were ‘fear’ and ‘gaps in provision’. The perceived gaps in provision will be discussed in chapter 22 because it feeds into the wider discussion regarding service availability. This chapter will therefore focus on the role of fear as an identified barrier to support.

Overall, fear was found to be the primary barrier to accessing support for both substance use and domestic abuse; however, multiple types of fear were highlighted (figure seven). In domestic abuse research, fear is the most common factor inhibiting a woman from seeking support (Pain, 2012, online); which is why it was a common feeling expressed during the interviews. The topic of fear was not solely related to domestic abuse. As Gina’s experience demonstrated, her feelings of fear were multifaceted, because she was afraid of her abusive partners, she was afraid to speak to the police because her partners were gang members, she was afraid of losing her drug supply if she left the violent partners, and she was afraid of losing her children. Gina’s experience shows that feeling afraid to seek support is not influenced by domestic abuse solely, but by a number of factors.

Other women in this study demonstrated the complexity of fear also. As the findings presented in chapter 16 show, Kim was also afraid of the repercussions from her partner if she spoke to the police. Her fears are somewhat justified because analysis from Domestic Homicide Reviews (Cheeseman, 2017a; Cheeseman 2017b; Benbow, 2015) repeatedly show that ending or leaving an abusive relationship can be the most dangerous time for women, messages that are also highlighted by domestic abuse agencies such as Women’s Aid and Refuge. This is not to say that women should stay in abusive relationships, but rather, reinforce the role of fear in women’s access to support.

As the findings also show, the relationship between fear and substance use was further heightened by children. Fear of losing custody of children is a common theme on the topic of women and substance use. Anecdotally in drug and alcohol services, the role of children as a barrier to seeking substance use and domestic support has

been long discussed. The 2004 United Nations Report *Substance abuse treatment and care for women: case studies and lessons learned* (United Nations, 2004) cited 'fear of losing custody of children' (2004:20) as a personal barrier to treatment access for women affected by substance use. Similar findings were identified in a qualitative study by Elms et al. (2018). Conducting focus groups with 10 mothers who had a history of substance use in Canada, Elms et al. (2018) identified fear to disclose substance use as a barrier to support. Falletta et al. (2018) also identified fear of child protection services as a barrier to care for pregnant or recently pregnant opioid using mothers in the USA. Findings from Falletta et al. (2018) also found that some women were so worried about losing custody of their children, they tried to stop using substances alone. Gina's experience mirrors this finding somewhat. Similarly, Stone (2015) highlighted fear of losing children as a common reason for not accessing medical care in her qualitative study with 30 pregnant women. Although only small-scale studies, these findings highlight the personal barriers as shared by women affected by substance use. Other studies that have explored barriers to support among substance using women include Taylor's (2010) discussion piece, which highlighted a lack of childcare, fear of losing children, fear of stigma, lack of family support, lack of financial support, treatment accessibility, denial and co-morbidities as key barriers to support. Although useful to understand the varying factors impacting support, Taylor's discussion piece is predominantly based on USA studies and localised service level reports. Taylor's piece, along with the aforementioned studies, echo findings highlighted in Greenfield et al.'s (2007) literature review exploring substance use treatment entry, retention and outcomes in women. Although helpful in gaining an understanding into the topic, these studies are all USA based and so, cannot be generalised to UK populations because of the differing health care systems. For example, drug use in the USA, especially among pregnant women, can result in punitive action being taken by authorities, which can further prevent women from seeking support (Stone, 2015), something that differs to the UK. The studies identified also vary methodologically and so cannot be generalised to wider populations. However, they demonstrate barriers to support; something that is lacking in UK based research.

When exploring the barriers to support for women affected by substance use, identified studies highlighted specific sub-groups of substance using women such as homeless women (Upshur et al. 2017 - USA), incarcerated women (Grace, 2017; Moore, 2011- UK), pregnant women (Philips et al. 2007; Jessup, 2003 - USA) and sex-workers (Jeal et al. 2017 - UK). Such studies are important when exploring the barriers to support for women affected by homelessness, incarceration, prostitution and pregnancy because, as the findings showed, such barriers were met by many of the women in this study. Identifying British studies that explored barriers to support among female substance users who have not fit into a specific sub-group proved difficult, despite anecdotal understandings of the barriers. For example, as I have already pointed out, in substance use services, children are often seen to be a barrier for women to engage in services, however, peer-reviewed articles highlighting this barrier among British populations are lacking. A British study by Neale et al. (2008) for example, qualitatively explored the barriers to accessing general practice among injecting drug users in the UK. Fear of speaking to social workers and more generic services that may have contact with social workers, was highlighted as a barrier to accessing generic health and social care services for most of the injecting drug using women in the study. Although children and fear of social workers are cited as a barrier to support, Neale et al.'s (2008) study focused on generic health and social care services, rather than substance use services. This study also reported results from both men and women, limiting the capacity to focus specifically on the female experience. A further UK-based study was that of Galvani and Humphrey's (2007), who conducted literature reviews and interviews with key informants to understand the impact of violence and abuse on engagement and retention rates for women in substance use treatment. Although over 10 years old, this study is still important in understanding the barriers to support for British populations, especially because few studies have examined this topic further. The findings presented by Galvani and Humphrey's (2007) highlighted factors including fear of children being removed, stigma, lack of resources, bad experience of previous treatment, perpetrators control, ignorance about issues, childcare issues, inflexible service structures, lack of refuges taking substance using women and lengthy waiting times to access support. Findings that mirror Taylor (2010) and Greenfield et al. (2007). However, as Galvani

and Humphrey's point out, their literature review relied heavily on USA based research and the authors also stressed caution due to the methodological flaws they identified in the studies reviewed.

As this chapter has shown, there is a lack of understanding about the personal barriers to support among women seeking help for substance use in the UK. Even less is known about the barriers that impact help-seeking among women affected by co-occurring substance use and domestic abuse. This lack of knowledge stems from the fact that women's voices not being listened to. In trying to understand what the barriers to support are, it is vital that women who have direct experience are asked to share their views because '...we cannot comprehend adequately the problems that women dependent on substances [...] have without knowledge 'grounded in practical lived experience' (Ettorre, 1992:20). By focusing on the lived experiences of women, this research adds depth to our understanding of fear as a barrier to accessing support among women affected by substance use and co-occurring domestic abuse. This discussion also presents an opportunity for practitioners in health and social care services to understand the personal barriers women cite as impacting their engagement with support. If practitioners understand the deep-rooted fears of women who experience substance use and domestic abuse, and acknowledge these fears with the women themselves, they may be able to support women to engage sooner because, as this research has shown, support workers who showed understanding of the women's lives, who had experience of substance use or

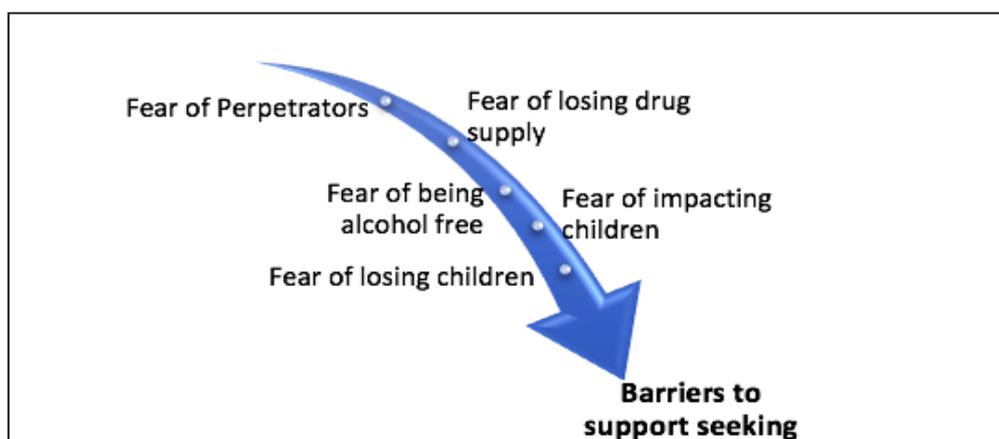


Figure 7. Multiple fears impacting access to support

domestic abuse and who 'were real' with the women, had a positive impact on their engagement with support.

21.2 Motivation to Access Support

The discussion presented so far has shown fear to be complex and multifaceted, so much so that the feeling was found to be a barrier to support seeking for some of the women in this study. As chapter 15 and 16 have shown, fear, among other factors (see fig.8), was also a motivating factor for some of the women. Highlighting the duality of fear as both a barrier and a motivator for the same person is necessary and important to understand because it demonstrates how and why women chose to seek support, but also, how and why they chose not to seek support.

Fear motivated Lou to access support at two different points in her life. Both internal and external motivating factors have been found to impact treatment access, however, external motivators e.g. pressure from family, have been found to have a short-term impact on recovery outcomes. In contrast, internal motivators (referred to as personal motivators in this study) such as fear, has been found to have a stronger impact on long-term change (DiClemente (1999), Deci and Ryan (2000) Groshkova (2010)). This was evidenced by Lou in part four, but also by Kim and Elaine who spoke about initial attempts to access treatment.

The interviews also demonstrated the impact health had on the women's motivation to access support, this was also highlighted by both Dani and Michelle in chapter 15, as they demonstrated a sense of being 'fed up' with their poor health. This is not an uncommon research finding as studies by O'Toole et al. (2006) and Grosso et al. (2013) found. In a study of 180 women seeking treatment for substance use, health as a motivating factor was reported by over 40% of women (Grosso et al. 2013) while just under 40% (38.9%) cited mental health as a leading motivator for accessing support. Mental ill-health was also found to be a motivation for support by some of the women in this study. As Kat's experience shows, her mental ill-health added to her existing feelings of fear, which influenced her motivation to access support. Laura and Michelle were also motivated to engage in support following attempts of suicide.

This correlates with findings by Rhodes et al. (2018) who highlighted mental health as a motivator for treatment among 30 pregnant drug-using mothers in the USA. A motivating factor related to both physical and mental health, could be a realisation of one's own mortality, as Rhodes et al. (2018) found in her research. Fear of dying has already been described as a motivating factor for Kat, however, witnessing one's own physical health deterioration, as well as surviving a suicide attempt, could have had an impact on the women's motivation to live and subsequently access support. For Michelle especially, the motivation to stay alive and become alcohol free was associated with her children.

As chapter 15 highlighted, children as a motivator for change was a divisive topic among the women. As discussed previously, children were seen as a barrier for many women wanting to access support, but some women also said their children were the reason they accessed support. Fraser et al. (2008), conducted interviews with parents and children to understand the impact of parental substance use on children and parents, and found children motivated both parents, but especially mothers, to change their substance use. Bohrman et al. (2017), also found that children had an impact on women's motivation to stop using substances, when they conducted motivational interviewing sessions with 32 women in an emergency department in North America.

Although children have been found to motivate women to stop using substances, this study has found that being a mother is not necessarily the main driver of change among substance using women. Nine of the women in this study were mothers but only two spoke about their children as having an impact on their motivation to access support. The relationship between children and motivation to access support among mothers was challenged by findings from Wilke et al. (2005). In a secondary analysis of over 1300 surveys, the authors found that children had a negative impact on treatment motivation among substance using women. The authors believe that a potential reason for this outcome could be based on previous custody losses experienced by some women in the study, however, such presumptions cannot be generalised because not all of the women in Wilke's study experienced custody loss.

Wilke et al.'s (2005) findings relate to comments made by Dani during the interviews. As part four illustrated, Dani never lost custody of her children but she said that she was not motivated to stop using substances for her children. Laura's choice to put her children into care rather than seek support for substance use further challenges the belief that women are motivated to change for their children. Within the interviews overall, the lack of conversation regarding children as a motivator further strengthens this notion. Perhaps the presumption that women are motivated by their children ties into a societal belief that women are care-givers and so, are motivated by their caring 'duties', when actually, there are other drivers that are more motivating for women.

This study has shown that fear, children and health are motivating factors that can influence women to access support. Poorer psychological functioning, a desire to stop using substances and 'concern over lack of control of drinking' have also been cited as motivating factors (Wilke et al. 2005; Grosso et al. 2013). 'Rock-bottom moments' including, experiences of physical abuse, experiencing homelessness, accidental overdose and suicidal attempts, were also identified as motivators to access treatment by Rhodes et al. (2018). Similar motivating factors were perceived as rock-bottom moments by some of the women in this study. However, when the women arrived at these rock-bottom moments, they also brought with them an innate feeling of self-determination to change their lives. For most of the women, this feeling of self-determination came from an innate feeling of strength.

Although the interviews did not examine the origins of this self-determination specifically, the women's interviews did illicit a general feeling of being ready to access support because they were so fed up with their day-to-day life. This sense of being fed-up could be influenced by the varying motivating factors that have been discussed so far in this chapter. Their lifelong experiences of trauma (discussed in chapter 20) could also feed into this general sense of being fed-up.

As the closing quotations in chapter 15 show, multiple factors led the women to reach a point where they wanted to access support, it is therefore vital that practitioners

who engage with women, acknowledge their motivations, bolster their sense of determination and ensure adequate services are in place to support them in their needs.

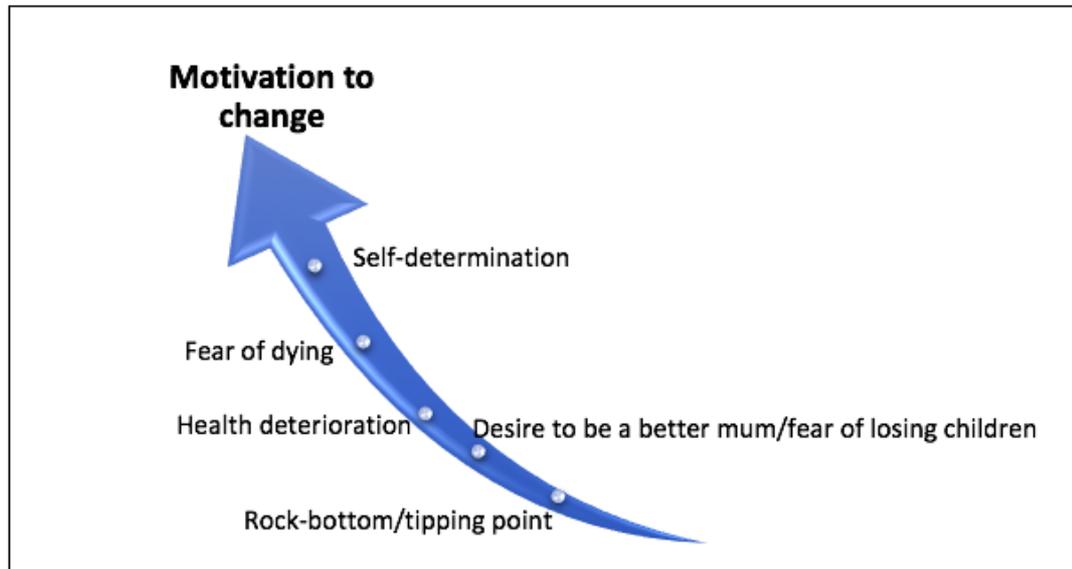


Figure 8. Motivation to access support

21.3 Accessing support

As the discussion has demonstrated, the personal barriers and motivators for accessing support are complex. Combined with a tipping point and innate feelings of self-determination, most of the women in this study were motivated to access support. However, it is interesting to note that substance use support was focused on. As chapter 16 presented, most of the women accessed support for their substance use rather than domestic abuse support. Only three of the women accessed any type of support for domestic abuse, but this was not necessarily a choice made by the women. For example, Kat was motivated to access refuge support, but she had to be at a point where she was ready to stop drinking before she could access that support. Although Kat had two competing needs, the lack of available services meant she felt she had to focus on her substance use in order to get support for the domestic abuse. Because support was not available when she needed it, her safety was compromised. Kim's safety was also compromised because she had to wait four months to receive a space on a rehabilitation programme after her initial assessment. Her safety was compromised by the waiting time, because she

was suicidal, drinking dangerous quantities and using drug while waiting to access support.

Furthermore, although some women were explicit when they said that substance use was the priority for them when accessing support, the lack of available support that focused on substances use and domestic abuse meant the women's support centred predominantly on substance use. As such, most of the women never received support for their domestic abuse. The lack of available services to meet the needs of women with complex needs will be discussed further in chapter 22, however, the discussion offered so far in this chapter, shows the complex journey women with multiple needs make in order to access support. This journey is represented in a spiral diagram presented in figure 10. This diagram is a visual representation of the complex journey to support. It is by no means generalisable to wider populations of women. However, it serves to show the women's journey to support as illustrated in this research.

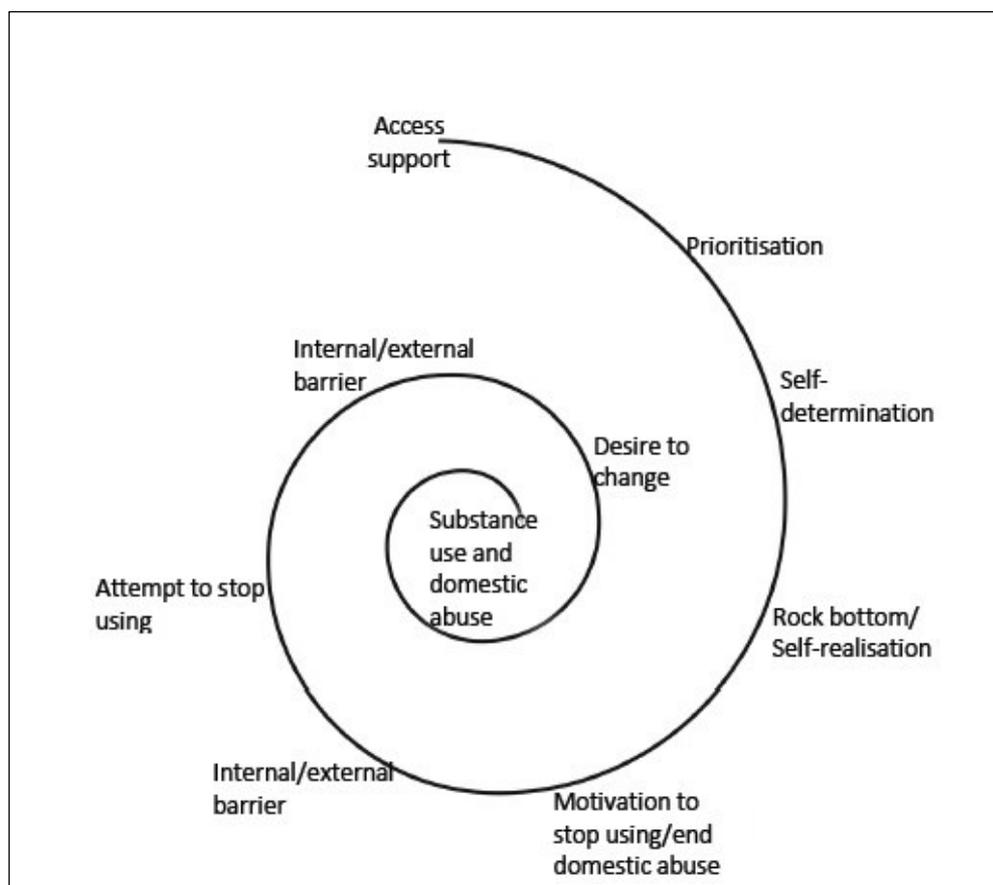


Figure 9. Complex journey to support

21.4 Prioritising Needs – The Steps of Change Model

As chapter 15 discussed, reaching a point where the women were motivated to access support was complex. They wanted to stop using substances and access support, but they also felt unable to because of personal barriers. This internal conflict correlates with the concept of ambivalence, a term used in motivational interviewing (Miller and Rollnick, 2013) that defines the desire to change but also the desire to stay the same. Miller and Rollnick (2013) explain that ambivalence is an important part of the change process because ‘if you’re ambivalent, you’re one step closer to changing.’ (2013:6). Being in a state of ambivalence, as well as the spiral diagram presented in figure nine, reflects the movement on the ‘stages of change’ model (Prochaska et al. 1992). The model hypothesises that people with addictive behaviours can sit at, and move through, various stages of readiness to change.

The six stages of the stages of change model are, pre-contemplation, contemplation, preparation, action, maintenance, and termination (Prochaska et al. 1992) and are represented in a three-tiered spiral diagram (figure 10). Based on studies conducted with individuals affected by various addictions including smoking, food and alcohol, the model is often used as a rough guide by addiction practitioners to understand whether people with addiction are ready to change their substance use. The authors (Prochaska et al. 1992) posit that information and specific support should be offered based on where a person currently sits on the model at the time of assessment. The model has come under fire due to the ‘arbitrarily defined timescale’ (West, 2006:18) associated with each stage. As West (2006) also points out, the model uses dividing lines between stages and assumes that people make plans to stop using, therefore negating those who move from pre-

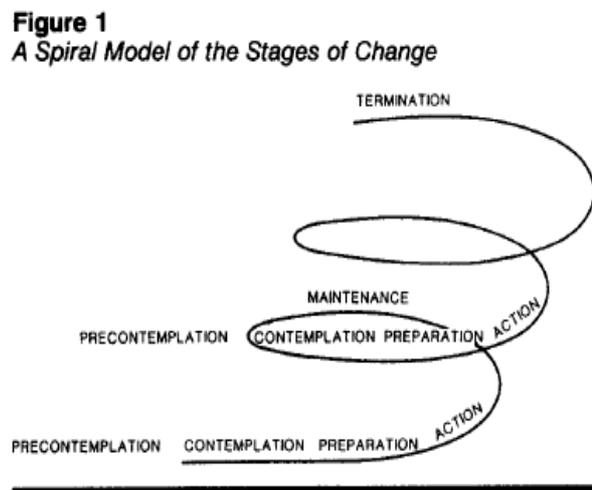


Figure 10. Stages of change model in Prochaska et al. (1992:1104)

contemplation to action for example (West, 2006). As the women in this study have shown, the decision to stop using substances cannot be hypothesised by such a model, because barriers are often in place, which negatively affects their sense of readiness to change. The lack of substance use support for Kat for example, saw her move from the preparation stage back to the pre-contemplation stage. Whereas Gina moved from pre-contemplation to action following an unplanned encounter with AA.

The stages of change model also fails to account for the role of gender in substance use. Assuming that individuals will move through the various stages of change, the model does not account for the multiple issues that accompany substance use, such as domestic abuse, prostitution and mental ill-health. As this research has highlighted several times, women who use substances are impacted by complex issues such as domestic abuse, which serve as a barrier to accessing support for substance use. As such, prioritisation was an important factor in the women's journey to support, something the stages of change model does not consider. The spiral represented in figure nine, therefore tries to demonstrate the realities of accessing support for women with multiple complex needs.

In response to the gender-blind, stages of change model, Brown et al. (2000) asks,

When one studies the process whereby a woman with these multiple issues makes the decision to accept help and enroll in substance abuse treatment, there are several questions that need to be investigated. First, will such a woman enter drug treatment with these conflicting demands? Second, which of these needs and demands and risks takes priority as the woman decides to enter treatment? Third, will acute dangers of occurring or possible domestic violence propel such a woman toward or away from drug treatment? Fourth, is the readiness to make changes in various co-occurring problem areas a single disposition or more independent ones? Fifth, is readiness to make changes in various problem areas related differentially to entry into different types of substance abuse treatment? (Brown et al., 2000:232)

Exploring the relationship between readiness to change and prioritisation, Brown et al. (2000) produced the 'steps of change model' as a multidimensional stages of change model. The steps of change model acknowledge that women who present to services with problematic substance use, bring with them multiple and competing needs.

Entry into substance abuse treatment for these women not only involves a process of contemplation, preparation, and action to obtain help with substance abuse issues, but also involves a series of other conflicting needs and priorities (Brown et al., 2000:232).

In order to support these women in their substance use, practitioners should explore the women's multiple needs with them, and they (the women) need to decide what the priority is, because quite often the women's perception of what is important may differ to the support worker. Focusing on readiness to deal with substance use, domestic abuse, sex risk behaviour and emotional problems, the steps of change model acknowledges that women may want to deal with these problems simultaneously or as they deem to be most immediate, which is why the model is portrayed in step formation (see figure 11). However, it is important to consider that it may not be their choice to engage with support in the first place. External pressures from family, social workers and perpetrators, as well as wider societal pressures, may be influencing the women to access support in the first incidence. The steps of change model does not account for why women may want to engage in support.

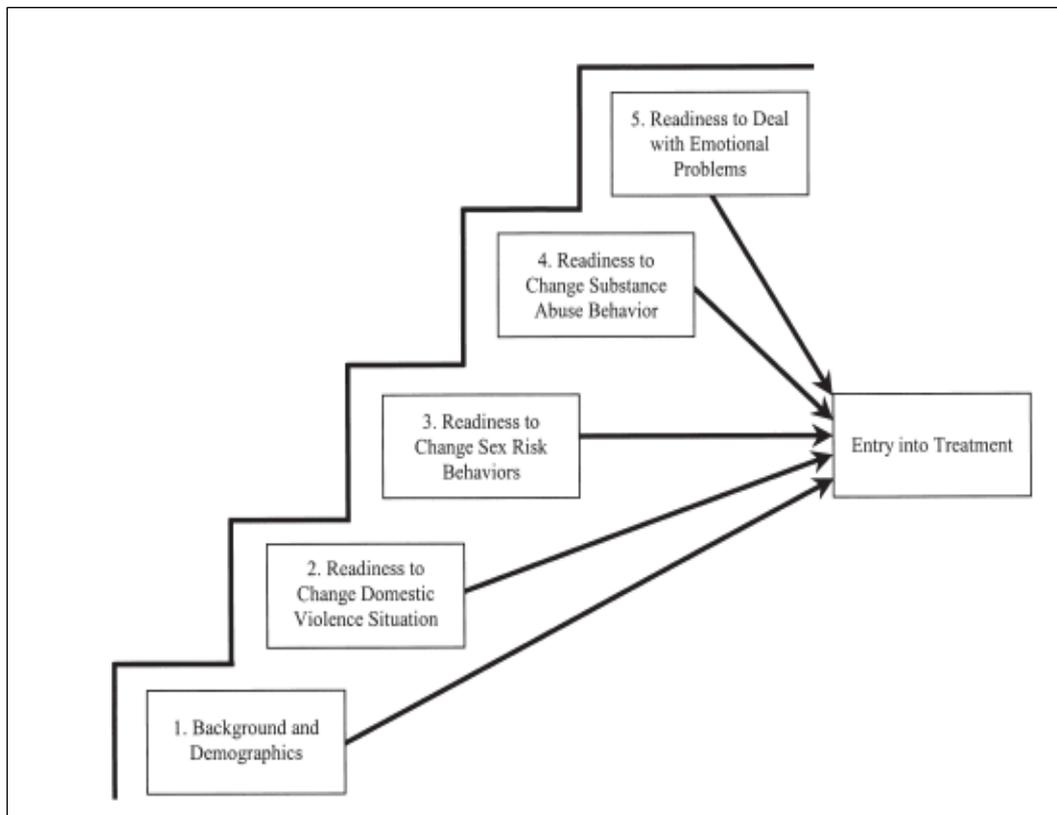


Figure 11. Steps of change, taken from Brown et al. (2000:232)

The steps of change model feeds into The PROTYPES Women's Outreach Program, a case-management, readiness to change model that was designed in the late 1990's in the USA, to help women address multiple needs alongside problematic substance use. Brown et al. (2000) explains that,

...a key component of the treatment model is that a woman identifies the areas of her life she wants to change and the time at which she is ready to do so. For those expressed wishes, appropriate service recommendations are made within the tightly linked services model. (Brown et al., 2000:234)

Evaluation of the model has shown that no single common factor explained willingness to change in a sample of 451 women who took part in the service evaluation. The evaluation also found that women were more likely to want to change issues that appeared to have the most immediate harm, with domestic abuse being the most prolific. Overall, the steps of change model showed that women do

not have a generalised readiness to change (Brown et al. 2000) as multiple factors impact their journey to change, something that was also identified within this study.

The steps of change model is used to explore substance use needs within a gendered framework, and offers an alternative to the stages of change model. Although beneficial to the PROTOTYPES Women's Outreach Program (Brown et al. 2000), it is not a generalisable tool that can be used with a British social care system without some adjustments. Although it does serve as a foundation in engaging women with complex needs in service, the model could benefit from a wider acknowledgment of women's substance use needs. The model also needs to consider the wider malecentric environment and treatment systems in place. For example, the model does not consider women as mothers for example. And the model is also individualistic, negating the wider socio-cultural factors that may impact a women's access to support.

21.5 More Than the Women

The specific focus on women within this chapter, serves to demonstrate the importance of agency. As the narratives have shown, the women had to be ready to access support for themselves. This agency is presented in chapter 15 where some of the women said that accessing support and getting help for their substance use had to be about them. While it is necessary to focus on their agency, it is also important to consider the wider social factors that prohibited them from seeking support sooner.

As the interviews illustrated, many of the women were afraid to talk about substance use because they were mothers, despite a desire to stop using. They were especially afraid to open up to social workers, because they worried they would lose custody of their children. As chapter one presented, historically, women's use of substances is only examined when their behaviour negates their assigned gender role as 'care-giver'. The women's narratives reinforced this, as social workers came into their lives as adults, because they were substance using mothers or victims of domestic abuse with children. While it is vital that children are protected, there is also a conflict

between what services such as social work expect, and what is realistic. The lack of appropriate services for women as mothers, such as addiction services with childcare facilities, sends a message that mothers should not have problems with substances. Such messages therefore silence women from speaking about their needs because they feel like bad mothers for going against the perceived status quo. The wider cultural messages surrounding women who use substances is centred around their maternal responsibility yet, services are not built to support this. The lack of appropriate services for women who have children stems from wider government policies and social and cultural expectations of women. If services are not built to support the everyday needs of women as substance using mothers, women will remain silenced.

This narrative can be extended to account for women who use substances regardless of children. Domestic abuse refuge policies that do not account for substance using victims, sends a message to women that they should not have substance use needs. The lack of trauma informed support in substance use services (discussed further in chapter 23), tells women that their experiences of childhood and adult trauma is not a central concern. The siloed working environments within social care more broadly, also fail to account for the complexity of experiencing domestic abuse. Being able to get away to appointments because of perpetrator control or childcare has an impact on women's ability to access support. Women with co-occurring substance use and domestic abuse issues, who need support, are being failed by the systems in place. Such systems stem from a wider cultural failure. National drug and alcohol policies do not consider the gendered experiences of substance use, nor do they consider the complexity of multiple needs for women. By not highlighting the relationships between substance use, domestic abuse and other complex needs, governmental policies, like those outlined in chapter five, send a message that the multiple needs of women who use substances, is an individual problem. The lack of services available specifically to women substance users sends a message that their experiences should be hidden. This message is further influenced by historical and outdated gender inequalities, where women are still perceived to be the caregiver; the difference in maternity and paternity care is an example of such inequality. Because of this

conflicting message, women continue to feel stigmatised and shamed, and their voices remain silenced.

Figure 12 has been created to demonstrate the impact wider socio-cultural factors have on women with co-occurring substance use and domestic abuse. As the figure shows, the wider gender biased social norms, impact on the creation of policy and practice that represents women’s lived realities. Because policy fails to represent the lived realities of women with multiple and complex needs, services are not created to support women. Drug and alcohol services in particular are not designed to account for the day-to-day practical realities of being a mother or being a victim of domestic abuse. As such, women, with co-occurring substance use and domestic abuse continue to experience various complexities.

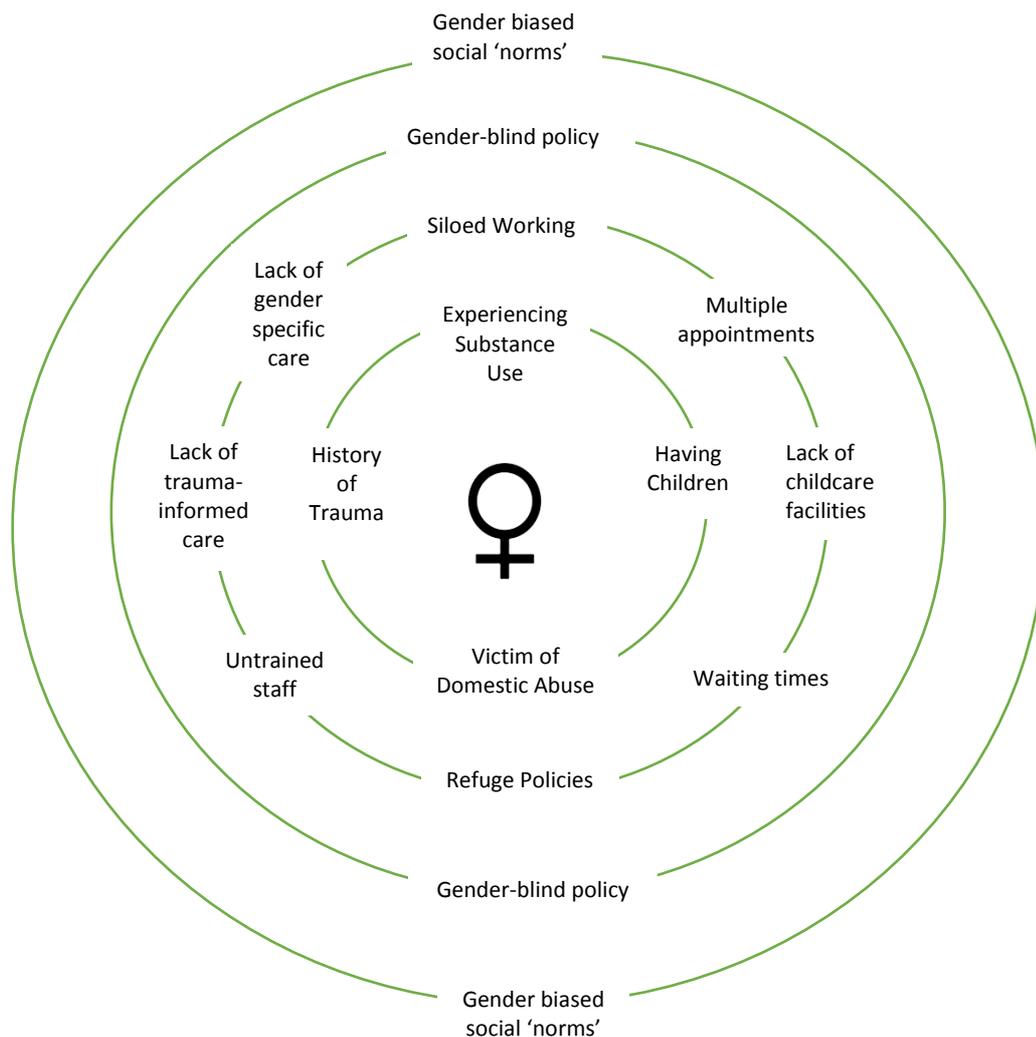


Figure 12. Wider influences impacting women’s access to support

21.6 Concluding Comments

The discussion has taken an in-depth look at the personal barriers and motivators women experience on their journey to support. This chapter has shown that accessing support is complex because, despite a desire to engage with support, internal and external barriers were also in place prohibiting the women from taking the next step.

The spiral diagram presented in figure nine was created to visually demonstrate the complex nature of accessing support for women with multiple needs. The steps of change model was also presented as an alternative to the stages of change model, because it focused on the complex and multiple needs of women who use substances. Although beneficial because of its women-specific focus, the steps of change model, as well as the focus on personal barriers and motivators overall, has not considered the wider influences on women's access to support.

The identified barriers do explain why some of the women did not engage with support sooner, despite their desire to change. However, as this chapter has also discussed, access to support for women with multiple needs is about more than the women's readiness to engage. As figure 12 presented, a lack of support specific to their need's stems from wider socio-cultural factors. To effectively support women who experience substance use and domestic abuse, we must consider the trickle-down effect gender-biased social norms and governmental policies have on women's engagement. The following chapter will explore the impact these socio-cultural factors have on systematic barriers to support

Chapter 22

Discussion

Systemic Barriers to Support and Help-Seeking

The findings presented in chapter 16 showed that support was available for most of the women when they were ready to engage with it. However, as chapter 21 has discussed, accessing support was impacted by complex ambiguities. The women's access to support, although centred on their readiness to engage, was also impacted by wider socio-cultural factors. As chapter also 21 discussed, substance use support was prioritised for most of the women because the necessary services were not available to meet their substance use and domestic abuse needs. Fear of speaking to social work was also described as a barrier to support by some of the women, with some women stating that they felt judged and stigmatised by their social workers because they were substance-using mothers. Examining the wider social failures of service provision, this chapter will therefore discuss the gaps in service provision as barriers to accessing support, including the gap in social work education as a barrier to support for women who use substances.

22.1 Barriers to support -Gaps in service provision

Chapter 16 highlighted three specific examples where gaps in support provision had an impact on the women. Holly said that her alcohol worker did not believe her when she said she drank because of domestic abuse. Such an example demonstrates the need for domestic abuse training in community addiction services. My own experience in the field of social care, anecdotal conversations with various social care professionals, and previous post-graduate research that I conducted (unpublished) exploring substance use practitioner's response to domestic abuse, has also shown the need for further education and training regarding domestic abuse. The need for such training was discussed in chapter four of the literature review.

The second glaring gap in support was in Khloe's narrative when she recalled an encounter with the police following an experience of rape. She believed the police could have done more to support her following the incident, but did not, possibly because she was engaged in prostitution at the time of the assault.

The support offered by police as a protection service, has also been identified as a barrier by other women in this study. Police response to domestic abuse has also come under scrutiny in the wider public for many years. A 2017 report from Her Majesty's Inspectorate of Constabulary, focusing on police response to domestic abuse said, that while there is an increasing demand for the police to respond to domestic abuse incidents,

Some police forces are still failing to assess the risk and respond appropriately at the first point of contact. Others are inconsistent in the way they use their powers to keep people safe. Some forces are still not doing enough to pursue positive outcomes, where perpetrators are charged with an offence and brought before a court. (HMICFRS, 2017:5).

There is also a risk that police attitudes to domestic abuse are impacted by the victims use of substances.

Both Holly's and Khloe's experiences demonstrate the need for greater education and training around domestic abuse and traumatic experiences. However, another gap in support, identified in Kat's narrative further reinforces the need for education and training in both substance use and domestic abuse practice. Kat shared two examples where practitioners failed to support her despite Kat wanting to engage. As chapter 16 demonstrated, Kat was told by an alcohol worker that there was nothing he could do for her because she was engaged with a sexual assault service and a mental health service. A couple of years later, she was told by domestic abuse staff that she could not have a space in refuge if she was drinking problematically. At the time of the interview, Kat was seeking support for substance use and domestic

abuse, but as her pen portrait shows, this support was siloed. This is not an uncommon experience of support in the UK.

A 2007 commentary by Simpson and McNulty highlighted a lack of gender-specific support for women affected by substance use in the UK and 10 years later, AVA and Agenda's 2017 report *Mapping the Maze* (Holly, 2017) made the same point. The report is pivotal because it is the first of its kind in the UK to examine the service environment for women affected by substance use, mental ill-health, homelessness (including domestic abuse refuges) and other complex issues, also known as 'multiple disadvantage'. Exploring service provision across local authorities in England and Wales, the *Mapping the Maze* report highlighted a lack of integrated working and a lack of gender specific support for women affected by multiple disadvantage. The report also found that just under half of all local authorities in England (n=74) and only five unitary authorities in Wales, reported service provision specific for women with substance use needs. However, the authors urge caution in the interpretation of results as 'the existence of support offers no indication of the level of assistance available nor how many women can be supported at any one time' (Holly, 2017:8). Upon further analysis, the majority of the 28 services that reported gender specific substance use provision were actually generic mixed-gender services with a weekly women's group that typically lasted a couple of hours. The majority of these groups were not trauma informed but rather, took the form of a 'knit and natter'² meet up. Such a group reinforces gender biased social norms, that women just want to come together to knit and gossip.

The report also found that a further 28 services reporting to be gender-specific, were classed as specialist substance misuse midwives. The scoping study also identified 10 women-only residential rehabilitation facilities across England and Wales; however, they found that there are 129 rehabilitation centres listed on the Public Health England website. The review also identified 8 non-residential women-only substance

² A group for women who come together to talk about 'everyday' things while engaging in some knitting. Also known as a 'bitch and stich' session.

use services, eight community-based domestic and sexual abuse services that supported women with complex needs, three refuges that supported substance-using women, and four supported accommodation services for women who use drugs or alcohol (under homeless support for women). The review did not find one service that integrated specialist support for substance use, domestic abuse, mental ill-health and other complex needs. Services were most often found to address issues singularly (e.g. substance misuse or mental ill-health) which, 'can see women being passed around services' (2017:1); an experience highlighted by Kat and also by Holly in this research.

22.1 The impact of Siloed Support

As chapter 16 also presented, many of the women in this study experienced siloed support. Although most of the women said they received the support when they wanted it, they were predominantly referring to substance use support because support was not available to meet their specific multiple needs. As a result of this single-issue focus, most of the women in this study never received any domestic abuse support. Chapter 19 illustrated that domestic abuse was normalised for many of the women in this study; if domestic abuse is not explored in detail during treatment for substance use, then the women are potentially at risk of their partners encouraging their return to the relationship or future violent partners, which could have implications for relapse; Gina's experience demonstrated this somewhat.

Services, commissioners and policy makers are putting women in a position where they have to choose which issue is more pressing. By failing to provide support to meet the specific needs of women such as those interviewed within this study, the women have no choice but to prioritise one issue over another. This is further escalated by the lack of refuge space that caters for substance using women. As Kat's experience highlighted, she was not given a space in refuge because she was using alcohol, so she stayed in an abusive relationship until she was at a point of readiness to stop using. Kat's safety was compromised because there were no services to support her dual substance use and domestic abuse needs. Of course, it could be

argued that she had to take responsibility for her actions with regards to substance use, however, Kat also spoke about alcohol as a coping mechanism and a 'friend' during this traumatic time. It is therefore vital that domestic abuse services acknowledge the role substances can play in domestic abuse victimisation. In acknowledging the role of substances, specific support plans can then be put in place to support women like Kat, so she does not reach a point where she feels 'either he would kill me or the drink [would]' (chapter 15).

22.3 Scale of Siloed Support

The siloed support is not uncommon in the UK. The majority of services appear to have an either-or approach to substance use and domestic abuse support. This was shown through the *Mapping the Maze* report but also by the national domestic abuse charity Women's Aid. Their annual reports consistently show that women are being turned away from refuge because the service does not have the sufficient resources to support women with substance use needs (Women's Aid, 2018, 2017, 2016). Such reports are not new unfortunately. Galvani and Humphreys' (2007) research, and projects such as *The Stella Project* (2007) highlighted the need for more holistic approaches to drug and alcohol support for women. A decade on, the same issues are being discussed in this thesis, because nothing has changed. As the literature review highlighted, 'drug and alcohol treatment appear to be facing disproportionate decrease in resources, likely to reduce treatment penetration and the quality of treatment in England' (ACMD, 2017:1). Due to local authority funding cuts, a trickle-down effect is taking place, which also impacts domestic abuse services. This was found in a 2017 report from the Bureau of Investigative Journalism, who reported that 'local authorities across England have cut their spending on domestic violence refuges by nearly a quarter (24%) since 2010' (McClenaghan and Andersson, 2017, online). Given the continued cuts across local authorities in England, 'specialist domestic violence services are being hollowed out by council cuts forced by the government's austerity programme' (McClenaghan and Andersson, 2017, online). Specialist services that take a holistic approach to drug and alcohol treatment among women in particular, are therefore less likely to be established in this current financial

climate, despite more than a decade of recommendations from services such as AVA and researchers such as Galvani and Humphreys (2007).

Women such as those included in this research, will continue to need support. It is therefore vital that policy makers and commissioners create space for women with multiple and complex needs. Austerity is not going to deter problematic substance use and domestic abuse, but rather, may increase both issues for both victims and perpetrators as research by Fahmy et al., (no date) found when they investigated the relationship between poverty and domestic abuse for the Joseph Rowntree Foundation.

22.4 Barriers to Support – The Role of Social Workers

For most of these women, engagement with social workers occurred at multiple points of their lives. Most often, their engagement as adults came about because they were using substances as mothers and putting their children at risk of significant harm. Among these women, negative feelings were expressed towards social workers, because the women felt stigmatised and judged by their social workers.

Galvani (2017) explains that a failure by social workers to support substance-using individuals is not the fault of the individual social worker per se, but rather a wider systematic issue associated with structural pressures and constraints both now and historically. Social workers in the UK are not adequately, if at all, trained in the area of substance use (Galvani, 2017, 2018), despite substance use being ‘a core subject that spans, and effects, all service user groups.’ (Galvani, 2007:701). For example, Cleaver et al. (2008) found that 60% of child protection referrals in six local authorities in England involved substance use. Dance et al. (2014) also conducted online surveys (n=597), 12 focus groups with practitioners and 21 interviews with key informants and found that drug and alcohol use by service users appeared in all areas of social care and social work, more so for those in children’s services, and adult mental health services.

Despite the number of services users engaged with social workers in the UK, higher education is not responding to the lived experiences of social work practice. Within higher education, substance use is not a mandatory part of the social work curriculum in UK universities (Galvani, 2017). Galvani (2017) argues that the lack of focus on substance use within social work education and training is historic, which impacts on an ideology that substance use is not part of the social work role. This ideology impacts on the creation of policy both within health and education departments across government. The lack of policy therefore reinforces the status quo that substance use is not a social work issue yet individuals with substance use problems will still be part of social worker's caseloads. As such, Galvani says:

Social work as a profession must engage with substance use as part of its core work and therefore as part of its core education curriculum. Failure to do so results in an ongoing failure of social work service delivery and of its duty of care to people affected by problematic substance use (Galvani, 2017:14).

During the interviews, social workers were also spoken about as being judgmental and stigmatising. Although it is important to explore these feelings, it is also necessary to consider the actual role of social workers. Social workers have a responsibility to judge and assess the scale of risk to children who live with substance using parents. When parents cannot see the harm that they are causing to their children, which was highlighted by some of the women in this study, social workers are therefore seen as 'the baddies'. It is therefore important when we explore women's feelings regarding the social work profession, that the broader statutory role of the service is considered. However, it is also important to consider the attitude and approach social workers may have regarding substance using mothers.

The lack of substance use training within social work education may also impact on the perceived judgement the women felt. For example, Fenster and Monti (2017) found that American social work students who completed a 15-week substance use course showed a positive change in attitudes towards people with substance use

disorders and a positive attitude in the use of harm reduction methods as opposed to abstinence. Senriech and Straussner (2013) also found a more positive attitude change in social work students after completing substance use training.

A lack of training on substance use has the potential to impact how social workers interact with service users, in particular, personal experiences of familial alcohol use has an impact on social workers understanding (Livingston, 2017). Research by Galvani and Hughes (2010) found that the majority (69%) of 121 qualifying and post-qualifying students on an English social work programme, had no previous substance use training and the majority were not confident about their knowledge. The majority of the sample (95%) also felt that training on substances was relevant to social work practice. Even in the job, a lack of continuous professional development has been identified. Galvani and Forrester (2011) conducted online questionnaires with newly qualified social workers in England (n=284), exploring their views and experiences of substance use education and preparedness at the end of training. Less than half of the newly qualified social workers felt their course prepared them for substance problems on the job. Only 26% felt training adequately prepared them to understand the gender differences of substance use. Forty-one percent had further training since qualifying, however, those employed in local authority services were found to have had the least amount of training, as such, some participants actively sought out substance use training. Similar results were also found by Grant et al. (2017) who conducted online surveys with 205 newly qualified social workers in their first year of employment and found that the majority of the participants were concerned about the lack of development opportunities in their role, especially with regard to substance use. A lack of guidance on standardised substance use assessment is not available for social workers and Galvani et al. (2014a) concluded that identifying and assessing problematic use, differed between workers.

Many of the women in this study felt stigmatised by their social workers because they were substance using mothers. However, as this chapter has shown, the role of the social worker is to protect children at potential harm. Social workers are being failed

by the structural systems in place. The lack of appropriate substance use education and training within the higher education curriculum as well as the workplace, means that they are being set up to fail. This is further exacerbated by the high number of caseloads social workers are responsible for. For example, a recent survey by Community Care (Stevenson, 2018) found that 81% of children's social workers (total number 815) felt their current caseload was unmanageable. Dani also highlighted this during the interviews. There is, therefore, a tension between the women's expectations of social work support and the actual role and ability of the social worker to respond. Because of this clash, the women in this study were less likely to open up to social workers about their substance use.

22.5 Concluding Comments

At the beginning of this research process, I presumed that women would have difficulty accessing support for domestic abuse because they were using substances. I also presumed that substance use services would not fully engage with domestic abuse histories in treatment. To an extent, the literature review highlighted a gap in support for women affected by co-occurring substance use and domestic abuse, which corroborated my presumptions somewhat. My initial presumptions have also been confirmed by the women in this study. Although generalisations cannot be made due to the small sample size, by listening to the 12 women, this research has shown that there are gaps in support, and these gaps also pose as barriers to accessing support. Whereas chapter 21 highlighted the personal barriers to support, this chapter has shown the systematic barriers as experienced by the women in this study. Lack of sufficient service provision, in the form of domestic abuse and substance use support, was demonstrated. Identifying these gaps in support is important because, it helps both practitioners and policy makers to understand why more women are not accessing support for substance use. Understanding the women's experiences of social work is also important because it highlights the need for more informed learning regarding substance use within the social work curriculum and continued professional development.

Chapter 23

Discussion

What Works?

Using Women's Voices to Inform Policy and Practice

A core aim of this research was to understand the journeys to, and experiences of help-seeking and support as shared by the 12 women who took part in this study. By focusing on the voices of women who have experienced co-occurring substance use and domestic abuse, we are afforded the opportunity to learn from them. The 12 women in this study offered a unique perspective of what it is like to navigate support and help-seeking when services are not responsive to their co-occurring needs. This is important because until now, research has failed to account for these specific experiences.

Although there are many themes that could be explored further in this research, the three key messages discussed so far stood out as being integral to the overarching research question. Overall, these messages have demonstrated that prior to accessing support, personal and systemic barriers were perceived to inhibit the women from making a change sooner yet, various motivating factors eventually influenced them to seek support. When the women in this study accessed support, substance use was prioritised, however, they also brought with them a history of trauma and abuse, experiences that were not explored or supported in service. The three themes have shown that accessing support is not a linear process, it is not based on one specific issue and, the practices that the women engaged with, did not effectively respond to their complexities. These findings are important, because they offer a unique perspective of support and help-seeking among women with substance use and domestic abuse experiences. A perspective that has previously been hidden from research, policy and practice because women have not been asked to tell their story.

Thinking about these unique findings, this final discussion chapter will now discuss what works for women affected by co-occurring substance use and domestic abuse. Drawing on the themes outlined so far in part five, as well as the recommendations shared by the women and outlined in chapter 18, this chapter will explore the need for a gender-responsive trauma-informed approach to support, the importance of acknowledging the complexities that women bring with them to services and the importance of positive relationships with practitioners. In particular, this chapter will reiterate what the women in this study want from support, focusing on the importance of open communication, using their voice and trusting relationships.

23.1 Responding to Multiple Needs

As this research has shown, substance use was the focus of support for most of the women and when they accessed support they brought with them histories of complexity including adverse childhood experiences, experiences of domestic abuse, and other adult adversities such as prostitution; issues that are risk factors for problematic substance use and relapse (Gilchrist et al. 2012; Covington, 2008). These experiences demonstrate the necessity for services to respond to the whole of women's experiences but currently, services are siloed in the support that they provide. For example, both Kim and Lou attended residential rehabilitation programmes for their substance use where domestic abuse was only briefly touched upon. Trauma therapy did not appear to play a role in their rehabilitation programme despite the relationship between past trauma history and relapse among women (Heffner et al. 2011, Hyman, 2008). Lou's account of rehabilitation suggests that the rehabilitation counsellors appropriated feelings of guilt and self-blame rather than an examination of trauma histories.

To achieve positive longitudinal outcomes in harm-reduction and abstinence, it is important that a holistic approach to support is offered. This will help account for the complex and traumatic histories that many women bring with them. Unfortunately, as the *Mapping the Maze* (Holly, 2017) report has shown, there is a gap in the support that is available to women with complex needs in England and Wales. To overcome this gap, research recommendations by AVA and Agenda (Holly, 2017), Covington

(2008) and Holly and Scalabrino, (2012) have highlighted the need for gender-specific treatments that focus on the needs and experiences of women who use substances. Greater effectiveness has been found in treatments that address the needs specific of women (Greenfield et al. 2007), in what Covington (2002) refers to as 'gender responsiveness' (2002:52). However, a recent study of Neale et al. (2018) argued that the common assumption that women with complex drug and alcohol needs want women-only treatment is poorly evidenced. As such, Neale et al. (2018) conducted interviews with 19 women from a women's only rehabilitation facility and found that women were apprehensive about entering gender-specific support, but once there, they appreciated having the space to speak freely about their lives and experiences in the absence of men. Results also found that some women did not like living in a women's only space because of the tensions and conflicts that came with living in close proximity with other women. Neale et al. (2018) therefore suggests that women are given the option to enter a women-only service and are also given 'as much information as they want' (2018:7) before making the decision to engage.

Neale et al.'s (2018) findings are contradicted by Holly's (2017) interviews with 27 women as part of *Mapping the Maze* project. Holly (2017) found that women advocated for women-only spaces because of their previous failures in mixed-gender services, and also because of their past experiences of physical and sexual abuse perpetrated by men. The need for women-only drug and alcohol support was also acknowledged in the 2004 United Nations report, *Substance abuse treatment and care for women: case studies and lessons learned*. A more recent Board Report from the United Nations International Narcotics Control Board (2017) also highlighted the lack of support for women affected by substance use and recommended women-only spaces, including the provision of gender-sensitive, trauma-informed treatment programmes. Although Neale et al. (2018) argue there is poor evidence to suggest that women want gender-specific treatment, this is possibly because women are not being told about the benefits of engaging in women-only spaces which is hindered by the distinct lack of women's only drug and alcohol treatment in the UK. Furthermore, Grella's (2018) response to Neale et al. (2018) asks, 'Do women with SUD [substance use disorders] necessarily know what the best type of treatment is for them?' (Grella,

2018:1000). Although Grella (2018) acknowledges that presuming what is best for women runs the risk of infantilising them, she suggests the need for 'a critical evaluation of gender within addiction treatment [to] create a more nuanced and complex conceptualisation of gender dynamics [...] [which would] help both women and men make informed choices about the type of treatment that is best for them' (2018:1001). In response to Neale et al. (2018), Ettorre (2018) also points out the need to consider the wider influences that impact the epistemologies of ignorance, as she says,

...the knowledge-making practices present in addiction research and treatment have made the field resistant to examining the gendered, classed and racialized power differentials that structure women's lives. These power differentials need to be acknowledged, otherwise what we want to know about women's specific needs will continue to be unknown. (Ettorre, 2018:1).

Ettorre (2018) highlights the need to research and question what works for women who use substances, in order to create practice and policy that is reflective of women's realities. The various needs presented during the interviews with the women, and represented in figure six, suggest the need for women's only treatment and support that responds to their lived realities of substance use. In tailoring responses to women who use substances, Hawkins (2008) says the first-step is 'recognising that men's and women's needs differ' (Hawkins, 2008:95). This is echoed by Covington (2008) who says,

The key to developing effective services for women [is about] acknowledging and understanding their life experiences and the impact of living as a female in a male-based society. In other words, gender awareness must be part of the clinical perspective (Covington, 2008:378).

To respond to women's specific needs, the *Mapping the Maze* (Holly, 2017) report suggests a model that encompasses a gender-responsive, trauma-informed approach. Gender-responsive, as defined by Covington (2002) involves,

...creating an environment through site selection, staff selection, program development, content and material that reflects an understanding of the realities of women's lives and is responsible to the issues of the clients (Covington, 2002, pp.52-53).

Following interviews with service users and service professionals, the *Mapping the Maze* model advocate for a gender responsive approach, that reflects the views shared during the interviews with their service users. The model also advocates for a trauma informed approach informed by Elliot's (2005) principles of trauma-informed services. As part of the multi-site *Women, Co-occurring Disorders and Violence Study*, Elliot et al. (2005: 465-469) concluded that trauma- informed services should:

1. Recognise the impact of violence and victimisation on development and coping strategies
2. See recovery from trauma as a primary goal
3. Use an empowerment model where 'the ultimate goal [expands] a woman's resources and support network such that the woman becomes less and less reliant on professional services' (2005:466).
1. Aim to maximise a women's choice and control over her recovery
2. Based on a relational collaboration (recognising the power imbalance)
3. Create an atmosphere that is respectful of survivors need for safety, respect and acceptance
4. Emphasises women's strength, highlighting adaptations over symptoms and resilience over pathology
5. Minimise the possibilities of re-traumatisation
6. Be culturally competent and understand each woman in the context of her life experiences and cultural background
7. Include women in treatment design and evaluation.

Adhering to these principal's does not suddenly create a trauma-informed space. Rather, research by Thompkins and Neale (2016) found that trauma-informed treatment delivery was impacted by a stable and trained staff team, developing

therapeutic relationships, and creating and maintaining a stable and safe residential treatment environment. The importance of therapeutic relationships was also highlighted by the women in this study. Illustrated in chapter 17, some of the women focused on the importance of being listened to, explaining that they were more likely to engage with workers who made them feel like they were being heard. The importance of listening and being heard was an important resource for the women in this study and highlights the need for practitioners to give women space to talk. However, it is equally important that practitioners know what to do with the information they receive because asking about domestic abuse, substance use or other complex issues is not helpful if the appropriate referral pathways are not in place.

Although the *Mapping the Maze* model demonstrates the need for a trauma-informed gender-responsive approach to support, the model appears to be aimed at siloed services such as substance use services. Reflecting on chapter four of the literature review, further recommendations for services could focus on the integration and co-ordination of substance use and domestic abuse services. As Morton et al. (2015) demonstrated, taking a housing first approach to support has a positive impact on women with co-occurring issues, but also moves practitioners away from siloed approaches to working with service users, to a broader multi-agency approach. Similarities were presented in Bennett and O'Brien's (2007) study in the USA. Bringing substance use services and domestic abuse agencies together, has been shown to have a positive impact on women's substance use and domestic abuse outcomes, therefore, the integration and coordination of services is vital.

By unpicking the experiences of women as they journey to and engage with support, this research has shown that accessing and being engaged with support is complex. This research has therefore shown the need for more women orientated support options, however, the cynic in me knows it is not that simple.

Despite these recommendations for a trauma-informed approach to support or for integrated and coordinated services, UK policy is slow to respond. Within the drug

and alcohol treatment sector at present there is a contradiction between what is needed and what is available. This was identified following a review of the 2017 Public Health England report *An evidence review of the outcomes that can be expected of drug misuse treatment in England*. During the review, there was no mention of the word trauma, or reference to a holistic approach to support. Rather, the report focused on harm reduction, opioid replacement therapy and for those who were focused on abstinence, residential support was cited as good practice. *The Drug Strategy* (Home Office, 2017) also fails to focus on trauma-informed support for substance use. Although the 2017 *Drugs Strategy* (Home Office, 2017) sets out the Government's ambition to enhance treatment quality outcomes by tailoring intervention for different user groups, it fails to reference gender difference within the 'different user groups' (2017:28). For example, there was no reference to gender-specific treatment programmes. Under the title 'building recovery' the strategy also highlights the importance of joined up approaches to commissioning and delivering services and emphasizes the importance of collaboration among a number of services including 'all relevant community services and groups e.g. domestic abuse' (2017:29). However, it again fails to explain how this can be done and does not offer funding to achieve these aims. This was echoed by the ACMD's (Advisory Council on the Misuse of Drugs), report *Commissioning impact on drug treatment*, which was published in 2017 following the release of the *Drugs Strategy* (Home Office, 2017). The report expressed concerns over the aims outlined in the drugs strategy because the ACMD 'find it difficult to see how that aspiration can be delivered' (ACMD, 2017:2). Their response is especially relevant as reports show that drug and alcohol services in England have seen their funding cut by up to 30% since 2012, with more expected cuts in the future (Drummond, 2017).

Although the future of service provision does not look positive, by focusing on women's complex journey to support as this research has, and by communicating their journeys to the wider world, we continue to highlight the need for more resources and funding in both the drug and alcohol sector as well as the social care sector more widely.

23.2 Concluding Comments

This research is the first study from the UK to explore the experiences of support and help-seeking among women affected by co-occurring substance use and domestic abuse. By focusing on the women's journeys to support and their experiences of support, this study has shown that accessing support is complex. By focusing on the women's experiences before accessing support (chapter 20), and the personal and systematic barriers of accessing support (chapters 21 and 22), the final discussion piece offered here in chapter 23 has shown the need for support that is responsive of women's actual lived experiences. Support in the UK needs to offer an understanding of the gender differentials of substance use. It needs to account for the underlying experiences that women bring with them when they finally make it to support. It needs to account for the every-day needs of women as mothers. And support needs to listen to women about what they want from support.

This research identified many gaps in practice, research and policy relating to co-occurring substance use and domestic abuse. These identified gaps motivated me to speak to women with lived experiences of substance use and domestic abuse so that we could together, make recommendations for change in the future. Chapter 24 presents a list of recommendations for future practice, research and policy, which stem from engagement with the twelve women who took part in this research.

Chapter 24

Recommendations for Practice, Policy and Research

This research has created a new knowledge regarding women and substance use. Specifically, this research has focused on the voices of women who have experienced co-occurring substance use and domestic abuse, offering a unique perspective of support provision. This research has explored, in-depth, the women's journeys to support, and their experienced of support. By focusing on the multiplicity of women's needs and the nuanced reasons for substance use and domestic abuse engagement and non-engagement with services, we are given the opportunity to ensure more is done within practice, research and policy, to meet their specific needs. The following recommendations are influenced by my engagement with the 12 women in this study. Our recommendations for future practice, policy and research are:

24.1 Recommendations for Substance Use, Domestic Abuse Practice

1. Drug and alcohol services in England need to acknowledge the multiple complexities of the women presenting to their service. This includes an acknowledgement of their histories from childhood right through to their point of service.
2. In acknowledging women's histories when they present to services, it is vital that practitioners know what to do with the information that is presented to them. Asking about childhood experiences or adult re-traumatisation is not beneficial if appropriate support or referral pathways are not in place to deal with the underlying issues.
3. It is important that substance use practitioners are familiar with the local domestic abuse agencies in their area and vice versa.
4. Emergency referral pathways need to be set up between substance use services and domestic abuse services.
5. Substance use practitioners need to be trained to ask about women's histories of abuse.

6. Domestic abuse services need to acknowledge substance use as a coping mechanism or 'a friend' for many women who experience domestic abuse victimisation.
7. Domestic abuse services need to offer support to women with substance use needs.
8. Social work education needs to include substance use and domestic abuse within its core curriculum.
9. Substance use services need to be trauma-informed, utilising the principles outlined by Elliot et al., (2005) where possible.
10. Substance use services need to respond to the specific needs of women.
11. An integration of substance use and domestic abuse services is necessary.

24.2 Recommendations for Further Research

This research suggests the following areas for further research:

1. Quantitative studies that examine the prevalence and incidence of women affected by co-occurring substance use and domestic abuse in the UK.
2. Quantitative studies exploring the number of women accessing support (both formal and informal) with multiple needs.
3. Research that explores substance use as a form of domestic abuse.
4. Research exploring the impact adverse childhood experiences have on substance use and domestic abuse outcomes in the UK
5. Further research should also explore how sex, race, ethnicity and socioeconomic status impacts support and help-seeking for women affected by substance use and domestic abuse.
6. In-depth qualitative research exploring women's motivation to access support for substance use.
7. An examination of self-determination and empowerment on women's decision to access support for substance use.
8. Pilot studies exploring the integration and coordination of services in the UK.
9. Evaluations of staff awareness and training at local and national levels to ascertain what training is needed to ensure women are fully supported.

24.3 Recommendations for Future Policy

The following policy recommendations include:

1. An understanding of the gender differences of substance use.
2. Acknowledgment and recommendations for gender-specific substance use support.
3. An updated alcohol strategy for the UK that focuses on the gender differences of alcohol use.
4. A new alcohol strategy needs to also focus on the need for gender-specific alcohol support.
5. National policies need to account for the needs of substance using mothers, focusing on the need for childcare facilities.
6. Acknowledgement and implantation of care pathways for women who access support.

The aforementioned recommendations are influenced by the women's journeys to support, and their experiences of support, as presented in this thesis.

Chapter 25

Overall Conclusion

This research was conducted because women who experience substance use and domestic abuse are disadvantaged in health and social care practice. Anecdotal evidence has shown that substance-using women with histories of domestic abuse do not receive sufficient support in substance use services or domestic abuse agencies. This research, therefore, set out to explore the experiences of help-seeking and support among women affected by co-occurring substance use and domestic abuse. Influenced by anecdotal evidence and personal experience working within the field of social care, I wanted to know what women do to seek help, how they feel about the support they receive (or lack thereof), and what type of support is available to them, in a system that I know, is not built to respond to their needs.

Before defining the overarching research question, a review of literature sought to explore what is known about women who experience co-occurring substance use and domestic abuse. The review demonstrated the relationship between substance use and domestic abuse victimisation, by highlighting both quantitative and qualitative research evidence from the UK, USA and Europe. Because of the limited available research evidence and literature on the topic from the UK, the evidence cited, focused predominantly on studies from the USA. The literature review also examined the service landscape relating to co-occurring issues for women in the UK. Unfortunately, research evidence within a British context was lacking. However, the limited research that was found from the UK demonstrated that substance use and domestic abuse support and service provision is siloed. Exploring research outside of the UK, the review also discussed the impact of integrated and coordinated services on women's outcomes, as well as the impact domestic abuse policies have on women who use substances. A discussion on the lack of appropriate services for women with co-occurring substance use and domestic abuse led to an exploration of key governmental policy documents relating to substance use and domestic abuse. The discussion surrounding overarching policy in the UK concluded that there are many

gaps in policy, and these gaps have an impact on the creation and commissioning of substance use and domestic abuse services. By exploring the prevalence, service landscape and policy documents relating to co-occurring substance use and domestic abuse, the literature review influenced the creation of the overarching research question and subsequent research aims.

The overarching research question asked, 'what are the experiences of support and help-seeking among women affected by co-occurring substance use and domestic abuse?'. Reflecting on the review of literature, the research aims set out to explore women's motivations for support seeking, the barriers and/or enablers to accessing support, the wider influences on women's decision to seek help and, the practice of substance use services and domestic abuse agencies in supporting women with dual needs. In achieving these aims, I sought the views of 12 women who had experienced co-occurring substance use and domestic abuse. Using qualitative in-depth interviews, influenced by feminist theory and phenomenology, I was able to focus solely on the voices of women who experienced co-occurring substance use and domestic abuse. Using interpretive phenomenological analysis, the 12 interviews were analysed inductively to explore the in-depth experiences of navigating support with co-occurring substance use and domestic abuse.

The analysis of the interviews led to the presentation of 12 pen portraits and a sample profile. The pen portraits are included in this thesis because they illustrate the whole of the women's experiences of substance use and domestic abuse, before examining their dialogue in separate themes. The analysis of the interviews produced a number of pertinent themes that could form the basis of two more theses; however, by engaging with the overarching research question and subsequent research aims, I identified five superordinate themes and 28 sub-themes that I felt responded to the research question. These themes explored the relationship between childhood experiences and later adult substance use and domestic abuse, the motivations that influenced support access, the barriers that prohibited women from accessing support, their experience of support and, the impact support engagement had on them at the time of the interview.

As part four of this thesis illustrated, the 12 women in this study experienced a lifetime of adversity including, childhood physical and sexual abuse, witnessing parental substance use and domestic abuse, mental ill-health, homelessness, prostitution, rape and sexual abuse, domestic abuse and violence, motherhood and problematic substance use. Despite experiencing these multiple complexities and histories of abuse and substance use, this research has found that support is siloed in its availability. Before accessing support, the women moved back and forth in a state of ambivalence; often for years. This ambivalence was owed in part to the women's innate feelings of fear but is also due to wider socio-cultural factors. As part five of this thesis has demonstrated, women's agency was paramount in accessing support, but they were also impacted by a lack of support options. Service structures are not set up to respond to the gendered experiences of substance use and such failures stem from the wider environmental structures such as governmental policies, as well as wider social 'norms' regarding female substance use. Because of this siloed approach to support, none of the women in this study received support for their substance use and their domestic abuse from one service, or from coordinated working between services. Most of the women never received support for their domestic abuse, and most of the women never received support for their experiences of childhood abuse, neglect, sexual abuse, or rape. Women use substances and they experience multiple complex issues including domestic abuse. However, this research has shown that substance use services and domestic abuse agencies are not set up to respond to these needs, despite the fact that women continue to need support. As a result, women, like the 12 who took part in this study, never receive the support that they desperately need.

This is the first-time women's voices have been heard in terms of their service journey. Specifically, this research has focused on the voices of women who have experienced co-occurring substance use and domestic abuse, offering a unique perspective regarding their journey to support. By focusing on the voices and experiences of women, this research illuminates the complex histories that women have experienced. Rather than simply saying 'they have histories of trauma', this research has named the experiences of women to show that they never just access

support with one issue, but rather, a lifetime of complexity. This research is original because it portrays women's journeys to support, and their experiences of support, something other research and literature has not shown previously. This research shows us the impact siloed working has on those who need support; and it demonstrates a lived reality of accessing support in a climate where support is reducing.

This research does not seek to generalise from a sample of 12 women, however, this research does have the potential to instruct and inform both practice and policy in the areas of substance use and domestic abuse, as well as health and social care services broadly. This research has shown that there needs to be a dialogue between professionals in practice and in policy, and those who receive the service. Specifically, this dialogue needs to recognise the importance of privileging the voice of women because their experience tells us something that we have not heard before.

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Appendices

Appendix 1- Literature Review Database Search Terms and Parameters

Boolean Terms	AND, OR, NOT, *, "", ?
Search Terms	<p>"domestic abuse" OR "domestic violence" OR "intimate partner violence" OR batter*</p> <p>AND</p> <p>"substance *use" OR "drug *use" OR alcohol* OR "alcohol *use" OR addict*</p> <p>Following an initial search using the above search terms, the following terms were added to filter irrelevant sources:</p> <p>AND wom?n NOT perpetrat* AND (GeographicLocations:(United Kingdom))</p>
Inclusion Criteria	<p>Studies dated from 2000 +</p> <p>Studies written in English</p> <p>Full journal articles available online</p> <p>Studies that focused on domestic abuse victimisation</p> <p>Studies that focused on women</p>
Exclusion Criteria	<p>Studies that focused on perpetration</p> <p>Studies published before 2000</p> <p>Studies with a focus on children and young people</p>

Appendix 2 - Interview Guide



Manchester
Metropolitan
University

Interview Guide

Research Title: The Missing Conversation: Women, Substance Use and Domestic Abuse

Research Aim: Understand Women's lived experience of help-seeking when affected by dual substance use and domestic abuse.

Researcher's Notes:

Focus on experience of the research participant and what it means to them - **Probe**

If the woman becomes upset:

- Pause recording!
- Ask if she is okay and offer some water
- Offer to stop the interview
- Offer contact information for relevant people to talk to
- **REMEMBER! – YOU ARE NOT THE SUPPORT WORKER!!!!**

Interview Guide (This is a guide and may not follow in this order)

Open with an introduction of the project, ensure the participant is comfortable being recorded and take them through the consent form. When consent form has been signed and the participant has asked any questions they may have, proceed with recording.

Q1. So (name) you offered to take part in this interview because you identified as having a problem with drugs and/or alcohol- can you tell me what place substances have in your life now?

Q2. You also are here because of abuse in a relationship- can you tell me about that?

Q3. What about the relationship between the two (substance use and domestic abuse)- what is your understanding of that?

Q4. Can you describe the effect this has had on you? What about children/family life?

Q.5 Going through substance use and domestic abuse together- did you seek support at any stage or discuss it with anyone? Can you tell me more about this?

Q6. What prompted you to seek support?

Q.7 What happened when you tried to access support?

Who did you contact? What did they recommend? Did you agree? What was it you wanted from seeking support?

Q.8 Have things changed since?

Q.9 Is there anything you yourself would change about the support you received?

Q10. Is there anything else about your experience that stands out- that you feel was important?

Recap, thanks and close.

Appendix 3- Email to Services

Dear xx

I am a PhD candidate at MMU and I'm wondering if I can get support from a women's team in Manchester.

My research is titled: The Missing Conversation: Women, Substance Use and Domestic Abuse. My research seeks to explore women's experiences of dual substance use and domestic abuse. The aim of my research is to focus on the voice and experience of women regarding service provision and support when affected by dual substance use and domestic abuse. What I have found in literature and other research, is a lack of women's own voices regarding the duality of substance use and domestic abuse, particularly with regards to understanding how they seek support from services.

I am looking to recruit women who have attended various services, such as domestic abuse, substance use, homelessness and social care. Women can be referred by gatekeepers or they can contact me via email, Facebook (a special page has been set up with protocol in place), call or text. Women will be interviewed face to face and questions will explore their use of substances, the effect of domestic abuse, and their use and experiences of services when affected by both substance use and domestic abuse. Ethical approval has been granted by my university and I am being guided by my Director of Studies, Prof. Sarah Galvani. Additionally, I have practical experience working in homelessness, children's services and domestic abuse, and I hold a MSc in drug and alcohol studies and a MSc in Social Research; so, I am aware of the complexities for women affected by multiple disadvantage.

As you probably know, there are many women who are both victims of abuse and problematic substance users in varied social care systems, and often there is limited support and resources to meet their specific needs. I want to reach out and find out what is happening to these women.

I have attached the project information and a flyer to be circulated to whoever possible. If you can support me in reaching women with experiences of domestic abuse and problematic substance use, a more detailed information sheet is available to distribute to women. This research is not specific to Manchester and therefore I am more than willing to travel to conduct interviews if necessary.

If this is something you can facilitate, I would love to talk to you more over the phone. If there was an opportunity to come to the service, I would welcome the opportunity.

Thanks for your time.

Warm wishes,
Sarah

Sarah Fox
PhD Student
Dept of Social Care and Social Work
Manchester Metropolitan University

Appendix 4 – Recruitment Flyer



S.U.D.A Research
Understanding women's experiences of substance use and domestic abuse

I am a PhD student at Manchester Metropolitan University and I want to talk to women who have experienced substance use and domestic abuse at the same time. I want to know about your experiences of service support when affected by drug or alcohol use and domestic abuse. If you have been in contact with social work, social care, domestic abuse services, drug and/or alcohol services, police or homelessness, I would like to talk to you.

Domestic Abuse Definition: Any incident or pattern of incidents of controlling, coercive or threatening behaviours, violence or abuse from the age of 16 or over from intimate partners or family members. Abuse can be, but it not limited to: psychological, physical, sexual, financial or emotional. **Substance Use Definition:** Self-identifying a problem with drugs or alcohol. Or, identified by a professional as being problematic or an addiction.

**Process:**

- Interviews will be held at a location that is convenient to you.
- You will be provided with a consent form to sign.
- You will have the opportunity to ask any questions about the research.
- You can withdraw from the research at any time during the interview.
- Your name or any identifying information will not be published in the research.
- This research aims to inform services about women's experiences of substance use and domestic abuse.
- This research goes towards obtaining a PhD.

If you would like to take part in this research you can:

- Ask your worker to get in contact with me.
- Email me directly at: sarah.fox@stu.mmu.ac.uk
- Send me a private message on Facebook, simply look for '[Sarah Fox-Research](#)'.
- Text 07376786568

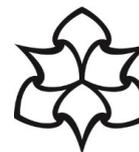
All contact made will be confidential.

Appendix 5- Ethical Approval

**Manchester Metropolitan
University**

M E M O R A N D U M

FACULTY ACADEMIC ETHICS COMMITTEE



Faculty of Health,
Psychology & Social Care

Brooks Building
Birley Fields Campus
53 Bonsall Street
Manchester
M15 6GX

+44 (0)161 247 2569

HPSCresearchdegrees@m
mu.ac.uk

To: Sarah Fox

From: Prof Carol Haigh

Date: 13/12/2016

Subject: Ethics Application 1324

Title: Understanding how women navigate through, and are supported by, services when experiencing simultaneous substance use and domestic abuse.

Thank you for your application for an amendment to your original ethical approval.

The Faculty Academic Ethics Committee review process has recommended approval of your amendment. This approval is granted for 42 months for full-time students or staff and 60 months for part-time students. Extensions to the approval period can be requested.

If your research changes you might need to seek ethical approval for the amendments. Please request an amendment form.

We wish you every success with your project.

Prof Carol Haigh and Prof Jois Stansfield
Chair and Deputy Chair
Faculty Academic Ethics Committee

Appendix 6 - Information Sheet for Gatekeepers

**Manchester
Metropolitan
University**

Project Information for Gatekeepers**Research Title: The Missing Conversation: Women, Substance Use and Domestic Abuse.**

Thank you for giving your time. Please read the following information at your own pace and get in contact with any questions.

Research Overview

I am a PhD candidate at Manchester Metropolitan University and I am doing research with women who have experienced problematic substance use (drugs and/or alcohol) and domestic abuse together. The purpose of this research is to explore the experiences of women who have been affected by problematic substance use and domestic abuse victimisation but, who have also come into contact with services (e.g. social work, homelessness, substance use, domestic abuse, police). This research seeks to learn about women's experiences of service provision when affected by these co-occurring issues. The information gathered from women will be analysed with a focus on their varied individual experiences of help-seeking. In doing this, I hope to inform support services about women's experiences of service provision when affected by dual substance use and domestic abuse victimisation.

Your Role

I am contacting you because of your role working in a service I wish to access. In conducting this research, I would like to interview women who have experienced or are currently experiencing problematic substance use while also being in an abusive relationship. I wish to interview these women so as to understand their experiences of help-seeking when affected by dual substance use and domestic abuse.

Your role is to help me notify women of the study and invite them to take part if they meet the following criteria:

- Woman
- 18 years +
- Affected by problematic drug and/or alcohol use (either self-classified or diagnosed by a professional)
- Victim/survivor of domestic abuse

I am particularly interested in speaking to women who have tried to access domestic abuse refuge but denied due to their substance use.

I will contact you 7 days following receipt of this information sheet, to ask if you can support me in this research. If you do not wish to take part in the interview, I will no longer contact you, however you have the opportunity to get in contact if you change your mind.

If you agree to act as gatekeeper for any women you suggest, I will email you a copy of the advertisement and information sheet to provide to your women. If a woman agrees to take part, communication will continue between me and her to ensure ethical procedure is followed.

Confidentiality and Anonymity

As this research focuses on women with vulnerable issues, the stories women share will be treated anonymously and in confidence in accordance with the Data Protection Act (1998). The data collected will be used for the purpose of this PhD research and subsequent publications and presentations. All women will be given time to consider participation. They will be informed about the aims of the research and they will be provided with a consent form prior to taking part. Upon transcription, the interviews will be anonymised, and pseudonyms will be used to replace the name of the women who take part. Any mention of a specific service or location will be redacted and replaced with: (name of service)/ (name of town). As this research study is part of the process to obtain a PhD qualification, transcripts will be kept until the final examination (viva) has been completed. When the qualification has been awarded, transcripts will be shredded in a university shredder.

With regards to your role as Gatekeeper, your name or identifying information will not be mentioned in the research. Only the service type (e.g. social work, homeless) will be highlighted. This is to highlight to the reader the agency type that the women are referring to in their interview.

Next Step

Due to the busy Christmas period in various social service settings, interviews will commence from January 2016. However, data recruitment with vulnerable individuals can take a long time and I am inviting you to think about individuals who may be suited to take part in this project in the new year. If you can assist in this project or have any questions, please contact me at the details below. If you do not feel you are able to assist but know another service who can, please let me know.

Thank you for taking the time. I look forward to hearing from you.

Kind regards,
Sarah Fox

Lead Researcher
Sarah Fox
Email: sarah.fox@stu.mmu.ac.uk

Research Supervisor
Prof. Sarah Galvani
Email: s.galvani@mmu.ac.uk
Contact: 0161 2472579

Appendix 7- Information Sheet for Women**Manchester
Metropolitan
University****Project Information for Women****Project Title: The Missing Conversation- Women, Substance Use and Domestic Abuse.**

Thank you for giving your time to consider participation in this research project. Please read the following information at your own pace and feel free to contact me with any questions you may have.

Research Overview

I am a PhD candidate at Manchester Metropolitan University and I am doing research with women who have experienced problematic substance use (drugs and/or alcohol) and domestic abuse together. The purpose of this research is to explore the experiences of women who have been affected by problematic substance use and domestic abuse victimisation but, who have also come into contact with services (e.g. social work, homelessness, substance use, domestic abuse, police). This research seeks to learn about women's experiences of service provision when affected by these co-occurring issues. The information gathered from women will be analysed with a focus on their varied individual experiences of help-seeking. In doing this, I hope to inform support services about women's experiences of service provision when affected by dual substance use and domestic abuse victimisation.

The Process

When you have read this information sheet and if you agree to take part in the research, a suitable and mutually convenient time and location for interview will be arranged. Each participant will be invited to interview once. Interviews are expected to last between 30 minutes and one hour. If a face-to-face interview is not possible we can discuss the possibility of an interview via skype/face-time or over the phone.

Prior to opening the interview, you will be presented with a consent form and given the opportunity to ask any questions regarding the process. When you are ready to begin the interview a recording device will be used to ensure accuracy. If you chose to interview through skype/face-time or over the phone, a consent form will be emailed to you and you will be asked to fill it in and email it back.

As a way of ensuring I get the best from your story, I will ask you some questions. These questions will be asked solely to inform the research being undertaken and will not be used for any other purposes. Once the interview is over, the recordings will be transcribed and deleted from the recording device. Taking part in this research is not compulsory and you can stop the interview at any stage. Any information recorded will be deleted if you wish.

The information shared by the participants in this study will contribute to a thesis, which will be used to obtain a PhD qualification from Manchester Metropolitan University. This thesis is intended to be used as a foundation piece of work in the area of substance use and domestic abuse. The information collected may also go towards the publication of journal articles, presentations, workshops, teachings and other written academic pieces.

Confidentiality and Anonymity

Confidentiality and anonymity are vital aspects of this research. In accordance with the Data Protection Act (1998) the information you share will be treated in complete confidence and will only be used for the purpose of this research and subsequent publications and presentations. To respect your privacy and keep your identity hidden, I will use pseudonyms for any information that may identify you. I will replace your name with a fake name and I will use information such as: (name of city) to substitute any identifying destinations you may mention during the interview. Your name will only appear on the consent sheet you are asked to sign should you wish to take part in this research. These consent forms will be kept in a locked cabinet and shredded when the research project has been completed. Consent forms are necessary to ensure this research keeps in line with ethical standards set out by Manchester Metropolitan University. If you chose to take part in the interview through skype/face-time or over the phone, a consent form will be emailed to you prior to interview and you will be asked to fill it in and email it back. It will then be printed and kept locked away.

As this research study is part of the process to obtain a PhD qualification, transcripts will be kept until the final examination (viva) has been completed. When the qualification has been awarded, transcripts will be shredded in a university shredder.

Protecting your identity will be my primary concern during data collection. However, as a social care researcher I have a duty of care to report any concerns of serious harm either to/from women interviewed within this study as well as any children or other vulnerable people who may be at harm.

Potential Risks as a Research Participant

This project aims to understand how women choose support services when affected by both substance use and domestic abuse. Questions will be asked about your experiences of substance use and domestic abuse. This research is considered a vulnerable topic as it has the potential to cause upset to those being interviewed. Reliving memories of substance use and domestic abuse can evoke negative feelings. This is something I am fully aware of as researcher. Although I cannot guarantee you will not become upset during the interview process, I have gone to great lengths to ensure this risk is kept to a minimum. I have experience supporting women and children who have experienced domestic abuse and substance use and so, should you become upset at any stage of the interview I will pause the recording and we can have a chat about what you would like to do. You will be under no obligations to continue the interview. If you chose to interview through skype/face-time or on the phone and become upset at any stage, I will also pause the recording and we can

have a chat about what you would like to do. It is important you are aware this may happen and are comfortable discussing this topic over skype/face-time/phone.

Thank you for taking the time to read this research information. I invite you to contact me or my research supervisor, Prof. Sarah Galvani (email: s.galvani@mmu.ac.uk 0161 2472579) with any questions you may have regarding your participation in this study. If you wish to take part, please contact me using the details below.

Kind regards,
Sarah Fox

Lead Researcher
Sarah Fox
Email: sarah.fox@stu.mmu.ac.uk

Research Supervisor
Prof. Sarah Galvani
Email: s.galvani@mmu.ac.uk
Contact: 0161 2472579

Appendix 8 - Consent Form



Consent Form

Project: Understanding women's experiences of substance use, domestic abuse and support services.

You are invited to take part in research that explores your views and experiences of substance use and domestic abuse. Please initial in the boxes and sign below if you agree to the following statements:

- I have been given a copy of the information sheet and enough time to consider taking part in this study.
- I am confident that any concerns or questions have been sufficiently answered.
- I understand that the researcher will respect my right to confidentiality and anonymity.
- I am comfortable that appropriate steps have been taken to protect my identity and identities I may potentially share through the interview.
- I understand that any information shared regarding the risk to vulnerable children or adults will be shared with necessary authorities.
- I understand that I can exit the interview at any time without prejudice and can choose to have my information deleted.
- I agree that the information shared can be used for research, publications and presentations.

By signing this consent, you agree to the terms outlined above and are happy to take part in the study:

Name of Participant	Date	Signature
_____	_____	_____
Name of Researcher	Date	Signature
_____	_____	_____