

“...you feel there’s nowhere left to go.” The barriers to support among women who experience substance use and domestic abuse in the UK.

Abstract

Purpose

Domestic abuse victimisation is a common experience among women with problematic substance use, but support provision for both issues is siloed within the UK. Research on the topic focuses on practitioner responses, dominating women’s voices within research, policy and practice. As such, this study sought to fill this gap and explore the lived experiences of these women as they attempted to seek help.

Design

Semi-structured interviews were conducted with 12 women who had a history of co-occurring problematic substance use and domestic abuse. Influenced by interpretive phenomenological analysis and feminist research praxis, the analysis explored how women with dual needs navigated support and help seeking and the barriers they faced.

Findings

The women reported the biggest barrier was the disconnect between substance use and domestic abuse support, including a gap in the communication of information. This resulted in them having to choose which of their needs to seek support for. None of the women received support for their combined experiences, and most of the women never received support for their domestic abuse experiences alone.

Originality

This is the first piece of research from the UK to explore, in-depth, women’s journey through support for their co-occurring substance use and domestic abuse victimisation. Previous research has not consulted with women to understand how they navigate the complex support systems available. This paper is therefore important, because it demonstrates the journeys to services these women take and the barriers they have to overcome.

Keywords: Substance use, domestic abuse, women, support, access to services

Introduction:

This paper focuses on the findings of a small scale, in-depth study that explored how women with lived experience of co-occurring problematic substance use (PSU) and domestic abuse victimisation (DAV), navigated their journey to support. This is the first study from the UK to present, in depth, the perspectives of women, and the various challenges they faced in accessing services for their multiple and complex needs. This paper will begin by briefly summarising the scale of the problem before exploring the limited qualitative literature.

The co-occurrence of problematic substance use and domestic abuse victimisation among women is an international problem (Gadd et al., 2019; Weaver et al., 2015; Devries et al., 2013). Studies from countries including, Australia, South Africa, Spain, Japan, the USA and Sweden have shown that DAV is a common experience among women with PSU (Ahmadabadi et al., 2019; Watt et al., 2017; Gilchrist et al., 2012; Yoshihama et al., 2010; Hughes et al., 2010; Stene et al., 2012). This was also identified in a meta-analysis by Cafferky et al., (2018) who analysed data from 285 international studies and found that substance use was significantly related to domestic abuse; with illicit drug use showing a stronger correlation to victimisation compared to alcohol. However, the analysis only focused on physical intimate partner violence (IPV), negating the link between PSU and non-physical forms of abuse.

In the UK, the Adult Psychiatric Morbidity Survey (APMS) and Crime Survey for England and Wales are the two main sources of current prevalence data, suggesting different levels of prevalence of substance use and co-occurring domestic abuse victimisation. First, figures from a secondary analysis of the Adult Psychiatric Morbidity Survey (APMS) found that 585 women had a problem with alcohol (Audit score of 8+) and of these women, 31% experienced extensive physical and sexual abuse as a child and adult, while 16% experienced extensive physical abuse from a partner at some point in their lives (Scott and McManus, 2016). However, these figures could be higher than indicated because the APMS, like Cafferky et al.'s (2018) international meta-analysis, did not account for non-physical forms of abuse. Second, data from the Crime Survey for England and Wales (ONS, 2018) shows that of the 1.3 million women who experienced domestic abuse in the past year, 8.1% were under the influence of

alcohol and 1.7% were under the influence of drugs during their most recent experience of abuse (ONS, 2018). These figures may also be higher than reported because 14.5% of victims responded 'don't know' or 'don't want to answer' when asked about their own alcohol use at the time of the abuse. While these figures offer some indication as to prevalence of co-occurring PSU and DAV, there remains limited data on which to judge the scale of the issue in the UK and, subsequently, to base calls for improved policy and service provision; this is also the case with qualitative literature. While several international qualitative studies have sought to explore the experiences of co-occurring substance use and domestic abuse victimisation among women in the past 15 years (Wilson et al., 2017; O'Brien et al. 2016; Abdul-Khabir et al., 2014; Macy et al. 2013; Rivaux et al., 2008; Call and Nelson 2007; Nehls and Sallmann 2005), only one study from the UK (Wright et al., 2007), was identified that focused on the relationship between PSU and DAV in the same time period. Wright et al. (2007), interviewed 45 drug using women from an array of substance use services in Northern England and found that the women who used drugs often felt coerced by partners to inject. While this study highlights the complex relationship between peer injecting and domestic abuse, the study did not explore the women's experiences of support or service provision. The lack of qualitative data focusing on the lived experiences of women with problematic substance use and domestic abuse victimisation was identified in a meta-ethnography by Gilchrist et al., (2019), who found four studies from the UK that explored the role of substance use in survivors and perpetrators accounts of IPV. The aforementioned study by Wright et al., (2007), was the only identified study in the meta-ethnography to focus on the experience of female victims who use substances. Therefore, as this data shows, there is a lack of research from the UK that focuses on the lived experience of co-occurring substance use and domestic abuse victimisation; however, this research begins to fill this evidence gap.

While there is a clear relationship between problematic substance use and domestic abuse victimisation among women, theoretical understanding of how and why this relationship occurs is complex. Various theories offer different perspectives on the relationship; the most popular theory stating that women use substances to cope with the physical and psychological feelings associated with the abuse (Humphreys, et al., 2005; Khantzian, 1997). However, alternative theories suggest that women may use drugs or alcohol as a means of growing closer with a romantic – albeit abusive - partner (Macy et al., 2013; Covington, 2007);

that a perpetrator may coerce and control the victim into using substances (O'Brien et al., 2016; Wright, 2007;); or, that the perpetrator may use the victim's substance use as an excuse for inflicting abuse (Fox, 2018). The importance of theorising the relationship between substance use and domestic abuse is that it often underpins service response and therefore where limited resources can be targeted.

Despite the association between PSU and DAV among women, and the theories about the connection between the two, the UK has a lack of services that respond to the needs of women who need support for both issues. A review of services by Holly (2017) identified eight community-based domestic and sexual abuse services that supported women with complex needs across England and Wales, and three domestic abuse refuges that supported substance-using women in the same regions. The lack of refuge provision for women with PSU is highlighted by England's national domestic abuse charity Women's Aid, whose annual reports show that women are often turned away from refuge if they have problematic substance use (Women's Aid, 2018, 2017, 2016). The review by Holly (2017) also found that just under half of all local authorities in England (74) offered gender specific drug and alcohol support for women, however, Holly (2017) offers caution in the interpretation of these 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). This caution raises key questions addressed by this research in relation to what level of support women are able to secure and the extent to which they are supported by health and social care professionals to link with other services to meet their needs. A study by Bailey et al., (2019) also highlighted how some practitioners from substance use, IPV, and criminal justice services in England, were trying to emulate support that was consistent with gender specific trauma-informed practice.

There are no UK studies that explore the impact this lack of service provision has on the lived experiences of women with problematic substance use and domestic abuse victimisation as they seek support. Knowledge is, therefore, missing; knowledge that could inform and shape policy and service provision for women. In the context of PSU and DAV, little is known about what women do to seek support, how they navigate their way between siloed services, how they feel about the support they receive, and the type of support available to them. This

research begins to fill this evidence gap. This paper will focus specifically on the systemic barriers as discussed by some of the women who took part.

Methodology and Methods

The overarching aim of this research was to explore the journeys to support among women with lived experience of PSU and DAV. In exploring their journeys to support, this study sought to understand their experiences of gaps in support, the barriers to accessing support and the response of services to them.

Theoretical Influences

This study is influenced by feminist research praxis; a process of doing research seeped in feminist theory where a commitment to the voice and experience of women is paramount (Hesse-Biber, 2014). Feminist research praxis does not lay claim to a specific method of conducting research, however, it aligns with the principles of interpretive phenomenological analysis (IPA) (Smith, et al., 2000) that is, a focus on the individual lived experience as portrayed by the research participant, as well as an awareness of the researcher's positionality throughout the research process.

Study Design

This was a qualitative study, using a semi-structured interview approach, as this allowed the interviewer to guide the research participant while being able to probe in real time (Smith et al., 2009). The identified gaps in literature relating to support for women with substance use and domestic abuse, influenced the design of the interview questions that explored the initial stages of the women's PSU and DAV, their motivations to access support, the challenges of support seeking and their lives at the point of the interview.

Recruitment Process

A purposive-convenience and snowballing recruitment approach was adopted (Valerio et al., 2015). Women were invited to take part in the study if they were over the age of 18, identified as experiencing PSU currently or historically and, identified as a victim or survivor of domestic abuse at the same time as their substance use.

The ethics board at Manchester Metropolitan University granted ethical approval in February 2016. Women from all over England were invited to take part in the study, however, recruitment predominately focused on London, the Midlands and the North West due to the contacts already established in these locations. Facebook was also used as a recruitment tool where groups that focused on substance use or domestic abuse were accessed. An e-flyer was shared within these groups and women were invited to make contact via Facebook messaging, email, text or phone call if they wanted further information.

Each woman was given an information sheet and invited to ask questions about their potential participation. The information sheet outlined the aims of the study, how their interview would be used, the process if they became upset during the interview or wanted to pull out at any stage, and the nature of confidentiality and anonymity. The information sheet also explained that confidentiality could not be guaranteed if they disclosed information that posed a risk to herself or another person. This information was presented in written form on the information sheet and discussed prior to signing the consent form.

Interviews were conducted between March and June 2017. They took place in drug and alcohol services, the women's homes and a private university office, and lasted between 30 minutes and two hours. None of the women were in relationships at the time of the interview. One woman was still living with her partner; however, she explained that the abuse was historical and while they lived together, they were not in a relationship. Following each interview, I spoke to the women about how they were feeling and asked if they had someone to talk to if they felt they needed to. All women said they had a friend, peer or support worker they could talk to. Each woman was offered information about services relating to substance use and domestic abuse and were given a box of chocolates as a gesture of thanks. The women were not contacted again following the interview.

Researcher Positionality

I am a white, cis-female, privileged academic, with practice experience within various social care services including DAV services. During the interview process, I was consciously aware of the power dynamics between myself and the women I wanted to interview. To minimise the

power imbalance and ensure the women felt comfortable with me I dressed casually, had a cup of tea with the women, chatted about every-day things while setting up and closing down the interview and talked through the research in plain language. I also reminded the women before and after the interview that they could change their mind if they wanted to.

Following each interview, I kept a reflective diary. This diary noted my initial thoughts regarding the women and their experiences, any potential bias I held based on my understanding of the field, and any initial themes that I felt were important to explore in further interviews. Throughout this process I was aware of how I framed each woman's narrative, wanting to ensure I did not present the women as passive victims. As a feminist researcher, the acknowledgement of such bias is an important part of the reflexive process. While I cannot guarantee complete unconscious bias, I tried to minimise bias by reflecting on my diary notes and by using a qualitative research group to discuss my thought processes throughout the stages of analysis.

Analysis

The recordings were transcribed, anonymised by using pseudonyms to replace names, and any identifying information, such as geographical locations or names of particular services, were removed. The transcripts were uploaded to NVivo, a computer-based management software that supports qualitative research. Using Smith et al., (2009) as a guide, the following steps were taken to analysis the data using IPA:

1. Transcripts were read while listening to the recordings. This engagement with the data helped me to familiarise myself further with each woman's interview and ensured, as far as possible, that I did not misrepresent their experiences.
2. I conducted a line-by-line re-read of each transcript, where descriptive experiences, the use of language, and questions in response to the participants' comments, were highlighted and coded, as suggested by Smith et al. (2009).
3. The transcript was read a third time to review the codes in relation to the narrative, feeding into Smith et al.'s (2009) concept of the hermeneutic circle; understanding the parts, that is, the codes to understand the whole narrative.
4. 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 theme because they were similar, for example, codes that were initially titled 'childhood' or 'adolescence' were grouped together under a new theme titled 'early life'. The process continued, with codes and themes continually being compared and contrasted in light of the overarching research aim, until I identified a final list of superordinate themes and sub-themes.

Following the process of analysis, five superordinate themes and 30 sub themes were developed that reflected the overarching research aim. Table 1 presents an overview of each superordinate theme and accompanying sub-themes. As this table shows, the superordinate themes and accompanying sub-themes focused on the early life of the women including their own experiences of living with a parent using substance, their motivations to effect change, the barriers to accessing support, and their overall experiences of various formal and informal support types. While the overarching aim of this research was concerned with women's engagement in support, by using IPA and taking an inductive approach to analysis, themes were identified that may have been overlooked had a more deductive thematic approach been taken.

Table 1 – Superordinate themes and sub-themes

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 • 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 • Khloe • Holly • Kat • Prioritising Need
Experiences of support	<ul style="list-style-type: none"> • Accessing Support • Experience of Workers • Social Workers • Support Workers • Domestic Abuse Support • Family, Friends and Peer Support • Twelve-step Programmes • Friends and Peer Support
Impact of Support	<ul style="list-style-type: none"> • Volunteering • Ongoing Recovery • Improving Support • Understanding • Communication

Findings:

Sample Profile

Seventeen women were sent the information sheet. Two women expressed interest in being interviewed, however one woman pulled out following the death of a friend and one woman pulled out explaining that she was worried about discussing things she had moved on from. After receiving the information sheet, three women did not respond to follow up messages.

Twelve women gave informed consent to be interviewed for this study. Seven women were recruited through Facebook, four women were recruited from two different PSU services, and one interviewee referred me to another woman who agreed to be interviewed.

The women were aged between 27 and 65 years at the time of the interviews. They used a combination of drugs and alcohol, and their time substance free ranged from zero days to 16 years, with one woman still drinking at the time of the interview. Nine of the women were mothers, seven had contact or custody of their children, and two women no longer had custody or contact with their children. Ten of the women experienced abuse from a male partner, and two women experienced abuse from a female partner. All 12 women accessed support from substance use, social care or general health at some point of their lives. Table 2 presents a profile of each woman, including the amount of time they were substance free at the point of the interview, and the key services they mentioned throughout the interview. Highlighting these services is important because it shows the various support types that woman can encounter when PSU and DAV is present in their lives.

Table 2 – Participant profile

Pseudonym	Age*	Ethnicity	Sexuality	Substance Use	Time substance free	Service Engagement
Laura	65	White British	Heterosexual	Drug and Alcohol Use	2.5 years alcohol and 3 years drug free	Psychiatric Hospital, Drug and Alcohol Service, Refuge, Social Work, Police, Prison
Michelle	35	White British	Heterosexual	Alcohol Use	7 months	Psychiatric Hospital, Drug and Alcohol Service, Residential Service, Social Work, Refuge, Detox Unit, Police
Kat	Unknown	White European	Heterosexual	Alcohol Use	7 months	Refuge, Drug and Alcohol Service, Psychiatric hospital, Counselling, Mental health charity, Rape and sexual assault charity, Other addiction service
Khloe	45	White British	Heterosexual	Predominantly drugs with a bit of alcohol. Still drinks but not heavily.	5 years drug free but still drinks occasionally	Drug and Alcohol Service, Detox Unit/rehab, Hostel, Police, Prison

Gina	45	Black British	Heterosexual	Drugs and a bit of alcohol but still drinks occasionally	Nearly 3 years but still drinks occasionally	NA & AA, Domestic Abuse Project, Social work, Police
Kim	32	White British	Heterosexual	Drugs, alcohol and painkillers	2 years	Rehab, AA & NA, Social Work, Support Work, Police
Lydia	28	White British	Gay	Drugs and alcohol but predominantly drugs	5 days	Drug and Alcohol service, Day service for substance use, NA/AA, Social Work, Police
Elaine	35	White British	Heterosexual	Drugs and alcohol	13 months	AA & NA, Counselling
Holly	Unknown	White British	Heterosexual	Alcohol Use	16 years	Refuge, 12-step, Mental health service, Drug and Alcohol service, Police
Lou	42	White British	Gay	Drugs and alcohol	6 years	Rehab, 12-step programme, Counselling, Police
Jo	Unknown	White British	Heterosexual	Alcohol Use	Ongoing	Counselling, Alcohol counsellor, Social Work, AA, Police
Dani	Unknown	White British	Heterosexual	Drugs and Alcohol	Drug free 7 years and alcohol free 6 years	Detox Unit, Support Worker, Social Work, Police, Prison

*Interviewer did not ask the age of every woman

Systemic Barriers to Support

While 12 women shared their experiences with me, not all of them spoke directly about systemic barriers, that is, barriers posed by systems and services, to accessing support. This is because some women only accessed substance use support such as AA, because they felt it was the more important issue in their lives. However, for some women, their access to services was negatively impacted by gaps in support and communication.

Gaps in support

Throughout the 12 interviews, none of the women ever received co-ordinated or integrated support for PSU and DAV, and most of the women never received any specific domestic abuse support. Their narratives suggest there were many gaps in support, which presented as barriers to ever receiving support for both issues.

Khloe explains that she had a long 'career' with drugs and alcohol. She lived in a hostel for drug-using sex-workers and was in various relationships where DAV was prominent during this time. Khloe explains that despite being engaged with a drugs service for many years, and despite drug workers knowing that Khloe experienced domestic abuse, little intervention was offered to her:

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...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)

Some of the women also spoke about a disconnect between the support that was offered to them and their actual needs. Holly explained that she began drinking to cope with the abuse, using it as an anaesthetic. Aware of her alcohol use, she tried to access support and contacted the community alcohol team, but 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 thought that the best thing for someone trapped in domestic violence to recover from alcohol is, to have a home detox...(Holly)

Kat was also met with gaps in the support she was offered. Following an attempted suicide, she engaged with a therapist and a community mental health service. During her engagement with her therapist, she began drinking heavily to cope with her feelings. She soon developed what she called, a "dependency on alcohol". Her psychiatrist referred her to an alcohol service, however, the alcohol worker informed Kat that he could not offer her more support as she was already accessing two other services, neither of which were alcohol specialists. She explains:

I went there [alcohol service] a couple of times, but 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 a mental health charity, I was basically told that there wasn't anything more that they [alcohol service] could do for me; [...] he [alcohol worker] said to me, because you have these other people involved he felt that there wasn't any sort of additional support that he could give me. (Kat)

She continued to drink heavily, and eventually engaged in a relationship with a man who was also a heavy drinker. This relationship became abusive and following a serious assault Kat contacted a domestic abuse service. However, she was given an ultimatum:

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

Kat continued to drink and reengaged with her partner. She reached a point of desperation as she explains:

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

Khloe, Holly and Kat's experience demonstrates the impact that siloed support can have on ongoing substance use and domestic abuse experiences. As Kat's narrative shows, she reached a point where she believed she would die from alcohol or from her partner. This point of realisation for Kat meant that she had to prioritise one need over another.

Prioritisation

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, Laura explained that she got into a new relationship so did not stay in the refuge for long and Michelle explained that she was kicked out of the refuge after consuming alcohol and starting an altercation with another resident. Only Kat and Holly accessed domestic abuse refuges and stayed until they were ready to move on. However, Kat explained that she was never given information about alcohol services when she contacted the domestic abuse service. As such, she stayed in the abusive relationship:

I mean, I felt that I had no option but to stay [with her partner] until I was ready to give up the drink myself... (Kat)

Her narrative shows that she had prioritised her substance use needs and had reached a point of desperation before she could get the support she wanted.

A lack of information about services also had an impact on the women's decision to prioritise their substance use needs over their domestic abuse needs. Gina was a mother, using drugs problematically and living with an abusive partner who supplied her with drugs. She explains that she did not know what to seek help for, and was unsure which issue was more pressing. Further, she was not sure where to go for support:

...yaknow it's that sort of chicken and egg scenario for me. [...] and then not knowing really who, or where to ask yaknow... (Gina)

Khloe also spoke about this lack of information, having never realised there were domestic abuse services available until she was drug-free:

...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 [domestic abuse]. (Khloe)

For some of the women, the absence of the abusive partner was enough for them to focus on abstinence and recovery from substances. However, their focus on their recovery meant they never received domestic abuse support up to the point of interview. For example, both Lou and Kim accessed residential rehabilitation and twelve-step fellowships to stop using

substances because they were not in abusive relationships at that point. Similarly, at the time of interview, Lydia was living in a residential substance use service and explained that she was not ready to think about her domestic abuse experiences, as she explained:

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)

Elaine also explained that she did not engage in domestic abuse support, rather opting for a twelve-step fellowship. She explained that she does not feel the need to explore her domestic abuse, that her drug use was always her priority:

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

As these narratives demonstrate, some of the women prioritised their substance use because they felt it was having a greater impact on their life at that point in time, especially because the perpetrator was no longer in their lives. However, some women explained that they would have welcomed support for both issues, but there was a gap in the communication of information. Some of the women felt this was because practitioners had a lack of understanding regarding the interconnection between substance use and domestic abuse.

Gaps in professionals' understanding

Among the women who were aware of domestic abuse support at the time of the interview, there was an expression of frustration that domestic abuse and substance use are supported separately with little overlap between services. Kat was in refuge at the time of the interview and accessing separate support for her alcohol use, however, she explained that there was no crossover between the two services:

...even when I started in recovery, when I said to my [domestic abuse] support worker [...] 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). (Kat)

For those who spoke about this separation of specialist support, they felt that services did not have a full understanding of the complexities of both issues and felt more training and understanding was needed for those working in both service types. Jo, who was still drinking at the time of the interview and living with her ex-partner who she says was no longer abusive, was also running an online support group for women affected by DAV. She expressed an element of annoyance during the interview when speaking about the siloing of services, as she perceived them:

...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)

Khloe also explained that those in need of services are not always aware of the support that is available. At the time of the interview, Khloe was running a peer support group for people who use substances and worked within the field of social care. She believes there are issues in communicating information about services:

...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. (Khloe)

Overall, the women agreed that support for domestic abuse would have been beneficial while engaging in substance use support. However, the narratives seem to suggest that their focus had to be their PSU because that was a trigger for DAV. All of the women therefore prioritised substance use support; however, Kat explained the complexity of needing support for both substance use and domestic abuse, and the complexity of accessing support in an environment where support is not responsive to the actual needs of women:

...yaknow a lot of these organisations they work with women who are still living in those circumstances not quite ready yet to maybe leave but desperate enough to want some support. Yaknow for the care to be more coordinated between the substance misuse services and the domestic violence charities, because, 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 being 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)

Throughout the 12 interviews, the overarching theme suggests that support for substance use and domestic abuse is siloed, and this siloing poses a barrier for women with co-occurring substance use and domestic abuse. As table one also showed, the women accessed various support types for many years, however, integrated or coordinated support encompassing both substance use and domestic abuse was not available to them. This will be discussed further in the proceeding section.

Discussion

This is the first study to explore, in-depth, how women navigate access to support services when they have histories of co-occurring problematic substance use and domestic abuse victimisation. Using feminist research praxis to prioritise the experiences, and voices, of women in this research, the findings offer some insight into their journeys to support and the complexities of their support needs.

The women's experiences show a separation between the support they need, and what is available to them. This separation resulted in the women having to prioritise substance use support over domestic abuse; consequentially, never receiving support for both issues. Despite their desire to access support, some of the women did not know where to ask for help, and some felt that practitioners did not understand their needs. As table two shows, the women accessed a range of services including GP, criminal justice, and various social care services, but their narratives suggest the need for information to be better communicated to them, through conversations with the various practitioners they encounter. However, their narratives also suggest that practitioners also need to be equipped with information about the support that is available.

In Ireland, Morton et al., (2015) demonstrated how training domestic abuse refuge staff about substance use and promoting a harm reduction housing-first approach by changing the refuge policies to include women with substance use, can begin to support women with dual needs. Morton et al., (2015) found that when women with dual needs were welcomed to the refuge, substance use within the refuge did not increase. The researchers believed that the stability or reduction of substance use among the women was 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 reported a greater level of confidence in discussing substance use and safety measures with the women using substances while living in the refuge.

While increased funding and more specialist services are paramount in supporting women with substance use and domestic abuse, as Morton et al., (2015) show, educating practitioners about the inter-relationship between problematic substance use and domestic abuse can have a positive impact on both the staff and the women in need of support. As some of the women in this study highlighted, they did not want to focus on their domestic abuse because they felt it was not relevant or important at the point of interview. However, other women explained that having information about services would have been beneficial to them. While some women may never choose to engage in any kind of support, ensuring information is available to women reduces the risk of prolonged PSU and DAV.

Some improvements have been made at a policy level. In responding to substance use and domestic abuse, the National Institute for Health and Care Excellence (NICE, 2014) recommend that people are asked about their substance use and domestic abuse experiences, are referred to the relevant health and social care services and, are offered support in settings where people might be identified or disclose abuse, such as GP surgeries, midwifery services or mental health services. Recommendations from the English Government’s strategic priorities including the 2017 Drugs Strategy (Home Office, 2017), The Ending Violence Against Women and Girls Strategy (Home Office, 2016) and the Drug Misuse and Dependence: UK Guidelines on Clinical Management (DHSC, 2017), also highlight the importance of integration and coordination across substance use and domestic abuse services. Other recommendations have included the approach that services need to take, for

example, recommendations from Holly's (2017) scoping study of women's services across England and Wales, advocates for trauma-informed and gender responsive services, i.e. services that understand the needs of women who have experienced trauma. Findings from Bailey et al.,'s (2019) narrative systemic review of interventions for reducing post-traumatic stress disorder and PSU among women with experiences of IPV, recommends focusing on "establishing external safety, emotional regulation and building positive self-identity and relations with others may well be the most appropriate treatment for some women" (2019:100).

It is not known whether these recommendations are followed within substance use and domestic abuse services, despite the existence of practice guidance to support people's enquiry about these two issues (Ava's Stella Project, 2007; Galvani, 2010). However, the fact that none of the women in this study were able to access a service that supported their dual needs, demonstrates the lack of progress in this area of practice, despite years of calls for improvements to services and collaborative working (Holly, 2017; AVA, 2007; Galvani and Humphreys, 2007; Humphreys et al., 2005). This is not the fault of individual services or staff, but rather, the failure of a wider system that does not understand the needs of women with co-occurring DAV and PSU. Wider gender-biased social norms impact the creation of policy, funding, and subsequent practice, which does not represent the lived realities of women with PSU and DAV. 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 PSU and DAV continue to experience systemic barriers to support.

It is an arguably depressing picture that the recommendations stemming from this research echo much of the recommendations about communication, training and joint working that have gone before, however, in challenging the barriers faced by women with PSU and DAV, this research recommends:

1. In the immediate term, targeted education for domestic abuse services about substance use and linking with substance use service providers.
2. Similarly, substance use services require targeted education on domestic abuse, its impact on people's substance use and the implications of that for interventions offered.

3. Appointment of champions in DAV and PSU services to develop care pathways between domestic abuse and substance use services.
4. Development of systemic and rolling programme of joint training on the support needs of women experiencing PSU and DAV for all health and social care specialists.

While small steps are being taken at a policy level, there needs to be systemic monitoring of whether and how that guidance is implemented. Future research should seek to determine the systemic and individual barriers to implementation of such guidance as well as identify whether previous pockets of good practice have been sustained and if not, why not.

Limitations:

This study could also have been enhanced with comparison data from practitioners working in the areas of substance use and domestic abuse and this offers an area for future research. While the sample of women did include black, European and gay women, a larger sample could explore intersectional differences in more detail. In adopting IPA, the research did not set out, methodologically, to achieve thematic saturation nor did it start with a pre-conceived hypothesis. Within some broad similarities, the women's experiences and opinions differed greatly, as such, it is possible that had a larger group of women been accessed, a common or shared truth may have been obtained, but this is unlikely as this is not a homogenous group.

Conclusion

This is the first study from the UK to explore, in-depth, the lived experiences of navigating support among women with co-occurring problematic substance use and domestic abuse victimisation. By focusing on the voices of women, their lived-experience of support seeking is uncovered; and by focusing on their diverse and lived realities, this study has shown that siloed support provision can have continued negative effects on their substance use and domestic abuse experiences. The relationship between substance use and domestic abuse victimisation is multifaceted and understanding the intricacies of being a woman with PSU and DAV is important if policy and services are to effectively meet the needs of women. As this study has shown, research that prioritises women's experiences and women's voices can be a powerful tool in understanding the impact of support, or lack of it, on those accessing it. Future research exploring women with PSU and DAV should ensure women with experience

of both issues are included because they offer an important insight not accessed through service and practitioner focussed research.

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