WE WOULD BE STRONGER

A REPORT ON THE NEEDS OF WOMEN IN LIMERICK WITH SUBSTANCE USE DIFFICULTIES

We Would Be Stronger:

A REPORT ON THE NEEDS OF WOMEN IN LIMERICK WITH SUBSTANCE USE DIFFICULTIES

Quality Matters
supporting improvement in social services

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Executive Summary

OVERVIEW

This report presents the findings of research undertaken with women who were using drug and alcohol services, homeless services and the Probation Service in Limerick in 2017. PALLS, as commissioner of this research, sought to develop a clear picture of the experiences of women attending local services, as well as their needs and challenges. The overall purpose of the research is to help inform service planning and development at a service and regional planning level. A Steering Group with representation from the Probation Service, HSE Mid-West Drug and Alcohol Service, Novas - McGarry House, Mid-West Simon Community, PALLS Project, Bedford Row Family Project and the Mid West Regional Drug and Alcohol Forum, was formed to ensure the research had a regional focus, both in terms of those involved and in the formation of pragmatic recommendations stemming from the research findings. The research received ethical approval from the Probation Service and from the Research Ethics Committee, University of Limerick Hospital, HSE.

The literature review explored a number of issues that were key to the research, including the correlation between childhood trauma, adulthood trauma, drug and alcohol use, homelessness, domestic violence and contact with the criminal justice system. This review outlined the strong correlation between experiences of childhood trauma and adult substance use, as well as adult experiences of intimate partner violence. To build on international research from an Irish perspective and to explore whether these themes were as pertinent to women's experiences as in other jurisdictions, the research inquired into women's experiences of these issues and their views on this theme. The needs analysis of the women was informed by current care planning good practice in Ireland including the National Drug Rehabilitation Framework. This identified a schedule of questions in relation to needs of the women in areas such as housing, finance, health and others.

The literature review also highlighted the increasing interest in trauma-informed approaches from a systems and organisational perspective, as a way of minimising the risk of women being re-traumatised in services, and to increase service effectiveness. To assess the organisational approach to these themes, the research also included a detailed survey for service providers, seeking information on key facets of service delivery.

FINDINGS RELATING TO TRAUMA

In total, 24 women took part in the research, all of the women were Irish settled and Traveller women. The women had an average age of 35, with the youngest being 24, and the eldest 56 years of age. In relation to trauma experiences, the research showed disproportionately high rates of ACEs (adverse childhood experiences). The points below highlight, how much more likely than the general population the women in the research cohort were to have experienced indicators of trauma. They were:

- 7 times more likely to have grown up in a household where there was an incarcerated person (e.g. family member)
- 6 – 8 times more likely to have 5 or more ACEs (six times more likely than women in the general population, eight times more likely than men)
- 3.6 times more likely to have grown up in a household where there was domestic violence
- 3 times more likely to have grown up in a household where there was somebody with a mental health illness
- 2.6 times more likely to have grown up in a house where there was substance abuse
- 2.5 – 6 times more likely to have experienced childhood sexual abuse (2.5 times more likely than women in the general population, 6 times more likely than men)

- 2.5 times more likely to have experienced physical abuse in childhood
- Twice as likely to have experienced verbal abuse in childhood
- 1.5 times more likely to have one ACE, than people in the general population
- 10 times LESS likely to have no ACEs at all.

The research also found that:

- 91% of the women had experienced intimate partner violence in adulthood
- 95% of the women considered their substance use to be related to, or somewhat related to their experiences of trauma

In line with trauma-informed principals of care, service users and service staff were asked to rate service provision in relation to a number of qualities associated with trauma-informed services, namely whether they were:

- Safe
- Caring
- Understanding
- Valuing of service users
- Respecting of service users
- Trusting of service users

The women who participated in the research were positive in their perception of drug and alcohol service providers, scoring on average between 4.3 and 5 out of 5 in all areas. Housing related services scored slightly less, between 2.5 and 3.7 out of 5. The least well-regarded services were offending related/ criminal justice services, which had scores ranging from poor to average; between 1.9 and 2.7 out of 5. It should be noted that the criminal justice related services included the Gardaí, the Courts and Probation services so it does not provide an accurate picture of service users' perception of any one individual agency within this sector. This is a point that would benefit from further research.

Staff in services were confident about their capacity to meet standards in relation to certain facets of Trauma-Informed Care including:

- Managing trauma, Triggers and Emotions
- Establishing a Safe and Friendly Environment
- Staff Support and Care
- Involving Service Users
- Cultural Accessibility

Generally, services scored themselves slightly higher in relation to these indicators than the women did. The area of most difference was respect. Women on average rated the services almost a full point lower than the services rated themselves.

FINDINGS IN RELATION TO THE NEEDS OF WOMEN

Parenting: Women highlighted the challenges of balancing caring for their children and building a future for themselves and their children. Women were delaying seeking services, or were not seeking services at all, as they were concerned that this may trigger a child protection issue, resulting in children being taken from their care. When the women did engage with services they encountered other barriers, such as a lack of a safe space to bring their children.

Housing and Homelessness: Women clearly identified the lack of safe, available housing as a core barrier to their progression. This was a central concern of the women, particularly for those with children under 18. The interviews also highlighted two specific system barriers that challenge their ability to secure housing; issues related to HAP acceptance by landlords and the lack of savings for a rental deposit.

Criminal Justice Issues: Women view housing and access to substance use treatment as stabilising factors that will support them to not re-offend, where this has been an issue in their past. Women underscored the value of Probation Officers when they were able to connect them with other support services, act as an advocate, and provide caring and firm motivational supports. Respondents also highlighted the need for regular appointments and appreciated flexibility in scheduling of these. It was highlighted by respondents that the stigmatised and criminalised nature of sex work was a factor that could deter women from seeking support.

Drug and Alcohol Use: Lack of access to counselling within substance misuse services was experienced as a barrier, as was a lack of choice in the type of rehabilitation services, and a lack of child-friendly services. Again, lack of access to appropriate housing was identified as a barrier to recovery from substance use difficulties. The need for drug and alcohol services not to re-traumatise or be discriminatory towards women was highlighted as important to engaging and retaining women in service provision.

Physical Health: Most women were satisfied with the support they were getting for their physical health, with some being unaware of available supports in relation to getting a medical card or assistance with travelling to appointments. Some women stated that they did not feel confident in identifying where they were unhappy with care received.

Mental Health: Mental health difficulties were prevalent among the group, and accessible services were viewed as a critical component of their care and progression by the interview participants. A number of factors impacted on women's access to mental health services including self-stigma, fear of child protection issues and judgemental attitudes of service providers. The participants in this group showed a strong appetite and capacity for self-advocacy regarding their mental health recovery. Potential was identified for services to explore recovery-based supports for women with dual diagnosis including training or support in self-advocacy and potentially joint case management approaches. These supports would need to be provided in addition to timely and appropriate access to mental health services.

FINDINGS IN RELATION TO THE OVERALL PROFILE OF WOMEN

To engender a broader profile of service users, a brief profile of 46 women was also included. This profile was undertaken using the Christo Inventory for Substance Misuse Services. This instrument seeks staff perspectives on client stability and engagement. A total of 46 valid profiles were included, which showed that while the levels of stability were within a normal range for out-patient treatment facilities, there may be a high level of poly-substance using among the population that requires targeted and specific harm reduction interventions.

RECOMMENDATIONS

After considering the findings, the Interagency Steering Group identified actions that would support service providers to improve the quality and range of supports available to the women in this study, and others like them. These included:

- Establishing an interagency working group to develop a trauma-informed women's drug and alcohol service
- Developing and delivering a trauma-informed standard and support package for service providers
- Establishing a working group to explore childcare challenges and barriers presented and seek solutions to them
- Establishing a women's peer worker programme to build on the commitment to change shown by women in this study and their peers within services
- Advocating for women and children in relation to:
  - Access to housing
  - Simplifying arrangements relating to work with Tusla in relation to children in care

FOREWORD

Foreword

It has become increasingly apparent, over the past ten years or so, that a considerable proportion of people availing of drugs and alcohol and allied services in Limerick are women. It has also been difficult, at times, to retain women in services and to be confident that their needs were being met in a consistent and effective way. The challenge for local services was to better understand the complex issues that women present with, and to design and deliver services appropriate to their needs. In order to meet this challenge, it was important to hear the views and experiences of the women, particularly in relation to their experiences of accessing services.

This report on the needs of women in Limerick with substance misuse difficulties gives voice to women service users who, with courage and fortitude, share personal and intimate details of their lives. The women talked about their experiences of trauma, both as children and adults, and they articulated their experiences of accessing drugs and alcohol services, homeless services and the criminal justice system. The women highlighted their need to avail of services in a safe, nurturing environment and for them to be respected by service providers. The generosity of the women in sharing their stories was evident in their belief that doing so was not likely to be personally beneficial to them, but may help other women.

The need to have trauma-informed services, delivered by workers who have the knowledge and skills and professional support to work in a trauma aware way, is a key recommendation of this report. This recommendation has local relevance in the Mid-West of Ireland, but it is also very likely to have national and international relevance.

This report was initiated by an interagency group who have worked together to highlight the gendered needs of women involved in substance use in Limerick, and it was commissioned by the PALLS project; I would like to acknowledge the foresight and work of this group over the past number of years. The research would also not have been possible without the support and co-operation of local services and their staff, who contributed themselves and who supported the women's participation.

I would like to acknowledge and thank Quality Matters, who conducted the research and approached their task with great sensitivity and integrity.

Finally, and most importantly, I would like to thank the women who contributed to this research by sharing their experiences. As this report underscores, their insights and observations tell a powerful story of how services can be better placed to meet their needs. The clear lesson is that services must be designed with the active engagement of service users. To do otherwise is no longer acceptable, and this is a challenge that service providers need to meet.

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Gearóid Prendergast
Co-ordinator of the Mid-West Regional Drugs and Alcohol Forum

INTRODUCTION

1 Introduction

This report provides a snapshot of the needs and challenges of a population of women using drug and alcohol and allied services in Limerick between October 2016 and April 2017. The report sought to develop a profile of the women presenting to services, their needs, experiences and challenges in accessing services as well as their ideas for how services can improve. This research was commissioned by PALLS, overseen by a multi-disciplinary interagency Steering Group, and undertaken by Quality Matters, an independent research charity. The research had ethical approval from the Probation Service and from the Research Ethics Committee, ULH, HSE.

Membership of the Steering Group was:

- Margaret Griffin, Probation Service
- Rory Keane, HSE Mid-West Drug & Alcohol Service
- Sinead Carey, Novas - McGarry House
- Tracey Reddy, Mid-West Simon Community
- Helen O'Shea, PALLS Project
- Bernie O'Grady, Bedford Row Family Project
- Gearóid Prendergast, Mid-West Regional Drug and Alcohol Forum

This report was made possible by the forthright and active participation of the women using the drug, alcohol and allied services. The staff of services were also key to the process through their facilitation of involvement of women using their service, as well as through their own engagement.

This report begins with a chapter providing a context for the study. This outlines the strategies guiding service provision, as well as an overview of drug and alcohol treatment figures in Limerick. A brief literature review outlines recent research on gender, trauma, violence, substance use and the implications for treatment.

Chapters 4-7 present the research findings; this includes a profile of the women as survivors of trauma, a summary of the needs identified by the women who participated in the research, a review of perspectives of the organisations providing certain services to them, as well as a separate profile of 44 women who took part in a profiling survey.

The report concludes with a series of recommendations for service development, which aim to improve the abilities of services to become places where women can get appropriate support in a safe and nurturing environment in order to heal, recover and grow.

CONTEXT IN LITERATURE

2 Context in Literature

2.1 OVERVIEW

The purpose of this section of the report is to provide an overview of the context in which this research was undertaken. It begins with an analysis of the data available on the treatment of substance misuse in the county of Limerick.

Reviewing Irish literature in relation to service delivery, the needs of women with substance use difficulties are discussed, highlighting a significant gap in Irish treatment services for women. Research is outlined in relation to the gender differences in the needs of women and men within treatment services, and in particular, women's experiences of trauma, intimate partner violence and how these issues are interlinked with homelessness, incarceration and substance misuse.

The final section of this context review explores the potential application of trauma-informed approaches to existing services. Trauma-informed approaches and interventions are highlighted as one potential mechanism to promote gender-responsiveness and effective supports for survivors of trauma who are accessing drug and alcohol treatment services.

2.2 TREATMENT FOR DRUG AND ALCOHOL USE IN LIMERICK

County Limerick is located in the province of Munster and is part of the Mid-West Region. The population of Limerick increased by 1.6% between the 2011 and 2016 censes. The population of the county is 194,899 of which 94,192 live in Limerick City and suburbs.

Services in the county for people with drug and alcohol related difficulties are funded primarily through the HSE Mid-West CHO 3 Drug and Alcohol Service and the Mid-West Regional Drugs and Alcohol Task Force, with additional funding coming from the Department of Justice, among others.

The National Drug Treatment Reporting System (NDTRS), which is a health database on treated drug and alcohol misuse in Ireland, provides data on treatment, which can be broken down by region. The NDTRS has been documenting drug treatment nationwide since 1995. Treatment is broadly defined as any activity which aims to improve the psychological, medical or social state of individuals who seek help for their substance misuse problems. In Limerick, as elsewhere, Treatment is provided in both residential and non-residential settings and may include one or more of the following: medication, brief intervention, counselling, group therapy, family therapy, psychotherapy, complementary therapy and life training skills[1].

The information that is currently available on drug and alcohol treatment has limitations in terms of illuminating the true extent of problem substance misuse. Not all people who need treatment either seek it or access it. In the UK, it is estimated that only 6% per year of people aged 16–65 years who are alcohol dependent receive treatment (1). Also, it should be noted that not everyone who receives treatment is recorded in the national database[2]. The database also provides information on treatment episodes, rather than individuals, this means that someone may be counted more than once, as they are receiving a service from different providers at the same time.

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1   http://www.hrb.ie/health-information-in-house-research/alcohol-drugs/ndtrs/
2   Not all treatment providers submit data to the national database

Figure 1: Drug and Alcohol Treatment in the county of Limerick 2012 – 2014

		Alcohol	Benzodiazepines	Cannabis	Opiates	Total
2012	**Total**	191	26	72	66	372
	Female	70	13	17	29	136
2013	**Total**	224	21	98	115	514
	Female	80	30	23	42	181
2014	**Total**	264	93	126	223	748
	Female	89	38	24	111	274
Female % Increase 2012 - 2014		27%	192%	41%	363%	102%

In 2014, the most recent year for which there is data, the figure above shows that 274 women in Limerick County received treatment for substance use. Figure 1 illustrates that the total drug and alcohol treatment episodes for women more than doubled between 2012 and 2014. This increase varies depending on the substance for which women sought treatment, with alcohol increasing by the smallest proportion (27%) and opiates recording the largest increase of 363%.

2.3 WOMEN, DRUG USE AND THE TREATMENT GAP

There is a growing body of research highlighting that women have particular experiences of drug use and drug addiction, and particular needs that may not be catered for by drug services designed to meet the needs of a predominantly male presenting population. Gender differences have been noted in a number of areas relating to substance misuse including prevalence of use, presentation at services, co-morbidity (e.g. the existence of addiction and other health issues), and treatment of substance use disorders (2)(3). There is also ample evidence of biological and psychological differences, as well as social and environmental factors, that impact on motivation to seek assistance, treatment availability and treatment effectiveness for women (2). In a summary of the literature, the seminal DAWN strategy document points to evidence that women respond and adhere better to treatment if included in psychotherapy and group counselling. They note that 'sexual education and family planning, as well as diagnosis of psychiatric co-morbidity, eating disorders and trauma related to sexual abuse and violence are priority issues to be integrated in the treatment agenda for women'(2).

A 2012 resolution by the United Nations, "Promoting strategies and measures addressing specific needs of women in the context of complete and integrated drug demand reduction programmes and strategies" calls on member states to, among other things (4):

- Consider and accommodate the specific needs of drug-dependent parents, including childcare and parental education;
- Take into account the needs of women who have experienced sexual and other violent trauma related to drug abuse;
- Take into account the specific needs of women in the prevention, early detection and intervention, treatment and care of drug dependence and drug-related diseases; and,
- Consider designing those services using a multi-agency approach so as to include specific female-oriented measures

The understanding of the importance of gender specific services is evident at a national level in Ireland, as well as at an international level. Ireland's new National Drugs Strategy 'Reducing Harm, Supporting Recovery 2017 – 2025' outlines a number of specific barriers experienced by women drug and alcohol users, including childcare, lack of specialised services, increased risks associated with drug and alcohol use and pregnancy, and the complexity of intersections of trauma and addiction.

To address the challenge of meeting women's needs effectively, the National Drugs Strategy 2017 – 2025 (5) includes two actions, as shown in the table below:

ACTIONS FROM THE NATIONAL DRUGS STRATEGY 2017 – 2025

EXPAND ADDICTION SERVICES FOR PREGNANT AND POSTNATAL WOMEN.

a) Strengthening links between maternity services and addiction services;

b) Quantifying the need for additional residential placements for pregnant and postnatal women who need in-patient treatment for addiction to drugs and/or alcohol across the country;

c) Developing services to meet that need, ensuring that such facilities support the development of the mother-baby relationship;

d) Providing dedicated support for pregnant women with alcohol dependency, including examining the need to expand the role of the Drug Liaison Midwife (DLM) in this regard. Any such expansion will likely generate a need to further increase the number of such midwives;

e) Resourcing the National Women and Infants Health Programme (NWIHP) to provide drug liaison midwives and specialist medical social workers in all maternity networks;

f) Supporting maternity hospitals/units to strengthen their methods of detecting alcohol abuse and supporting women to reduce their intake; and

g) Engaging the NWIHP to develop a consistent approach to informing women about the risks of alcohol consumption during pregnancy.

RESPOND TO THE NEEDS OF WOMEN WHO ARE USING DRUGS AND/OR ALCOHOL IN A HARMFUL MANNER.

a) Increasing the range of wraparound community and residential services equipped to meet the needs of women who are using drugs and/or alcohol in a harmful manner, including those with children and

b) Developing interventions to address gender and cultural specific risk factors for not taking up treatment.

The general absence of women-specific drug and alcohol services in Ireland (6) and in Limerick specifically (7) has been previously documented. However, there are a number of examples of women-specific drug services either provided as part of a larger service, or as stand-alone services in Ireland, and which can inform good practice. These include:

- **The SAOL Project** is a women's service established in 1995 that has been providing community-based support services to women drug users in the North Inner City. This CE programme has an onsite crèche for women attending the service.
- **Ashleigh House** is part of the Coolmine Therapeutic Community and provides residential rehabilitation services for women, with a number of mother and child units; the only service in the country.
- **Ballyfermot Star** is a service with onsite childcare provision for women attending any aspect of the rehabilitation, CE or education programmes provided by the service.
- **Inchicore Bluebell Community Addiction Team** provides a community childcare service on site for parents attending any aspect of this multistage rehabilitation programme.
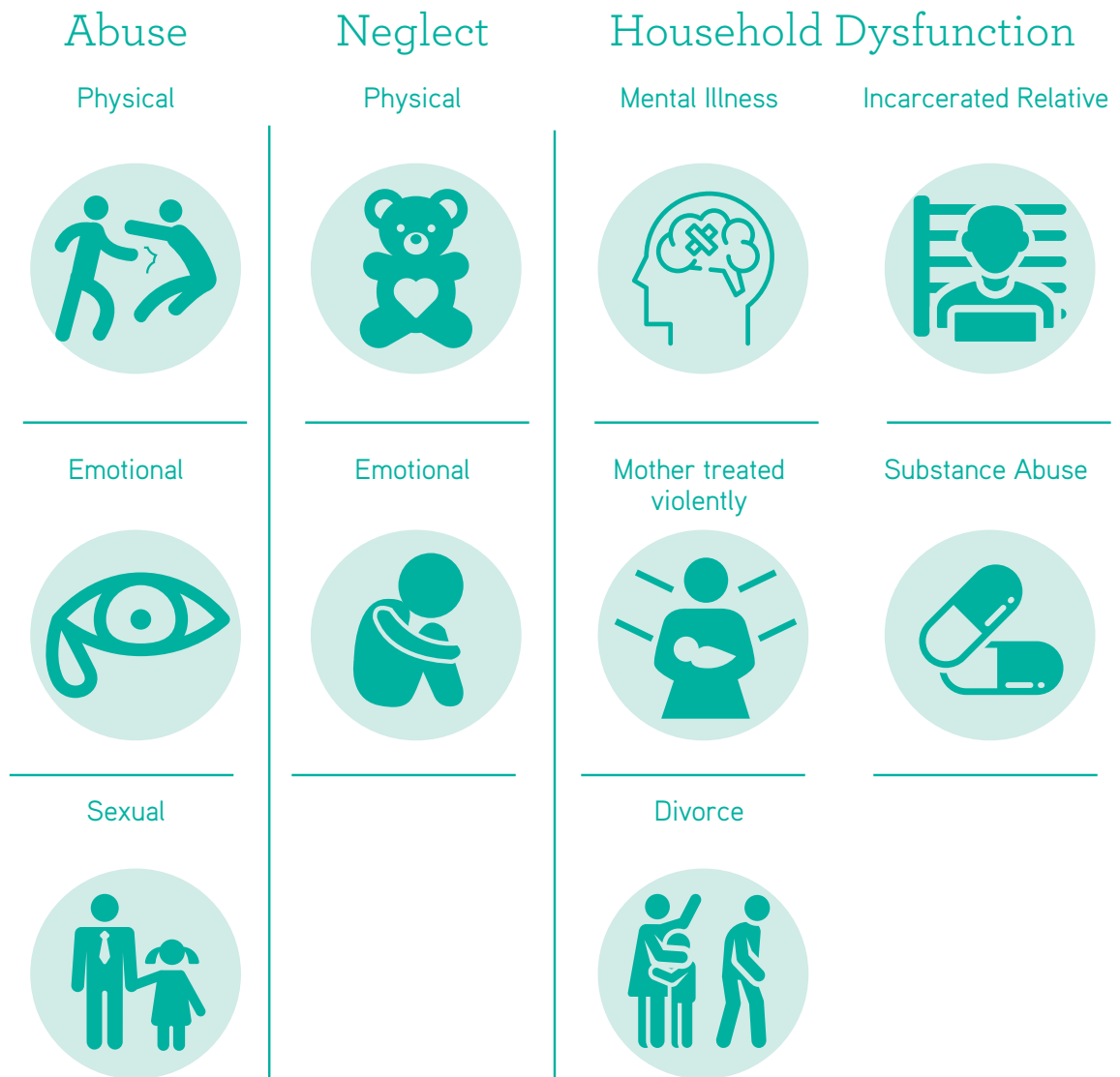
The importance given to the needs of women and parents in the National Strategy clarifies the policy priorities which will support local planning for more gender and family focused services. However proposals for new service development need to be financed by statutory agencies involved in the delivery of the Drugs Strategy; resourcing remains a core challenge to the success of any regional or local efforts.

2.4 GENDER BASED VIOLENCE, TRAUMA AND SUBSTANCE MISUSE
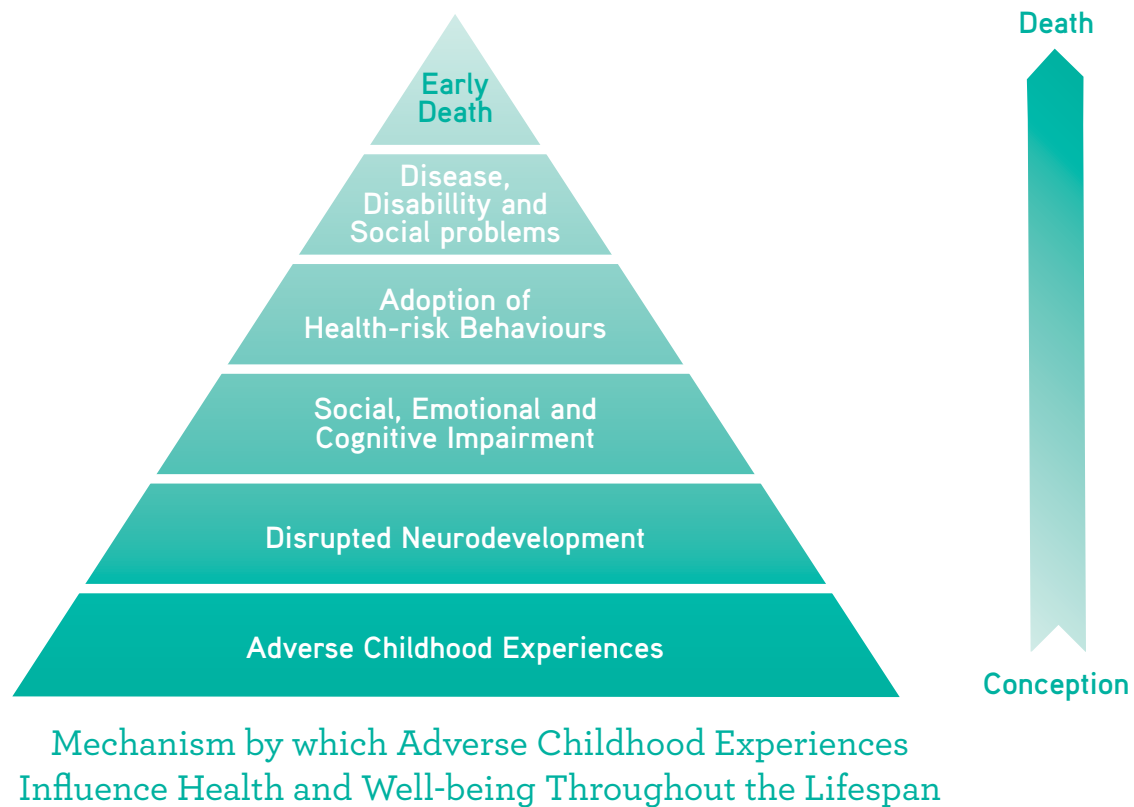
CHILDHOOD TRAUMA AND ADULT SUBSTANCE MISUSE

The relationship between trauma, particularly childhood trauma, and substance misuse is well documented (8–11). A summary of the literature by the National Institute of Drug Addiction in the US notes that up to two-thirds of people in treatment for drug abuse report that they were physically, sexually or emotionally abused during childhood (12). The seminal 'Adverse Childhood Experiences (ACE)' study has also shown a clear connection between childhood trauma and problematic alcohol and drug use. This study measured the prevalence of childhood trauma among the general population and the relationship between experiences of trauma and subsequent negative health experiences in later life. This study revealed a graded dose-response relationship between ACEs. This means that the more ACEs someone had, the more significant their negative health experiences were in later life (9). In relation to drug and alcohol use, the study found that people with five ACEs or more were seven to ten times more likely to report problems with drugs than people with ACE scores of zero. The ACE score also had a strong graded relationship to early initiation of drug use, drug problems in adulthood as well as more serious drug use (8). The graphic on the next page illustrates the three categories of childhood trauma and the specific experiences that fall under these categories that are shown to have negative impacts in later life.

Figure 2: Adverse Childhood Experiences (ACEs)

Abuse

Physical

Emotional

Sexual

Neglect

Physical

Emotional

Household Dysfunction

Mental Illness

Mother treated violently

Divorce

Incarcerated Relative

Substance Abuse

Source: Centers for Disease Control and Prevention

Figure 3: Impact of ACEs

Death

Early
Death

Disease,
Disabillity and
Social problems

Adoption of
Health-risk Behaviours

Social, Emotional and
Cognitive Impairment

Disrupted Neurodevelopment

Adverse Childhood Experiences

Conception

Mechanism by which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Source: Centers for Disease Control and Prevention

The illustration above shows the manner in which ACEs impact on health and wellbeing in later life. Trauma in early childhood can cause disrupted neuro development, which can impact on health behaviours and result in earlier death.

CHILDHOOD TRAUMA AND ADULT EXPERIENCES OF INTIMATE PARTNER VIOLENCE
A particular consideration for women is the relationship between childhood abuse and becoming a victim of intimate partner violence in adulthood. The ACEs study revealed that any one of the three violent childhood experiences (physical abuse, sexual abuse or witnessing mother being a victim of domestic abuse) doubled the risk of being a victim of intimate partner violence. Among women who had all three forms of violent childhood experiences, the risk of victimisation in adulthood increased 3.5 times (13).

INTIMATE PARTNER VIOLENCE IN THE GENERAL POPULATION
In Ireland, there is a small but growing body of evidence, detailed in this section, that begins to describe the extent of violence experienced by women. While the state has, to date, not established systems to collect data on experiences and reporting of domestic violence, a number of stand-alone studies provide some insight to the extent of this crime. The National Crime Council published the first large-scale report on the experiences of domestic violence in Ireland (14). Watson and Parsons (2005) surveyed over 3,000 women and men about their experiences of domestic abuse, including some in-depth interviews with particular groups of marginalised women. Figure 4 provides an overview of the findings of this research, which shows that almost one in ten women, in the population researched, had experienced severe physical abuse, one in eleven had experienced severe sexual abuse, and one in twelve had experienced severe emotional abuse. It is notable that abuse across all categories is always at least twice as common in women as in men and can be up to eight times higher in relation to sexual abuse.

Figure 4: Percent of people reporting severe abuse in Watson and Parsons (2005)

	Women	Men
Severe physical abuse	9%	4%
Severe sexual abuse	8.5%	1%
Severe emotional abuse	8%	3%

The research also showed that women who were economically disadvantaged were more likely to be victims of abuse. In 2002, the SAVI (Sexual Abuse and Violence in Ireland) Report was published, which outlined similar results. That research, published by the Dublin Rape Crisis Centre (15), was conducted with 3,000 adults in Ireland about their lifetime experiences of sexual abuse and violence. It found that one fifth of women (20%) experienced contact childhood sexual abuse. Over 6% of women in the survey reported being raped in adulthood. Women with disabilities were found to be at a higher risk of being abused in childhood or raped in adulthood.

Within Ireland, two other surveys were conducted in 2002 and 1995 on the experiences of women as victims of intimate partner violence. Kelleher and O'Connor, in their research for Women's Aid entitled Making the Links (16), included almost 600 randomly selected women who had ever been in an intimate relationship with a man in their survey; the results are conveyed in Figure 5 below. These show that almost one in five women had experienced some form of violence in their lifetime.

Figure 5: Experiences of violence in adult relationships (Kelleher and O'Connor 1995)

Some experience of violence	18%
Mental cruelty	13%
Physical violence	10%
Sexual violence	4%

Bradley et al, in 2002, surveyed almost 1,700 women over the age of 16. The study, undertaken in GP surgeries, found that 39% of women had experienced domestic violence. The authors were satisfied that their findings 'are likely to be widely applicable to Irish women attending general practice' (17).

It is also worth noting that a Europe-wide crime victimisation study in 2005 found that Ireland had the highest rate of sexual assault in Europe, and that about 1% of women in Ireland reported a serious sexual offence (rape, attempted rape or indecent assaults) in the previous year (18). Overall these studies find a repeated pattern of levels of experience of sexual violence of between 4% and 8.5% of the female population, with those experiencing broader violence often much higher than this. The research also indicates that these numbers are likely to be higher in at-risk populations. These very significant numbers underpin a clear need for the services and staff working with vulnerable people to be skilled in managing these issues, so they can best support the women and their families who face these challenges.

INTERSECTION OF ABUSE, HOMELESSNESS, INCARCERATION AND SUBSTANCE MISUSE

The relationship between substance use and domestic violence, domestic violence and homelessness, homelessness and incarceration, and how these impact on women due to the gendered nature of violence in the home, has been well documented (19–24). Irish research has also contributed to this body of research. Sonas Domestic Violence charity undertook research in 2016 which found that one in six families cited domestic violence as a key reason they were made homeless (25). In an Irish context, the intersection of homelessness, drug use and negative health outcomes has been documented in a Limerick study which involved 63 people, one third of whom were women (26). This study also highlighted concerns regarding dangerous drinking among homeless women.

Research in 2005, conducted in Ireland, on the progression routes of homeless people before the courts and/or in prison found that 33% of women were homeless on committal to prison. Furthermore, the same study undertook an analysis of Probation Service records, finding that almost half of the homeless people going to prison were women, despite women only comprising one fifth of the overall number of people in the Probation and Welfare community sample (27). Those women homeless upon committal were more educationally disadvantaged, more likely to have been unemployed prior to committal and more likely to have been drug-users prior to imprisonment. A longitudinal study with 40 drug using women prisoners in 2006, which evaluated drug-treatment outcomes for women, found that while many women reduced their drug use after incarceration, increased levels of anxiety and mental health issues were reported, alongside poor access to support services for women post-incarceration. In this study, Comisky highlighted the lack of in-reach services in the prison, a lack of gender specific research and services supporting women leaving prison (28).

This body of research highlights that there is an intersection of disadvantage which results in a population of women requiring specialised services for both substance misuse and homelessness, particularly when these women are also engaged with the criminal justice system. A review of the literature has highlighted a vicious cycle of substance use difficulties, victimisation and deterioration in the women's capacity to cope with these challenging life circumstances (29). This challenge is further deepened by a lack of accessible support services that are attuned to the needs of women with these life experiences.

2.5 IMPLICATIONS FOR TREATMENT: TRAUMA-INFORMED CARE

Given the clear connections between childhood trauma, adulthood trauma and substance misuse outlined above, there is an equally clear need for service providers to be adequately equipped to understand trauma, its manifestation, and appropriate ways to support trauma survivors. As stated by Stephanie Covington: 'Treatment for women's addictions is apt to be ineffective unless it acknowledges the realities of women's lives, which include the high prevalence of violence and other types of abuse' (10).

Trauma-Informed Care is an approach to the provision of human services that has gained increasing traction over the past 30 years, with its origins in the treatment of post-traumatic stress disorder among veterans in the United States(30). This growth in popularity is due, in part, to the increasing evidence of the efficacy of this approach, as well as its plausibility as a model and its reflection of many staff members' experience of service delivery(31). Gender-responsive, trauma-informed programmes have been shown to reduce depression, sleep disorders, anxiety, substance use and criminal activity in women with dual diagnoses of substance misuse and mental health challenges (10,32).

Trauma-Informed Care (TIC) can be provided either in trauma-specific programmes and interventions or through a whole-organisation trauma-informed approach. According to Harris and Fallot (2001), trauma-informed services:

- Are always cognisant of trauma;
- Make continued efforts to ensure staff understand implications of trauma on case management approaches;
- Ensure, as much as possible, that service provision does not trigger trauma; and,
- Support service users to recognise and manage their trauma" (33).

SAMHSA, the national resource for substance use in the US, established a centre for Trauma-Informed Care in 2005 and have done considerable work in developing resources to assist services seeking to work from a trauma-informed perspective. They note that this is not an insignificant undertaking, outlining how an organisation, that is seeking to become trauma-informed, must assess and potentially modify every facet of its operation to ensure that it can be effective in serving trauma survivors. They state that the creation of a trauma-informed organisation involves ten steps (34):

1. Commit to creating a trauma-informed agency.
2. Create an initial infrastructure to initiate, support, and guide changes.
3. Involve key stakeholders, including consumers who have histories of trauma.
4. Assess whether, and to what extent, the organisation's current policies, procedures, and operations either support TIC or interfere with the development of a trauma-informed approach.
5. Develop an organisational plan to implement and support the delivery of TIC within the agency.
6. Create collaborations between service providers and consumers, and among service providers and community agencies.
7. Put the organisational plan into action.
8. Reassess the implementation of the plan and its ability to meet the needs of consumers and to provide consistent TIC on an ongoing basis.
9. Implement quality improvement measures, as needs and problem areas are identified.
10. Institute practices that support sustainability, such as ongoing training, clinical supervision, consumer participation and feedback, and resource allocation".

Within the resources provided by SAMHSA, there is a range of assessments and planning tools for organisations wishing to move towards a more gender-responsive and trauma-informed approach. There is a growing interest from service providers within Ireland in TIC[3]. Programmes such as Seeking Safety[4] have also contributed to a raised profile for trauma-informed approaches. The potential for such approaches to impact on the Irish substance misuse services has also been highlighted by women focused services such as SAOL, the Dublin women's substance misuse service previously referenced in this review.

The findings of ACEs studies and trauma-informed approaches that stem from this growing evidence base, provide useful foundations for understanding the experiences of service users from a gendered perspective, as well as elucidating the challenges that exist for service providers in ensuring that services are optimally geared towards supporting their clients. It is hoped that this research will, in a small way, contribute to an understanding of these themes within an Irish context.

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3   This is based on discussions with academics working in the area of trauma research, who are increasing being asked to provide inputs on this

4   Seeking Safety is a model of care provision on a group or individual format which "supports people to attain safety from trauma or substance abuse". See www.seekingsafety.org

METHODOLOGY

3 *Methodology*

3.1 INTRODUCTION

This section explains the approach to undertaking this research, including the methods used and the steps taken to ensure compliance with good ethical practice in relation to protecting those who took part. Significant care was taken by the research steering group to ensure that sufficient checks and balances were implemented to protect participants, including achieving ethical approval from The Probation Service ethics board and the Research Ethics Committee, ULH, HSE..

3.2 DATA COLLECTION METHODS

SERVICE USER INTERVIEWS

Semi-structured interviews were conducted with 24 female service users from eight services in Limerick and were undertaken between October and November 2016. Interviews were between 35 minutes and one hour long, covering 65 questions in total, including both closed and open questions. Service users were openly recruited through posters and by invitations from staff of key services. Interviews took place in services, in Limerick, that the women were attending.

Informed consent was achieved with the women in advance of the interview, with firm emphasis being placed on the fact that the women could stop the interview, pause, go 'off record' or not answer any question with which they did not feel comfortable. There was only one instance within the 24 interviews where a service user left early and did not complete the full set of interview questions[5]. The semi-structured approach to the interviews provided women with flexibility in providing information that they felt was relevant. This was particularly the case with questions about how women felt when they interacted with services.

The interview tools used with the women drew on two frameworks. Firstly, the National Drug Rehabilitation Implementation Committee's standards for care-planning (35) informed the domains of need. Secondly, there were a number of questions relating to trauma that were drawn from the ACEs Study and definitions of the ACEs provided by the Centre for Disease Control (9). Instruments were developed by the research team, approved by the project steering group and then piloted prior to use in the field.

SERVICE PROVIDER SURVEYS

Surveys were distributed to front line service-providing staff in Limerick seeking their views on unmet needs of women using their service, and their perception of their capacity in relation to key facets of Trauma-Informed Care. The surveys were hosted and completed online and were distributed by email by service managers engaged in the study; participation was voluntary and anonymous. In total, 31 people completed the survey. Service provider participants included staff from drug and alcohol services, homeless services and The Probation Service; these sites correlated to where the women involved in the research were attending services.

The survey instruments were developed using a number of bespoke items, as well as items from the Trauma-Informed Care Project's organisational self-assessment[6]. The tool was developed by the research team, approved by the steering group and piloted prior to use.

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5   This woman left the interview early. She said that she was tired and not in the right frame of mind for an interview

6   www.traumainformedcareproject.org

CHRISTO ANALYSIS

The Christo Inventory for Substance Misuse Services (CISS) is a brief questionnaire designed to be completed by service providers to give an overview of the severity of challenges faced by their clients. It provides an indicator of the professional impression that staff have of the levels of challenges and treatment adherence by service users in the past month. The form is completed by staff without the engagement of clients and takes under five minutes. It has, in other studies, been used to: evaluate outcomes or programme effectiveness as a pre- and post-measure in drug and alcohol treatment settings (36–38); to generally measure change in participant well-being (39), used in combination with regression analysis to predict client outcomes (40); to help determine appropriate treatment settings; (40) and to describe or profile a participant group (41). The CISS tool provides score severity ranges and comparison data for three different categories of programme outcomes: "abstinence-based treatment," "harm minimisation prescribing based service," and "outpatient alcohol service. For this analysis, the score ranges associated with the "outpatient alcohol service" category were used, as the majority of service providers participating in the research fell into this category. Under this category, a score of 0-4 is considered to be low problem severity, a score of 5-11 is considered to be average problem severity, and a score of 12-20 is considered to be high problem severity.

For the purposes of this report, the Christo served to provide a broader profile of women using services in Limerick. Its use facilitated the inclusion of staff perspectives on client stability and engagement, in a manner which ensured a degree of comparability between staff. A total of 54 CISS were administered between December 2016 and April 2017 to women using services in Limerick. The individual results were screened for duplication by a central point of contact to ensure each inventory received was unique. Of those 54 returned, 8 were invalid due to missing data. The remaining 46 had occasional profile data missing but this was not significant enough to exclude them from the analysis.

3.3 MANAGEMENT OF ETHICAL CONCERNS

OVERVIEW

The researchers were committed to ensuring that this research would be a safe, empowering and positive experience for the women who participated, and to upholding good practice in research. The primary concern was to protect the dignity and safety of participants, and to undertake the research respectfully. A number of ethical risks and management strategies that were implemented are outlined here. Ethical approval for the research was also obtained from the Probation Service and the Research Ethics Committee, ULH, HSE.

ANONYMITY
Quotes:
Given the small number of women who access drug and alcohol services in Limerick, and the interconnected network of service provision for these women, participant information and inputs were completely anonymised – even unique identifiers or pseudonyms were not used. Multiple quotations were taken from each participant to ensure representativeness.

Low Numbers:
Where an issue was relevant to five or fewer people, it was not reported on to protect the confidentiality of participants.

Identifying Information:
No data provided to, or retained by, the researchers contained identifying information. No participants are identifiable in this report.

The same standards for anonymity were afforded to service provider participants.

INFORMED CONSENT

At the beginning of each interview, the researcher took clients through a 16-point informed consent checklist which outlined all facets of the research, what would be done with the information, how their information would be protected, anonymity and other key issues. Participants were informed of their ability to withdraw consent at any point, and that a choice to withdraw would not impact their ability to access services.

OTHER ETHICAL ISSUES: RISKS AND THEIR MANAGEMENT

Risk:
Clients could be defined as vulnerable adults

Management:
- All clients were over 18
- Researchers conducting interviews were Garda vetted through the research organisation, Quality Matters
- The research organisation had an active Child and Vulnerable Adult Protection Policy that was in line with national legislation and which guided the data collection process

Risk:
Sensitive issues arising in interviews

Management:
- Researchers had front-line experience in homeless/drug/ women's services
- Researchers had experience in conducting research with vulnerable client groups and were provided with refresher training on conducting sensitive interviews and managing disclosures in advance of this stage of data collection
- Clients were informed of the nature of the research and potential for difficulties to arise at all points of communication from recruitment to beginning the interview
- Clients were offered an opportunity to debrief at the end of the interview with the interviewer and/or with a designate staff member immediately after the interview
- Clients were provided, if they accepted them, with contact details for out of hours supports should they feel triggered later in the day

Risk:
Clients were providing their time for free while all others involved (e.g. researchers, members of the Steering Group as employees of their various organisations) were paid professionals

Management:
- Clients were given a €20 fee to cover expenses related to participation

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Risk:
Women would become distressed during the interview or at a later point

Management:
- Each participant was informed of the nature of the research and the nature of the questions being asked. At multiple points in the interview process, the interviewer asked if the participant was happy to continue.
- At the conclusion of each interview, the interviewer asked how the woman was feeling after the interview. Each woman was offered an opportunity to debrief at the end of the interview with the interviewer, or with a designate staff member immediately after the interview
- Women were also asked if they would like to be provided contact details for out of hours supports should they feel triggered later in the day

3.4 SUMMARY

The research methodology, which facilitated the development of a profile of women drug users in Limerick, and the needs of a cohort of women using services, was developed in a way that sought to minimise any potential harm to women who would take part in this research. The approach taken enabled a detailed profile of a small cohort of people to help inform the findings in the following section.

TRAUMA ANALYSIS

4 Trauma Analysis

4.1 OVERVIEW

This chapter of the report provides a profile of the women who participated in the research, in terms of the trauma that they have survived. Service providers' perceptions of their own capacity in providing services, in relation to trauma, are also outlined. The implications of all findings are discussed.

4.2 RESILIENCE AND ALTRUISM

The women participating in the interview processes were open, forthright and frank about their life experiences and interactions with service providers. Their rationale for participating in interviews was overwhelmingly to help improve services for other women. Four of the women, during interviews, freely expressed their desire to help other women if they were in a position to do so. The resiliency and grit of the women was evident throughout the interview process. This sensibility is best articulated in the women's own words:

> *Just help get them (women) back on their feet, let them know they can do it, give them a bit of a shove to move on - keep telling them they can do it because they can.*
> **(Woman Interviewee)**

4.3 ADVERSE CHILDHOOD EXPERIENCES SCORES

The women interviewed ranged in age from their early 20's to mid-50's with the average age being 35. All participants identified as Irish, and participants included settled and Traveller women. 63% (n=15) of the women have lived in Limerick their entire lives. Another 21% (n=5) had moved to Limerick within the last two years. Of the 24 women who took part, 23 answered the ACE questions, with the following aggregate results:

- The range of ACE scores was between 0 and 8
- The average ACE score was 5
- The most common ACE scores were 8 and 5, with 5 women each in these categories
- 13 women (over 55%) had scores of 5 or more
- Eight women had scores of 6 or more
- Five women had scores of 8

Figure 6 shows that women in this research cohort were more frequently affected by almost all forms of childhood trauma, than what has been found in the whole population - in many instances to a very significant degree.

Figure 6: Frequency of ACEs of Women in the Study

	General Population (8,42)	Women in this study	Difference in Frequency of experiences
Have at least one ACE	59 – 64%	96%	+ 1.5 x
Women with five or more ACEs	9%	57%	+ 6 x
Men with five or more ACEs	7%		+ 8 x
Sexual abuse of women	17%	42%	+ 2.4 x
Sexual abuse of men	7%		+ 6 x
Household substance abuse	29%	74%	+ 2.6 x
Verbal abuse	26%	56%	+ 2 x
Physical abuse	15%	39%	+ 2.6 x
Incarcerated family member	7%	52%	+ 7 x
Mentally ill household member	19%	52%	+ 2.7 x
Parental separation or divorce	27%	22%	-
Witnessed domestic violence	16%	57%	+ 3.6 x
No ACEs	41%	4%	- 10 x

Although this study involved a relatively small number of women (24), it provides data that is deserving of careful consideration. In conjunction with the existing evidence on trauma and women of a similar profile, this information may encourage service providers to dedicate attention and resources to ensuring their service is best placed to meet the needs of women who have survived significant levels of trauma. Implications of these trauma findings are further explored in the following sections of the report.

4.4 RELATIONSHIP TO SUBSTANCE MISUSE AND INTIMATE PARTNER VIOLENCE

As previously detailed in the literature review, the prevalence of ACEs is a predictor of health difficulties in later life, including substance misuse. It is also a predictor of increased experiences of adult violence. All of the women in this research, by virtue of taking part in it, had current or previous difficulties with drug and/or alcohol use. When asked about their substance misuse, over 65% (n=15) of the women stated that it was related to trauma and/or their life experiences. A further 30% (n=7) stated that their substance misuse was "somewhat" related to trauma and/or their life experiences. When discussing the relationship between the two, eight women stated that they had used drugs or alcohol to cope, in the past, with traumatic experiences. Discussing the role of services in relation to this, one respondent said:

> *Create a service that deals with the underlying trauma – it is hard to tell down the line if it is me, the person, or the trauma.*
> *(Woman interviewee)*

In addition to this report confirming links between ACEs and substance misuse, the research also highlights links, noted in the literature review, between early childhood trauma, substance misuse and experiences of intimate partner violence. In this study, 91% of the women had experienced violence by a partner in adulthood. This view was highlighted by staff, in relation to the current impact that they observed on women within their services - 32% (n=10) of service staff reported that domestic abuse impacted the women they supported and affected their ability to engage with services.

> *Being homeless accentuates risk factors in all areas and, in itself, can accentuate issues of abuse and control by men, which undermines motivation to change/recover.*
> *(Staff interviewee)*

4.5 SUMMARY

Given the extensive experiences of childhood trauma, adulthood substance misuse and adulthood violence experienced by the women who participated in this study, this profile portrays a group of women with significant resilience and capacity for survival despite these challenging life experiences. Although the cohort in this study is small, it highlights a group exposed to repeated traumas across their lifespan that must be considered in how services are designed and delivered to them. In trauma-informed services, service providers invest in reviewing their own practices and procedures in relation to trauma and seek to implement approaches that will further enhance the capacity of women and other trauma survivors using their services to heal and to grow.

PERSPECTIVES ON SERVICE QUALITY

5 Perspectives on Service Quality

5.1 OVERVIEW

Both service users and service staff were asked to rate service provision in relation to a number of qualities associated with trauma-informed services, namely whether they were:

- Safe
- Caring
- Understanding
- Valuing of service users
- Respecting of service users
- Trusting of service users

Service users were asked to rate their experiences in a variety of different services which were, on analysis, categorised as:

- Housing/homeless services
- Drug and alcohol services
- Criminal/offending related services (including the courts, probation services and the Gardaí)

The services were rated on a scale of 1 to 5, with 1 being 'not at all' and 5 being 'very much so'. Service staff were asked - on the same scale and on the same qualities - how they imagine the women with substance use difficulties using their services might rate them.

5.2 SERVICE USER AND SERVICE PROVIDER RATINGS OF THE SERVICE EXPERIENCE

The women who participated in the study were positive in their perception of drug and alcohol service providers scoring averages between 4.3 – 5.0 (n = 22) in relation to all areas, see Figure 7. In relation to feeling cared for, valued and respected, the average was the maximum score of 5. Housing related services scored in the average range, between 2.5 and 3.7 (n = 21). The least well-regarded services were offending related/criminal justice services, with scores ranging poor to average; between 1.9 – 2.7 (n = 19). It should be noted that the criminal justice related services included the Gardaí, the courts and Probation services so it does provide an accurate picture of perceptions of the various actors within this sector.
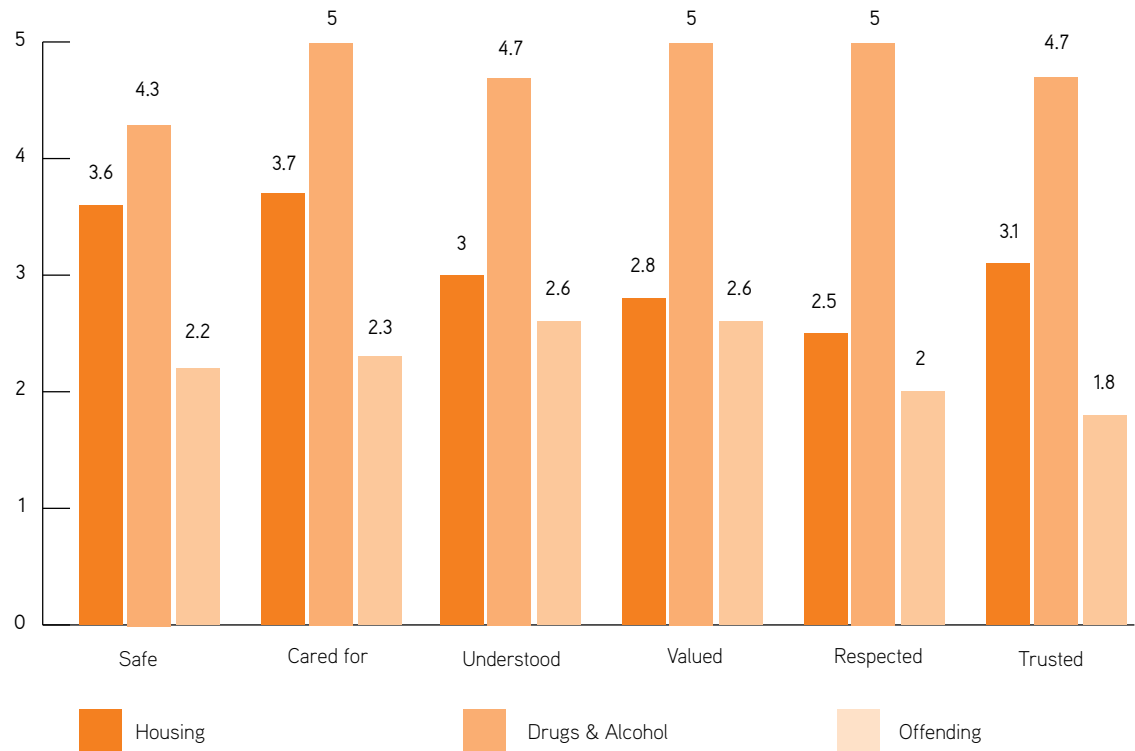
Figure 7: Service User Rating of Service Providers

Housing | Drugs & Alcohol | Offending

	Safe	Cared for	Understood	Valued	Respected	Trusted
Housing	3.6	3.7	3	2.8	2.5	3.1
Drugs & Alcohol	4.3	5	4.7	5	5	4.7
Offending	2.2	2.3	2.6	2.6	2	1.8

Figure 8: Comparison of Service Provider and Service User Ratings of Services

Staff | Women

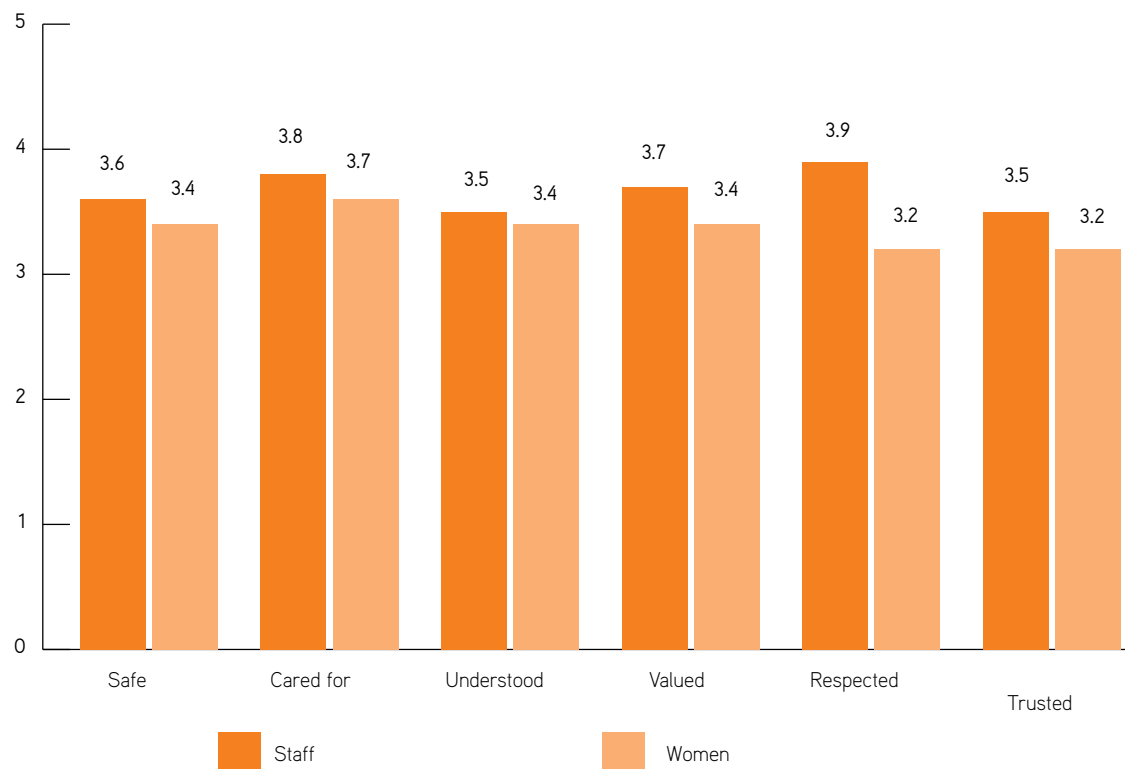|	Safe	Cared for	Understood	Valued	Respected	Trusted
Staff	3.6	3.8	3.5	3.7	3.9	3.5
Women	3.4	3.7	3.4	3.4	3.2	3.2

Figure 8 illustrates the overall rating of services in relation to the key qualities by stakeholder group. It shows that service providers have, for the most part, a realistic perception of how women with substance use difficulties feel using their services. The area of most difference was in the women feeling respected, where women on average rated the services almost a full point lower than services rated themselves.

5.3 SERVICE PROVIDER PERSPECTIVES ON THEIR CAPACITY REGARDING TRAUMA

Service staff were invited to rate a number of items drawn from trauma-informed service review tools, in order to provide a preliminary assessment of the services capacity in this regard. They were provided with statements and asked to indicate their level of agreement with the statements. Answers were collated and aggregated across the services. It should be noted that self-assessment by a handful of self-selected service providers is limited in its approach and this data only provides an indicator of some staff perceptions at a point in time. It should be noted that the usefulness of self-assessment by a small number of self-selected service users is limited, as this data only provides an indicator of some staff perceptions at a point in time.

MANAGING TRAUMA, TRIGGERS AND EMOTIONS
86 – 97% of staff who took part agreed that, in their organisations, staff have an understanding of:

- How gender impacts on a person's experience in our service
- The relationship between substance use and trauma (adult or childhood)
- How to help service users identify triggers (i.e. reminders of dangerous or frightening things that have happened in the past)
- How to help service users manage their feelings (e.g. helplessness, rage, sadness, terror)
- De-escalation strategies (i.e. ways to help people to calm down before reaching the point of crisis)
- How to establish and maintain healthy professional boundaries.
- Trauma, traumatic stress and its impact on women's mental health

ESTABLISHING A SAFE AND FRIENDLY ENVIRONMENT

Staff are confident in their ability to establish a safe and friendly environment. Only two areas scored lower than 77% - the environment being child friendly, and staff ability to make a safety plan with women:

- All staff are confident in how to ask about, and respond to, disclosures of domestic violence – 84% agreed

- The importance of service users' privacy and confidentiality is promoted in our organisation (e.g. policies are communicated to service users, private spaces for meetings etc.) – 84% agreed

- The building and environment promotes safety (e.g. inside and outside well lit, bathrooms can be locked) – 79% agreed

- All staff in our service promote women's safety (e.g. asking women about it, monitoring who comes in and out of the building) - 77% agreed

- All staff know how to create a safety plan with women in line with good practice, if this is required – 61% agreed

- The organisation is child friendly (visually appealing to children, safe places to play etc.) – 40% agreed

STAFF SUPPORT AND CARE

There were similarly relatively high levels (i.e. close to four out of five people) of agreement with facets of trauma-informed practice relating to staff care. Staff levels of agreement in relation to this area were:

- All staff are actively encouraged to share ideas to improve the service we provide – 81% agreed

- We have regular team meetings – 78% agreed

- Self-care (for staff) is important in our organisation (e.g. discussed, either in supervision or team meetings, have a debrief policy / practices after crises) – 77% agreed

Areas with slightly lower ratings:

- We are encouraged to reflect on and understand our own stress reactions – 74% agreed

- We have regular individual supervision – 65% agreed

INVOLVING SERVICE USERS

Staff were asked if they agreed that their organisation seeks to understand the strengths of their service users, to encourage their ownership of their care plans and if service users are encouraged to understand their rights. Levels of agreement to each statement ranged from 77% to 97%.

CULTURAL ACCESSIBILITY

Staff were asked if they agreed that their organisation seeks to be accessible to people from varied cultures. Staff were confident that they showed respect for, and acceptance of, different cultural and religious beliefs and practices (93% agreed), and that they have effective relationships to services that provide specialised care (84% agreed), but less confident that they are accessible to those who do not speak English as a first language (66% agreed).

Despite these apparent high levels of confidence, service providers commented that the effects of trauma and gender sensitivity on female drug misusers are often not understood or dealt with in a satisfactory manner by some services. Six service staff highlighted this in comments, four staff respondents specifically highlighted the lack of the provision of Trauma-Informed Care as being an impediment to female substance misusers receiving a quality service:

> *Also, staff may not be aware of gender sensitivity, for example male staff in services making sexual jokes to women in addiction who have survived sexual trauma and/or street work etc.*
> **(Staff interviewee)**

> *We need to work in a trauma-informed and non-judgmental way, no matter what the woman has experienced, her behaviours or her drug use. Keeping consistent, safe boundaries is important but I am around other workers and services that do not do this.*
> **(Staff interviewee)**

5.4 SUMMARY

Overall, this self-assessment found that services are currently confident that they have knowledge and practices in place that are in line with trauma-informed approaches. This finding is promising, but if services wish to become more trauma-informed, the issue requires additional investigation at individual service level. The ratings by women of services are in some cases aligned with staff perceptions of their own capacities in relation to trauma-informed practices, particularly in drug and alcohol services, and to some extent in housing services. However, they are less so in criminal justice related services. A number of women, in interviews, identified times where they had been treated disrespectfully in both drug and alcohol services and homeless services, and in some instances, women implied that there was a culture of disrespect towards women with drug and alcohol difficulties.

If the cycles of deprivation and trauma experienced by women in similar situations to those who took part in this research are to be broken, and if women are to be given the support that this requires, there is a need to turn the scrutiny and exploratory drive of this research inwards towards organisations themselves and the systems in which they operate. This will include consideration as to whether current structures are likely to support someone to move on from trauma, or whether they may in fact re-traumatise and further inhibit progress. There is potential for exploring and understanding current practices, applying learnings to do more of what works, and for resolving practices that might compromise the recovery and wellbeing of women who need their services.

ANALYSIS OF WOMEN'S EXPERIENCES AND NEEDS

# 6 Analysis of Women's Experiences and Needs

6.1 OVERVIEW

This section details service users' personal reflections on their backgrounds, their perspectives on the services received, challenges currently faced in accessing services, and what could be done to improve services. This section of the report describes the views of the 24 women who participated in interviews.

6.2 PARENTING AND CHILD WELFARE

CHILD–FRIENDLINESS

83% (n=20) of the women, who participated in interviews, were parents and 70% (n=14) of these women had more than one child. Both service providers and service users were also asked if they felt they provided a child-friendly environment. 60% of service providers (n = 18) disagreed when asked if their organisation is a child-friendly environment. Women substance misusers were also asked if the service they accessed was child-friendly, this is compared to staff responses in Figure 9 below.

Figure 9: Do Services Provide a Child Friendly Environment?
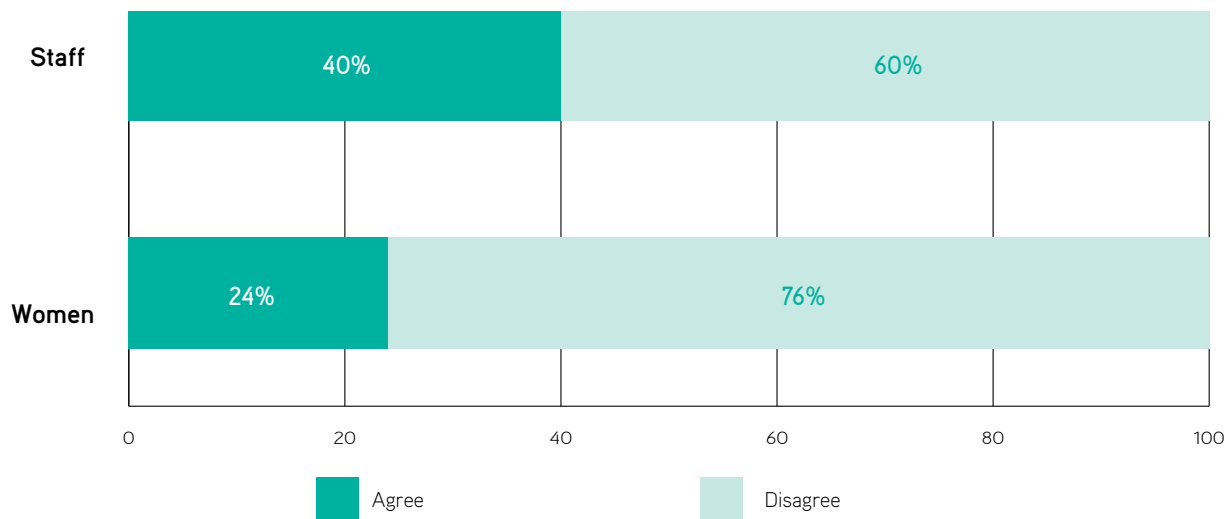
The majority of staff (n=18) and of women (n=16) disagree when asked if services provide an environment which is safe and welcoming for children. However, staff were more likely to believe they provide a child-friendly environment than the women to whom they provide services.

FEAR OF LOSING CHILDREN AS A BARRIER TO ACCESSING SERVICES

At the time of the interview, 71% (n=17) of the women had at least one child in someone else's care. Concerns relating to their children's welfare, their relationship with their children and/or those who could impact negatively on their parental role and relationship, were common concerns shared by the women. Of the 20 participating women with children, 49 of 58 children were under the age of 18. Of those under 18 years:

- 49% (n=24) were in the care of family members
- Almost 37% (n=18) were in the care of the state
- 14% (n=7) were either in the care of the woman or a current or former partner

Women were reluctant to bring their children to services for a range of reasons, including:

- That they would be judged (42%, n=10)
- Concern that staff would interfere with their relationship with their children or call social services (33%, n=8)
- That they felt services did not seem safe for children (29%, n=7)
- That they felt services did not seem welcoming for children (25%, n=6)

The fear of losing custody of their children reduced some women's engagement with services as reflected in the following quotes:

> *Never went to a service (for two years) because I knew the kids would have been taken off me. I handed them over to my mam before it got to that stage... (the fear) kept me from asking for help... I know everything is watched... I know women who have brought their kids and social workers were on top of them and took them away... a social worker is a heart stopper.*
> **(Woman Interviewee)**

Four service staff also specifically highlighted in their comments that women feel they cannot be fully honest and or engage effectively with the supports they need as they may fear losing custody of their children:

> *Women have a fear of social worker involvement if they are truly honest about their addiction, as this may lead to the losing custody of children.*
> **(Staff Interviewee)**

It was acknowledged by staff and the women alike that this was a challenging area as staff want to support women, and women understand that staff have legal obligations in relation to the safety of all children. The need for an open, supportive approach to parenting and child welfare was highlighted.

STRESS OF ENGAGEMENT WITH SOCIAL SERVICES

Almost 46% (n=11) of women provided unsolicited commentary on their interactions with Social Workers. While some commentary was positive, the majority highlighted the fear and/or concerns that women had about the power of social workers in their lives and that of their children's, the following quote provides an illustration of these concerns:

I feel like the social workers are not straight with me... Social Workers need to be more honest and open with mothers. They tell you to do something, you do it and then they don't honour their side - they are not happy with the progress that is being made. There is always something and you are never quite able to get the children back.
(Woman interviewee)

They kind of look down on you. It is not an equal conversation. You are just another number - stats and all that... I remember a Social Worker telling me that I wasn't going to make it in recovery and that I was just another number.
(Woman Interviewee)

Participants who had multiple children in care spoke about wanting one dedicated Social Worker for their children. Here, one woman speaks about the challenge she faced having multiple Social Workers:

Trying to manage all the various people (Social Workers and Foster Carers) is actually making my life challenging - having just one Social Worker would be much better. There are so many reviews, so many case conferences.
(Woman Interviewee)

Also a few women spoke about the benefit of positive relationships with their children's Foster Parents as exampled in the following statement:

There is a good relationship with the Foster Parents - I can see them when I want. The kids are in the same area and have a single Social Worker.
(Woman Interviewee)

FEAR OF HARM TO CHILDREN AS A BARRIER TO ACCESSING SERVICES

A minority of women interviewed said that services felt welcoming to children. Almost 42% (n=10) of the women spoke about wanting to protect their children as the reason for not bringing their children to services; they viewed them as unsafe or inappropriate environments. This is reflected in the following participant statements:

I don't want my kid in there because everyone (there) just wants the next fix; I don't want my kid listening to conversations in waiting rooms. (The child) is very clever and would pick up on what they are talking about.
(Woman Interviewee)

> *Children are too young to know all this (addiction, homelessness, drugs); children don't belong in those places... people are talking about drugs...they are too young to be brought into services.*
> **(Woman Interviewee)**

LACK OF CHILDCARE IS A BARRIER TO PROGRESSION

Of the 18 participants who had children under 18 years of age, 33% (n=6) felt that access to childcare interfered with their ability to access services:

> *Having kids might impact a woman's ability to get on a course or training; there are not enough places in crèches to take care of kids.*
> **(Woman Interviewee)**

> *When I was trying to get into recovery before, I couldn't go to the day programme because there was no crèche for my (child). I suppose it delayed my recovery by about a year... my using was getting worse while I was waiting.*
> **(Woman Interviewee)**

It is important to note that 61% (n=11) of the women who felt access to childcare had not interfered with their ability to obtain services stated that their children were in the care of someone else. 39% (n=7) had one or more child in the care of family and 33% (n=6) had one or more child in the care of the state or with a current or former partner. One of the women said she could access childcare support from family:

> *...having a child has not been a barrier to services because I have family who can care for the child.*
> **(Woman Interviewee)**

MAKING SERVICES CHILD-FRIENDLY WOULD INCREASE ACCESS

58% (n=14) of participants reported that creating more child-friendly environments would support women to better engage with services. Further, they provided suggestions on what services could do to become more child friendly such as: having women and child only service scheduled in, childcare available, child-friendly spaces so children can attend, partnerships with crèches etc. These suggestions are outlined below:

> *There should be a play area or sitter to look after kids while mothers are meeting with services.*
> **(Woman Interviewee)**

> *Child-friendly, play room, link in with crèches - I feel like that is a major thing - have a six-week slot so a woman can do a programme, leave an open space so she can get time on her own as part of the recovery process.*
> **(Woman Interviewee)**

> *A space beside or in the building with a crèche with people trained to look after kids, while women are doing their services or counselling. Or a creche specifically for women in recovery. It would be a good networking option for women so they wouldn't be so isolated and when they go to meetings because it is disrupting to have kids in meeting... Women often can't get a babysitter or leave them with their parents. The service could also offer a playgroup for recovering moms and their kids.*
> **(Woman Interviewee)**

26% (n=8) of service staff also highlighted that childcare issues and the child-friendliness of services can impede women's engagement with services:

> *Women need a safe place to meet where they can bring their children.*
> **(Staff Interviewee)**

Four service staff specifically highlighted that appropriate childcare services, which would enable women to effectively engage with services, are often not in place:

> *Families do not have the supports to organise childminding in their absence [or] for appointments or they are simply too chaotic to organise this.*
> **(Staff Interviewee)**

> *Timing of appointments is an issue as many women are collecting children from school, thereby services need to be responsive to this.*
> **(Staff Interviewee)**

SUMMARY

The importance of providing appropriate care and support services to women who are parents cannot be underestimated and, as articulated by service staff, is crucial to effective engagement. Doing so means tackling generational disadvantage of women service users who are, as this cohort demonstrates, largely survivors of complex, long-term traumas. The implications for services are that women with experience of trauma may not only delay seeking services but are also likely to have significant barriers to engaging effectively with services for multiple reasons. These reasons may include fear of losing access to their children if they seek support, and lack of appropriate service provision for the safety and well-being of their children.

One key issue in this area points to the need for services to proactively address the fears of women with children who require services, given the number of interviewees who highlighted the challenges of balancing finding care for their children and making a successful recovery.

6.3 HOMELESSNESS AND HOUSING SUPPORT

PROFILE OF HOMELESSNESS
79% (n=19) of the women had experienced homelessness at least once in their lives with 46% (n=11) experiencing homelessness either frequently or most of their adult lives. 21% (n=5) had, at some point in their childhood, been cared for in a foster or group home. 46% (n=11) were currently living in homeless accommodation and 21% (n=5) were either temporarily staying with someone or sleeping rough at the time of their interview, which means that 67% of those interviewed were homeless at the time of the research.

HOUSING FIRST
Almost 42% (n=10) of women stated that housing was critical to their progression with 29% (n=7) stating it was the most important thing, particularly in relation to their children, as noted by the quote below:

> *Housing is huge - Housing first, then rest of services. You can deal with the rest... I would prefer my own place because I can be away from a dangerous environment with drugs and could get my child back and give them a safe space.*
> **(Woman Interviewee)**

30% (n=6) of the 20 women, with children under 18 years of age, stated that that the lack of housing was stopping them from getting what they needed in relation to their children, with each woman stating that housing was the first step to their progression, as evidenced below:

> *I just need a house first and then get her (my child) back. I just need a home first - a key to a door and saying it is mine.*
> **(Woman Interviewee)**

Over 48% of service staff also highlighted the lack of safe accommodation to be a significant issue for women with one stating:

> *I believe that the biggest challenge facing women substance users in Limerick is a lack of suitable accommodation. There is a dearth of accommodation providers willing to provide accommodation to women who misuse substances.*
> **(Staff Interviewee)**

Four of the staff specifically highlighted the lack of availability of female beds in low threshold services and the high demand for such services.

BARRIERS TO HOUSING

Women cited a number of specific barriers they faced in seeking to secure housing. 42% (n=10) of women stated that services were too slow in meeting their needs (e.g. time between appointments, time on waiting lists) and an equal number stated that housing supply in Limerick was an issue that impacted their ability to move into a home.

> *I have been on the housing list for over 10 years... There are no rentals out there -*
> *I have a deposit, I have the whole lot but just can't get a place.*
> **(Woman Interviewee)**

42% (n=13) of service staff also highlighted significant time on waiting lists as a key concern.

One service user expressed frustration that they were not treated respectfully by a housing assistance service, saying:

> *They wouldn't come out to speak with me and only spoke to me through the*
> *intercom. They need people skills, they don't treat me like a person.*
> **(Woman Interviewee)**

21% (n=5) of women stated that they had experience of landlords who didn't want to rent to Housing Assistance Payment (HAP) scheme participants.

> *Landlords don't want hassle to deal with HAP, they just want the money up front.*
> *The ones that do accept HAP have higher prices.*
> **(Woman Interviewee)**

33% (n=8) of women stated that they needed financial support, frequently citing the challenges of saving while paying for accommodation in homeless housing services:

> *Not able to do it (pay) on my own and I need a bit of help... financial and*
> *searching help... I have some of my deposit but not sure where I am going to*
> *come up with the rest of the money for the deposit and rent... 50% of my income*
> *goes to rent at (service)... so it is hard to save.*
> **(Woman Interviewee)**

SAFETY CONCERNS IN RELATION TO HOUSING

33% (n=8) of women stated that they had safety concerns with their current accommodation or location, and that safety was a priority for them:

> *I live in an area that is not ideal for a recovering addict... dealers in the area; people using, anti-social behaviour... if I could, I would prefer to move to an area that was a bit more diversified in terms of those on housing schemes.*
> **(Woman Interviewee)**

63% (n=15) have lived in Limerick their entire lives indicating that they were rooted within the community. In some instances, the fact that they had been there so long added to safety challenges. Some women felt that getting housing outside the city would be safer for them than being in the city:

> *There are parts of Limerick I can't go to because of my (family).*
> **(Woman Interviewee)**

A number of women had stated serious concerns with lower threshold housing services which they said made them feel unsafe and threatened, and that being in those spaces was counterproductive to their wellbeing and/or recovery.

SUMMARY

The women clearly identified the lack of safe, available housing as a core barrier to their progression, particularly for the women with children under 18. Additionally, the interviews highlighted three other areas that challenge their ability to find housing: landlords not wanting to accept HAP, the lack of savings for rental deposit, and the need to have safe, secure facilities for them and their children.

These requirements for services indicate a potential for more coordination in and amongst services that work with this particular cohort, including promotion of a case management approach. There is a need for outreach and synergised approaches, which may include a focus on gender and Trauma-Informed Care.

6.4 CRIMINAL JUSTICE ISSUES

OVERVIEW OF ENGAGEMENT WITH CRIMINAL JUSTICE SYSTEM

Of the women interviewed, 83% (n=20) had ever engaged with the Irish legal system (either the courts, Gardaí and/or probation) in relation to drugs, alcohol, crime, or domestic violence,. 75% (n=18) had been to court with the following frequency: 38% (n=9) more than 10 times, and 38% (n=9) between 1 and 10 times. 21% (n=5) had never been to court in relation to drugs, alcohol, crime, or domestic violence. For those who had interacted with the court system, 50% (n=12) had done so within the previous year at the time of their interview. The average age of women when they first appeared in a court was 22 years.

COURTS AND IDENTIFIED SUPPORTS

Women relayed that they were attending court appointments for various reasons including child custody, domestic violence issues with former or current partners and drug related charges. Many women reported supports increasing when they had criminal justice issues:

> *Last year I didn't have the support I have now. Now I have a Probation Officer,*
> *Solicitor and a Counsellor so I have some of the support I need.*
> *Now I need a place to live.*
> *(Woman Interviewee)*

Women who cited the need for supports also focused on a number of areas, including someone to accompany them to court proceedings, financial support for legal fees, and better coordinated services to support women who are having difficulty with the criminal justice system:

> *I have a solicitor but it would be really useful and supportive to have a person*
> *(always the same person) to go with me to court so they can see the whole story.*
> *[The Service] is good like that because they usually won't let me go to courts on*
> *my own and send someone with me. It's just that sometimes they don't have staff.*
> *(Woman Interviewee)*

OFFENDING AND PROBATION

100% (n=18) of the women who answered the question "Do you want to stop offending" answered "Yes". 29% (n=7) of all respondents felt that their Probation Officer could assist them with not re-offending. The comments from women who felt that their Probation Officer could help them, reflect a sense of support, mutual respect, genuine caring and of "rowing in" behind them.

> *Yes, if you get the right one. Someone that listens but won't take excuses,*
> *who will call you out on stuff and not let you get away with anything. But you*
> *also know she was there for you if you needed anything. I will never forget my*
> *Probation Officer. She motivated me to do better because I cared for her.*
> *(Woman Interviewee)*

> *They can help you if you let them - it is up to you to stop doing it. My Probation*
> *Officer was firm, caring and I trusted her. I trusted her because her body*
> *language was relaxed, she followed through, did what she said she was going to*
> *do - she was brilliant.*
> *(Woman Interviewee)*

Nine women, approximately 37%, felt that their Probation Officer could not help them to stop re-offending. All of them highlighted the fact that offending is a personal choice and not within the Probation Officer's control:

> *I don't think that there is anything that can be done to help - people can do it if they want. Eventually you will get sick of re-offending and get bored.*
> (Woman Interviewee)

> *No because... you're only getting into the trouble because you're drunk or stoned. As soon as they're gone, the bottle comes out and they can't stop you from drinking, which causes the trouble. These things wouldn't happen if you were sober.*
> (Woman Interviewee)

During the interviews, one participant voiced a feeling that it was never safe to fully see Probation as a support and express what was happening to them because of an awareness of the Probation Officer's role in working with social services.

> *There is fear is in the back of my head – I am reserved and don't want to say too much because it could be used against you when you go to get your kids back... so I never really fully trust them and will always hold back because they all have a duty to report.*
> (Woman Interviewee)

PROBATION APPOINTMENTS

Over half of the women, 66.7% (n=16), had been on probation with 81% (n=13) of these women stating that they generally kept their appointments. Women cited a number of reasons for missed appointments, including lack of stability, mental health difficulties, and fears for their safety:

> *I missed my appointment because I had to go into town – I was afraid I would be attacked by someone who could hurt me. Depression is also a cause. Sometimes it is hard to get out of bed.*
> (Woman Interviewee)

Other interviewees stated that their priority was either seeing their children and/or meeting with children's Social Workers (in some cases where there was more than one Social Worker assigned within a family) which complicated the process of balancing multiple meetings (Social Workers, Counsellors, Probation Officers, Lawyers, Courts etc.). As one participant stated:

> *I have more than one Social Worker, I miss appointments, I get appointments confused... There are so many reviews, so many case conferences.*
> (Woman Interviewee)

This sentiment was also echoed by a staff member:

> *Accessing all the appropriate services and keeping various appointments at different locations can be very difficult for women in vulnerable and chaotic situations.*
> **(Staff interviewee)**

A few women noted that within Justice services, Probation Officers were flexible and accommodating when it came to appointments:

> *I missed an appointment because I was physically assaulted but I was able to call probation and reschedule.*
> **(Woman Interviewee)**

When asked about what would have helped them in keeping appointments, the women cited a number of items including outreach-based appointments, consistency in appointment times and reminders by phone or text.

> *A little push or reminder to go to the appointment. The reminder in the morning is helpful... when they call.*
> **(Woman Interviewee)**

CONNECTION BETWEEN REHAB AND OFFENDING

Some women stated that their primary need in relation to their criminal justice issues was support in finding a slot in rehabilitation and that the lack of a place to detox was contributing to their offending, as illustrated below:

> *The waiting list at rehab is seven months... they need to shorten this time because it is too long... just waiting for a place is slowing everything else up and preventing my progress. Rehab needs more slots.*
> **(Woman Interviewee)**

Service staff also echoed this concern with 42% (n=13) stating long waiting lists are a barrier to progression.

SUMMARY

The key themes in the area of interactions with the Irish legal system highlight that women view housing and access to treatment as a stabilising factor that will support them not to reoffend. Women underscored the value of Probation Officers that were able to connect them with services, act as an advocate, and provide firm but caring motivation. Feedback from the interviews also points to the value of flexibility in scheduling probation appointments but also underscores the need for regular appointments.

For women engaging in sex work, services might explore the possibility of increasing engagement around this highly stigmatised issue, to ensure that those women who are engaging in sex work have appropriate health and other supports.

6.5 DRUG AND ALCOHOL RELATED

OVERVIEW OF SUBSTANCE USE

Women reported consuming alcohol and drugs at varying rates. The majority of women at the time of the interview 'rarely' or 'never' used alcohol or drugs. A significant minority of women, 39% (n=9) reported daily or weekly drug use, as illustrated in Figure 10 below.

Figure 10: Frequency of Alcohol and Drug Use

	Alcohol		Drugs	
Never	61 %	14	35%	8
Rarely	30 %	7	22%	5
Monthly				
Weekly		< 5	39%	9
Daily				

ALCOHOL RECOVERY SUPPORTS

For those women who were receiving support for alcohol recovery, they were either attending Alcoholics Anonymous meetings and/or using counselling as a support. One suggestion that came from a participant was to start some form of meeting for recovering adults and their children - for support both with the recovery process and to share experiences. In relation to recovery and available resources outside the city of Limerick, a participant noted that:

> *I think the people out in the country are worse off than town people for addiction...there is no help out there for them.*
> (Woman Interviewee)

One participant noted that the lack of childcare is a major factor preventing them from getting what they need in terms of support for alcohol use.

DRUGS SERVICE SUPPORTS AND AVAILABILITY

All women who participated in interviews were already connected with drug and alcohol services, in some form. However, as noted in quotes above, there were women who felt that there were services that they needed, which they could not avail of due to limited places and long waiting lists.

Almost 35% (n=8) of participants were happy with the supports that they were receiving for their illicit substance use. However, the same percentage were happy but wanted more or different supports. Here, one woman discusses how she values the support she receives:

> *If I get a craving, I can talk about it. The freedom from it has allowed me to talk about it.*
> (Woman Interviewee)

The women who noted that they wanted more or different supports emphasised the need for counselling[7], engaged support workers, support for court appointments, access to safe, dry supported housing, access to independent housing away from other drug users:

> *I need to have proper counselling... Once a week would be enough. It would be the safe space I think I am missing. I need a place to go where I can talk. I need to trust them - need them not to be bound by the same restrictions as other services.*
> **(Woman Interviewee)**

The three women who stated that they were not receiving support at the moment but wanted it, expressed the need for linking in with supports for detoxing, including access to rehabilitation programmes, prescriptions for methadone, and counselling supports.

Concerns were raised by the women in relation to one particular service, where staff made comments that were considered by the women as having a shaming impact on them. The following story was provided to illustrate this sentiment:

> *The [staff member] came in to a group of us women in the service and said – 'see those gentlemen over there, most of them wouldn't be here if women did what they were supposed to do like motherhood and looking after their children properly, not using or drinking and taking care of the men'. [Staff member] didn't recognise the women were there because they were hurt by men... I got so mad at that - apparently this was the speech she gave for years and years - to groups of women who needed help.*
> **(Women Interviewee)**

THE NEED FOR GENDER SPECIFIC SERVICES

The need for gender specific services was highlighted both by the women and staff. 46% (n=11) of the women Interviewees specifically named 'women only' services as a need. Benefits of such services from the women's perspective are reflected below and include increased feeling of safety, support and the opportunity for positive role models.

> *Women would benefit from women only services - we would be stronger because when a man is around, he thinks he owns you... I would be nervous with a man sitting here.*
> **(Women Interviewee)**

Service staff (n=9) also specifically highlighted the lack of 'women only' services a barrier to effective engagement. Four staff members stated that there is a lack of accessible detox services, and the same number highlighted the lack of appropriate services for women substance misusers who become pregnant.

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7   Approximately 44% (n=10) women stated that they either needed support or wanted more or different supports for mental health with the predominate request being counselling services. This need was stated either directly or characterised as a 'safe place to talk'. This is also highlighted in the mental health section below.

Support needs to be provided to women who are using [and] who find themselves pregnant as there is a total lack of support structures in place for these women.
(Staff Interviewee)

More services need to open - there are hardly any out there. We need more women's services; women do better when it is a woman only environment.
(Staff interviewee)

SUMMARY

The primary needs identified in relation to drug and alcohol supports were: the need for access to counselling; the need for access to choices in rehabilitation services; facilities where children can be while women are receiving services; and dry facilities where women could be assured that they were safe once they had finished a programme, particularly for women with children. Once again, housing was identified as a stabilising factor for the women wishing to address their substance misuse. The need to ensure that services do not stigmatise women was highlighted. Implications for services include the need for strategic, proactive service planning including, potentially, the development of a women's only service or a review and redevelopment of a facet of an existing service that recognises the gendered nature of drug and alcohol use, and of trauma experienced by women.

6.6 PHYSICAL HEALTH

Most women were satisfied that they had access to supports in relation to their physical health. Only 6 people said they needed more support, and a number of these women did not have medical cards. Participants expressed some concerns about confidentiality, stigma around health issues as a barrier to seeking help, as well as the quality of medical care that they received as noted below:

I have [a communicable disease], I am afraid of people finding out and it [fear] is stopping me from accessing services...I just don't want people to know. They will only start panicking - so I am just careful.
(Woman interviewee)

I have [heart/circulation difficulties] and am getting some help. My GP is lovely but I need some assistance with traveling to appointments.
(Woman interviewee)

SUMMARY

During the interviews, the vast majority of women who answered questions about their physical health were connected to medical service providers and were happy with the care that they were receiving. Those who needed additional supports identified assistance to obtain a medical card and assistance traveling to appointments. Services might consider exploring how they either advocate on behalf of, or assist women in self-advocacy with medical services, given a few instances where women were concerned about identifying their medical issues or were not satisfied with the quality of care.

6.7 MENTAL HEALTH

OVERVIEW

65% (n=15) of women self-identified as having mental health issues and almost 35% (n=8) stated that they did not. It should be noted that even among those who did not self-identify as having a mental health issue, half of them were receiving support in the form of counselling and or medication for anxiety or depression. Further, 75% (n=18) of the women stated that access to counselling services was very important to their future progression. Approximately 44% (n=10) of women identified significant challenges with accessing mental health supports that sufficiently met their needs. The types of challenges detailed below in this section relate to timing, access, quality, and/or trusting their provider.

SOCIAL SUPPORT AND ISOLATION

For most women who took part, social supports were not strong. When asked to rate, on a scale of one to five (1 = Not at all, 5 = Very much so), the level of support women received from their parents, family and friends, the following were the average scores per category: 3.5 – parents, 2.3 - other family members and 2.2 – friends. The ratings reveal that support from family and friends, other than parents, was generally perceived to be poor, and support from parents to be average.

Statements of feeling alone or isolated were mentioned by 41% (n=10) women over the course of the interviews, as exemplified below:

> *I feel particularly isolated... left to my own devices.*
> **(Woman Interviewee)**

> *The weekends are hard - there is no support on the weekend.*
> *This is when isolation kicked in for me.*
> **(Woman Interviewee)**

IMPORTANCE OF TRUSTING HEALTH PROVIDERS

The participants who spoke about their mental health needs highlighted that it is critical that they can trust the health providers they were engaging with:

> *I would really like weekly counselling - to get things off my chest... it is important*
> *to have someone I trust who can explain my mental health options.*
> **(Women Interviewee)**

A number of women reported feeling judged by their GP or by a mental health service provider and said that this was a deterrent to them seeking support in accessing mental health services. In addition to being able to trust the health providers they engaged with, the women also spoke about the importance of being treated with respect and dignity:

> *I feel really judged by my doctor. He is not helpful or honest. I don't trust him*
> *at [service]. I need someone to talk to confidentially who is understanding*
> *and who I can trust.*
> **(Woman Interviewee)**

STIGMA FACED BY SERVICE USERS

While not explicitly named by the women, service staff (n=6) specifically named stigma and shame as key issues faced by women service users including related to substance misuse, sex work and mental health difficulties. In some instances, the religious attitudes of some services exacerbated the stigmatisation of women accessing services, as expressed in the following staff quotes:

> *There is a shame around admitting to street working, which makes putting safety measures in place a challenge.*
> **(Staff interviewee)**

> *Most of the treatment centres women can access outside of Dublin have a religious and conservative view and approach to women. Women are not encouraged or feel comfortable to discuss issues around sexuality, sexual abuse, sex work, rape and sexual orientation.*
> **(Woman Interviewee)**

Both real experiences of stigma illustrated by these quotes, as well as perceived stigma in relation to parenting mentioned earlier, were noted by staff and women alike to have potentially negative impacts on women's wellbeing and mental health.

FREQUENCY AND TIMELINESS OF MENTAL HEALTH SUPPORT

The women also spoke about the need for more swift and frequent access to mental health services and support, and its impact on engagement with health services:

> *I have been diagnosed with [several mental health issues] but I don't have any mental health supports. I have asked about counselling help from [a service] but still don't have any. When I am not getting support quick enough and then I kind of give up.*
> **(Woman Interviewee)**

> *I am on the waiting list because I missed my last appointment... Depression makes it hard to get going... I was feeling really bad one day and [the service] refused to see me. There is no one checking in on me. They should see you when you need to be seen, not when it is convenient for them.*
> **(Woman Interviewee)**

HAVING DUAL DIAGNOSIS

During the interview process, women often spoke about mental health and addiction simultaneously – not viewing them as separate entities and underpinning the connection between the two. Participants highlighted the need for connection amongst and between services:

> *I received [mental health] help to get me off [medication] and so I don't have a benzo issue any more but there are not enough places you can get help for poly drug use. Treatment centres [for mental health] should be connected with detox and other services.*
> **(Woman Interviewee)**

Service staff (n=6) also highlighted the challenges for women who try to access dual diagnosis services and the issues they encounter from a lack of or severely limited service provision to a lack of outreach to support women with mental health and addiction challenges:

> *One of the biggest problems that I have seen is the difficulty women have in accessing appropriate support if they have additional mental health problems. There are very limited services that will provide dual diagnosis specific support.*
> **(Women Interviewee)**

MENTAL HEALTH AND CHILDREN

As evidenced above, the importance to women of access to, and ability to care for, their children was a core topic in interviews. The impact of not seeing, or being fearful of not seeing their children was raised during conversations as having a negative impact on mental health. The fear of disclosing mental health difficulties as something that could prevent the women from having access to their children was also raised by a number of women"

> *I need [mental health] help... not seeing my kids is affecting my mental health severely.*
> **(Woman Interviewee)**

> *I have issues and would like support, but I am really afraid of the impact of talking about mental health issues and depression on getting my kids back. So I haven't asked for help, but know I need it. The fear is stopping me from getting what I need.*
> **(Woman Interviewee)**

BARRIERS TO MENTAL HEALTH RECOVERY

Issues of self-directed recovery and agency, and participants' ability to direct their treatment or challenge providers regarding their mental health were raised during questions about mental health. The women underscored a desire to advocate for themselves. However, those quoted below, also point to barriers that impacted those receiving mental health services and their satisfaction with those services:

> *They gave me [multiple medications] that made me sick and paranoid... they are switching back and forth with drugs. I want to switch doctors but...*
> *HSE won't let me.*
> **(Woman Interviewee)**

> *I feel like my depression is not being managed properly... I don't feel like there is expertise to help me understand my addiction and depression...*
> *I had to learn on my own.*
> **(Woman Interviewee)**

> *When I asked a question about the medicine he [the doctor] prescribed, he told me not to question him and wouldn't change my prescription even after I asked.*
> **(Woman Interviewee)**

Participants made suggestions for additional services needed, including a peer-led mental health/recovery support group for women with similar experiences, and a crisis/out of hours service, either phone based or in-person.

6.8 SUMMARY

Mental health difficulties were prevalent among the group, and effective services were viewed as a critical component to progression by the interview participants. The judgemental attitudes of some mental health practitioners was a deterrent to some women accessing services, and this presents a particular challenge to a group who may already avoid help seeking due to stigma, or fears around child protection issues. The participants in this group showed a strong appetite and capacity for self-advocacy regarding their mental health recovery. There is potential for services to explore recovery-based supports for women with dual diagnosis, including training or support in self-advocacy and potentially joint case management approaches, in addition to timely and appropriate access to mental health services.

INTERAGENCY CHALLENGES

7 Interagency Challenges

7.1 OVERVIEW

This section notes some issues raised by service providers in relation to how multiple agencies work with this cohort of women, and some potential solutions to them. These issues primarily relate to poor communication, lack of clarity around referral pathways and the need for better coordinated working.

7.2 FINDINGS

Service staff reported that poor interagency working and communication create a system that can make it difficult for substance misusers to engage confidently with services. 32% (n=10) of service staff highlighted this issue with two staff reporting that requiring female substance misusers to recount their story to multiple services had a detrimental effect on women's access to services, as highlighted below:

> *It would make sense if a woman who is engaging with a number of services could have a more streamlined experience rather than having to make different appointments and repeat her story over and over. We are all trying to support the same outcomes.*
> **(Staff Interviewee)**

> *Interagency work needs to be better, because of the amount of services that have become involved i.e. Mental Health, Túsla, Gardaí, and Education & Welfare Board etc… This is difficult for the client and services involved. It can be overwhelming for the client and a nightmare for professionals.*
> **(Staff Interviewee)**

Poor referral pathways were also highlighted as a significant issue by five of the service staff, echoing what the women themselves said. Service staff sentiments are captured by the following quote:

> *…women who have wanted to make changes, engage with services outside and work on themselves are often soon drawn back into lives of addiction, domestic violence with little or no options… there should be stronger links and referral pathways established with organisations who provide support and services to women - in particular rape crisis, domestic violence etc.*
> **(Staff Interviewee)**

Three of the respondents specifically highlighted that substance misuse can act as a barrier to accessing services, including domestic abuse services:

> *…most counselling services and respite houses… will refuse support due to their [women's] substance abuse and therefore [women] will not always disclose full information.*
> **(Staff Interviewee)**

The lack of interagency working was also noted by one service user who needed coordinated services, and experienced challenges in accessing these:

> *The services are not knitted together and you don't have consistency with who is helping you – a case management approach. [Experiencing] no coordination is really difficult. Different people interpret different things and can get it wrong, which causes problems and forces me to keep proving myself which is a huge pressure, and is mentally draining.*
> **(Woman Interviewee)**

SUMMARY

This section highlights potential for further embedding a model of interagency working that will provide accessible, navigable and coherent support to women using services, regardless of the service at which they present.

A PROFILE OF FORTY-FOUR WOMEN

8 A Profile of Forty-Four Women

8.1 OVERVIEW

This section of the report provides data on the staff assessment of the engagement with services and related the challenges of 44 women using substance misuse and homeless services in Limerick between December 2016 and April 2017. This data generated using the Christo Inventory (CISS); a validated instrument that measures service providers' perspectives on service users' situations. Efforts were made to minimise or avoid duplication between those who participated in interviews and those for whom the CISS was completed. The purpose of this aspect of the study was to provide additional profile information on Limerick women services users and their needs, to complement the smaller cohort who took part in this research.

8.2 AGE AND HOUSING STATUS

The average age of women was 34, and ages ranged from 23 to 52. Over half of respondents were living in their own home, and almost one third were homeless. This age cohort is similar to that of the smaller population of women who took part in interviews.

8.3 DRUG USE

44% of the women profiled were poly–substance users, with 24% of the total having three or more substances of choice. 50% listed only one substance of choice. The substances most commonly cited as drugs of choice were:

- Heroin – 30 respondents (65%)
- Benzodiazepines - 27 respondents (59%)
- Methadone - 12 respondents (26%)

Figure 11: Three top drugs of choice
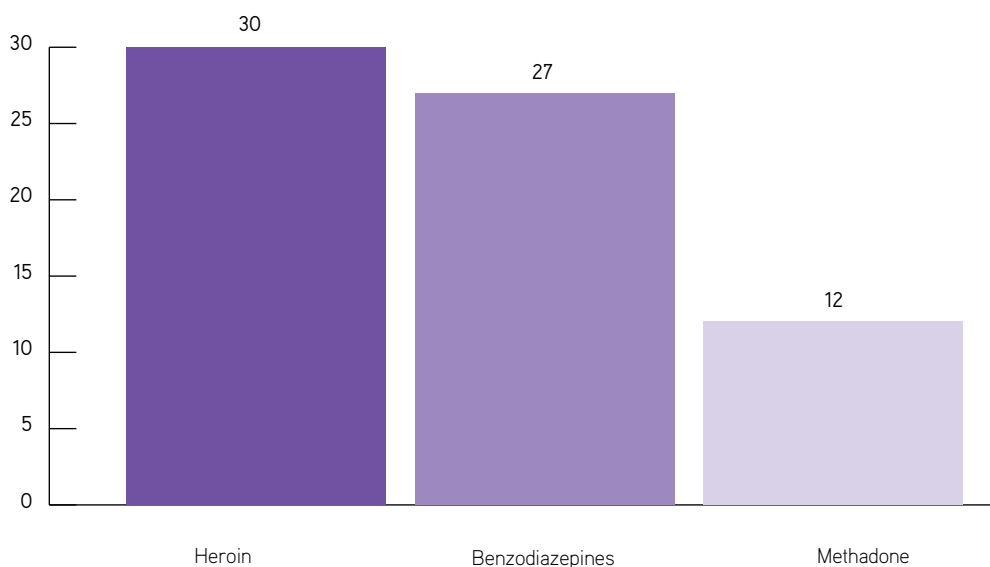
This information is complementary to that gathered in the interviews, where women were not asked about specific substances, but rather about frequency of use of drugs and/or alcohol.

8.4 AGGREGATE CISS SCORES

The aggregate CISS scores show that the challenges facing women using services in Limerick are largely similar to, or slightly below, that of other similar populations based on the Christo scoring system. The Christo instrument rates users of services on ten different areas of challenge, with answer values ranging from 0 to 2, therefore giving a maximum possible score of 20. In this population:

- Total scores ranged from a low of 1 to a high of 15.
- The most common total score (mode) was 7 and the average was 7.4. This is lower than the average total score of 8.1 found in the CISS researcher's study of outpatient alcohol services.

The CISS tool provides ranges of scores that are 'low', 'average' and 'high' depending on the type of treatment setting. For the purposes of this profile it was felt most appropriate to use the 'outpatient' setting categories. However, it should be noted that a broad range of service providers provided data for this section including Probation, housing and drug and alcohol services. They are not necessarily comparable with out-patient alcohol treament services, however this was deemed to be the most appropriate of the three CISS categories for the purposes of benchmarking in this research.

A majority of respondents (69.5%) received a score that fell within the range for average problem severity in out-patient services. The breakdown is as follows:

- Low score (0-4) – 9 respondents (19.5%)
- Average score (5-11) – 32 respondents (69.5%)
- High score (12-20) – 5 respondents (11%)

The graph below highlights that for an outpatient setting, the majority of women using services have an average profile of challenge and need.

Figure 12: CISS Score Severity
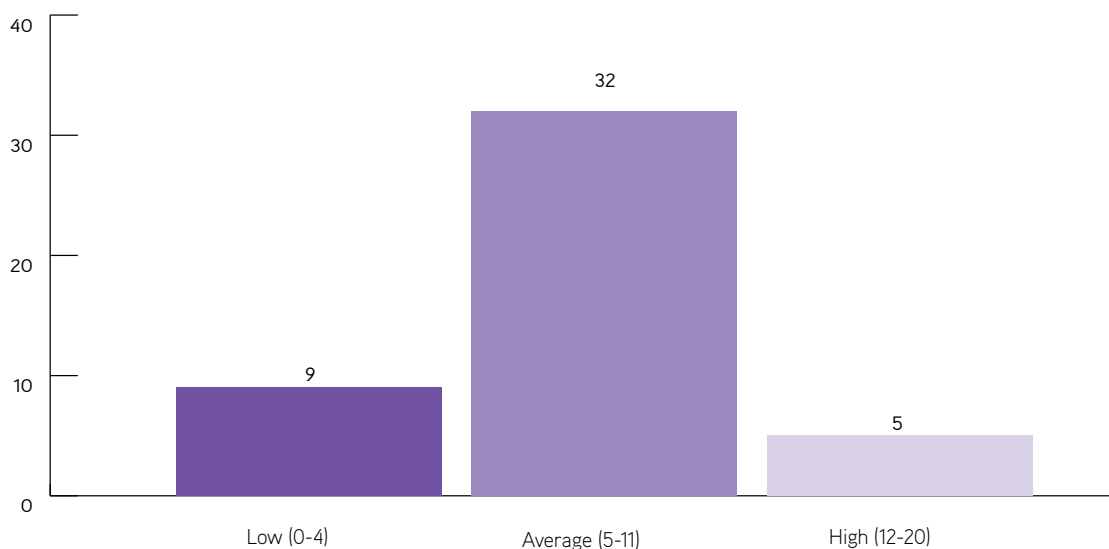
The areas where women were reported to have the most challenges were in social functioning (e.g. housing, relationships and general stability), as well as general health and sexual or injecting risk behaviour. Areas where the women were reported to have the least problems were in relation to working relationships (e.g. with the service itself), compliance (e.g. with treatment/care plans.) and on-going support (e.g. attending external meetings and supports). The level of challenges across the group, as estimated by service providers, are ordered from most problematic to least problematic as shown in the list below:

1. Social functioning
2. General health
3. Sexual/injecting risk behavior
4. Psychological
5. Occupation
6. Criminal involvement
7. Drug/alcohol use
8. Ongoing support
9. Compliance
10. Working relationship (with the service)

8.5 SUMMARY

This section of the report reveals that staff perception of the range of challenges experienced by women using services in Limerick, for drug and alcohol related difficulties, is similar to that captured in other research. Particular areas of challenge include health, risk behaviours and the chaos created by social instability in the form of housing and social networks. This section draws attention to the high levels of poly-substance use, which when combined with high levels of risk behaviour, highlight the importance of having targeted harm-reduction services.

RECOMMENDATIONS

9 Recommendations: How Services Can Better Support Women

9.1 OVERVIEW

The recommendations in this section of the report were developed to respond to the issues identified within the key findings of research. The process for their development involved the research team presenting the findings of the steering group in a workshop, and facilitating discussion on practical interagency responses to the emerging issues.

9.2 ACTION RECOMMENDATIONS

ESTABLISH A TRAUMA-INFORMED WOMEN'S DRUG AND ALCOHOL SERVICE

Establish an interagency working group to develop a women's drug and alcohol service in Limerick city. The process should address the following critical success factors:

- Establishment of clear terms of reference for the group.
- Identification of resources to support the development of this service and assurance of support from key statutory and community and voluntary partners
- Use of a co-design approach with women who will use the service. This process to be informed by trauma-informed principals.
- Inclusion of the needs of women who are pregnant or parenting are included in the plan.
- Appropriate consideration as to how interagency working, and access to necessary resources, will be managed, with a particular focus on mental health and housing.
- Consideration to be given to the role of Women's Peer Workers in service development and delivery (see recommendation below).

DEVELOP AND DELIVER A TRAUMA-INFORMED STANDARD AND SUPPORT PACKAGE FOR SERVICE PROVIDERS WORKING WITH WOMEN WITH HIGH NEEDS IN LIMERICK

In line with evidenced-based good practice, to develop or access an existing trauma-informed quality standard, and to support the implementation and audit of this standard within local services.

ESTABLISH A WORKING GROUP TO FIND SOLUTIONS TO CHILDCARE ISSUES

Establish an interagency, multi-disciplinary working group to explore how service providers in Limerick can better meet the needs of drug and alcohol using parents, for example:

- To further clarify the extent of local need for childcare places for people using drug and alcohol services. This should involve direct contact with women themselves and be informed by an understanding that some women who need this service may be reluctant to identify this need, prior to strong relationships being built with them.
- The potential for current services to become more child-friendly by creating, for example, 'parent and child friendly' times or spaces, or providing childcare. Models of delivery of childcare in drug and alcohol services in Ireland and UK should be reviewed to support identification of appropriate options, including outsourced and in situ options.

ESTABLISH A WOMEN'S PEER WORKER PROGRAMME

The development of a Peer Worker Programme to engage women who are not currently accessing supports to be initially developed by an identified lead agency with the support of other partners in terms of planning for resourcing or roll out. Considerations for this should include:

- Developing role descriptions and role requirements
- Identifying local resources to support the programme
- Developing a training programme for peer workers
- Agreeing support structures for peer workers
- Identifying how childcare issues for participants can be managed
- Agreeing an approach to paying expenses
- Identifying an organisation to house and incubate this programme
- Ensuring that the programme is replicable
- Considering progression of peer workers into similar roles in a new service
- Engaging peer workers in the review and development of the model

9.3 ADVOCACY RECOMMENDATIONS

INCREASING ACCESS TO HOUSING

The Regional Drug and Alcohol Task Force, or a sub-group thereof, to create opportunities to strengthen relationships with local authorities in order to advocate for the needs of women drug users, particularly those with children. The goal of this advocacy is to attain ring-fenced housing for Women and their children who have experienced complex trauma and who are homeless. In addition, opportunities to be sought to advocate for the extension of the Housing First model in the county, so further housing stock is released for this service user group.

PILOT TO SUPPORT ENGAGEMENT OF SOCIAL WORK SERVICES WITH PARENTS WITH COMPLEX NEEDS

An interagency working group to be established with the goal of identifying and piloting an innovative interagency response to the challenge of working with parents with complex needs and issues arising for them including avoidance of treatment services, trying to manage multiple social workers where more than one child is in care etc.

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APPENDIX

Appendix: ACE Definitions of Childhood Trauma

- **Emotional abuse** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.
- **Mother treated violently** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- **Household substance abuse** A household member was a problem drinker or alcoholic or a household member used street drugs.
- **Mental illness in household** A household member was depressed or mentally ill or a household member attempted suicide.
- **Parental separation or divorce** Your parents were ever separated or divorced.
- **Criminal household member** A household member went to prison.
- **Emotional neglect** Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.
- **Physical neglect** There was someone to take care of you, protect you, and take you to the doctor if you needed it, you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

Notes

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