Gendered Approaches to Service Provision

Research Report

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The research was funded by the Scottish Government Challenge Fund with the funding secured by Dundee Women's Aid. The research team from the School of Social Sciences, University of Dundee, was commissioned to undertake this research by Dundee Women's Aid. The Research Oversight Group included representatives from Dundee Women's Aid, Dundee Voluntary Action, Dundee Health and Social Care Partnership (Integrated Substance Misuse Services), and Dundee City Council Housing Services. The authors wish to thank Dundee Women's Aid and the Oversight Group for their support in undertaking the research.

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Key Findings:

Gendered Approaches to Service Provision

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Women who experience Gender-Based Violence, homelessness and substance use issues often have a range of multiple complex needs that require support from a wide range of services. Policy is increasingly recognising the importance of ensuring that services take gendered approaches to service provision. While there are examples of good practice, there are also barriers to providing services.

This research was funded by the Scottish Government Challenge Fund. The funding was secured by Dundee Women's Aid to undertake research on the views of women who are service users in Dundee and the ideas of staff working in this sector about improving future service delivery. A research team from the University of Dundee was commissioned to undertake this research by Dundee Women's Aid. The Research Oversight Group included representatives of Dundee Women's Aid, Addaction, Dundee Voluntary Action, Dundee Health and Social Care Partnership (ISMS), Dundee City Council Housing Services.

This paper examines barriers faced by women in Dundee, identifies what is important in supportive service provision and provides recommendations to ensure the needs of women are met.

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- Routes into and experiences of substance use and homelessness have distinctive gender-specific aspects. Both are also highly linked to women's experiences of gender-based violence.
- Dundee has the 2nd highest incidence of domestic abuse per 10,000 population, 40% higher than the rate across all of Scotland. Additionally, the ratio of male to female drug deaths is 59:41%, compared to a national average of 70:30% (Dundee Health and Social Care Partnership Implementation Plan 2019-2022). Dundee's review of temporary housing recognises specific needs for women.
- Local organisations in Dundee report women with multiple complex needs presenting at crisis point who have experienced repeated and diverse challenges and where interventions are often ineffective.

We carried out focus groups with 39 women who use services **and** 53 members of staff to **get an insight into how services are working for women in Dundee.**

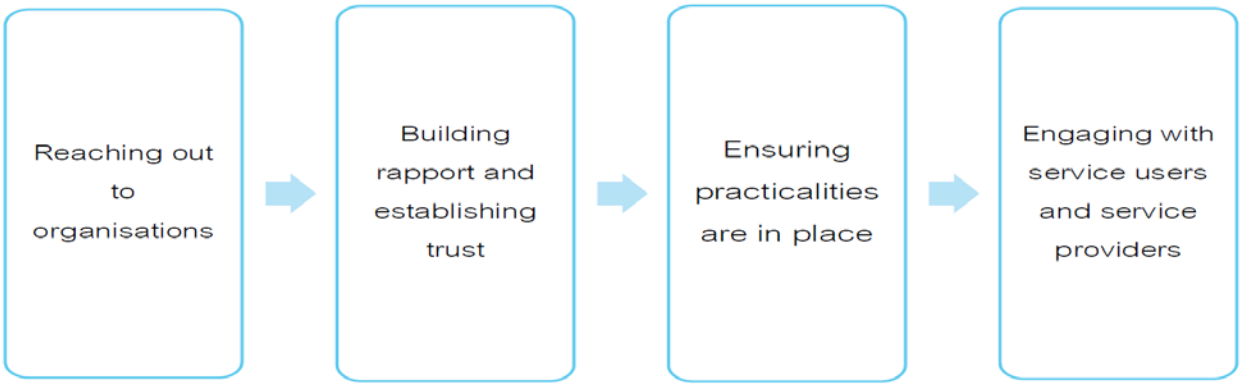
THE QUESTIONS WE ASKED

- **How can services better address the complex service needs of women with experiences of gender-based violence, substance use and/or homelessness in Dundee?**
- **What are the views of women who use these services and the staff who provide these services?**

What were the experiences of the women who used the services?

Women rarely fit into a single service model as they presented themselves as having multiple complex needs.

Our approach



Women liked services with the following attributes

- Services that were "always there for you" and provided on-going support
- Services that were respectful and understanding and allowed women to make their own choices, that listened to them but avoided asking them to talk about traumatic events repeatedly.
- Services that fitted around the person
- Services that used "trauma-informed" practice (although women did not always yse that term)
- Services that provided childcare and/or option of women-only spaces/ support increased engagement for some

Women reported the following difficulties when accessing services

- Services that did not take them or their concerns seriously, in some cases even judging or placing conditions on access to support
- Services which did not take their specific needs into consideration, e.g. childcare (including concerns about leaving children with others), flexible hours/locations (around work/ care responsibilities)
- Lack of choice/availability in services leading to increased vulnerability (e.g. in hostel accommodation)
- Non-specialists referring support on Gender-Based Violence to specialist services, delaying necessary immediate support

Women felt that these were the most significant gaps

- Safe women-only temprary accommodation (including for women with children)
- Mental health support (both formal and less formal types), particularly when dealing with substance use and Gender-Based Violence, and without restrictive conditions attached
- (For GBV) encounters with the Police and Criminal Justice System could be experienced negatively

Service attributes favoured by women

"She always says that if I need her she is there. She always listens to me and not many people do."

"[The] people who were running the groups had been through it themselves so they knew what was happening."

Trust and continuity	Controlling
Empowerment	Disrespectful
Non-judgmental and respectful	Judgemental and stigmatisi
Trauma-informed	Inconsistency
Working with peer mentors	Lack of communication
Support with everyday practicalities	Unprofessional conduct
Inclusion of family members	Pitying
Option of women-only spaces	

"When they were speaking about budgeting your money, they were much more controlling. [...] You feel as though it's Big Brother is watching you."

"I went in and totally opened up and the woman just felt so sorry for me, but that was not what I was there for. I don't want you to feel sorry for me, I want you to help me, so I just never went back."

Issues related specifically to GBV

Women valued supportive environments, in which they were consulted in the decision-making processes and were empowered to make their own decisions

Some staff who were not trained in GBV, did not know how to respond adequately to the women seeking help.

Women stated they wondered why they sought support in the first place if they were not believed or referred somewhere else.

"When I started coming here, [...] I was getting my own choice to make my own decisions. Like they draw you into making your own decisions, before I came, I couldn't think for myself, I couldn't make decisions for myself [...] it helps because it made women feel like they were powerful again."

Substance use services

"[I]t has been proven that most addicts have mental health issues and they act as if the mental health issues have been caused by drugs. In my opinion most people have mental health issues before they went on drugs. That's why they are using [...]"

Supportive and non-judgemental care through support workers or support groups were highly valued

Mental health support is not available for women dealing with substance use

"There's no judgement. Even if you're drinking or taking drugs, it doesn't matter."

Housing and homelessness

"I did not want to go to a homeless hostel. With my drug addiction I find it very difficult, because there aren't many women. If you are a pretty average looking girl every guy in there wants...you know what I mean. [...]. You constantly get drugs offered. It is really difficult."

Housing First approaches provided a sense of safety and offered women ongoing support

Sharing living spaces with men (e.g. in homeless hostels) frequently led to exploitation, exposure to drug use and being targeted

"I used to be scared of getting my own flat in case I was found dead in the flat, and that's being truthful. [...] Since I've been working with Housing First, I'm finding it easier to get to sleep at night."

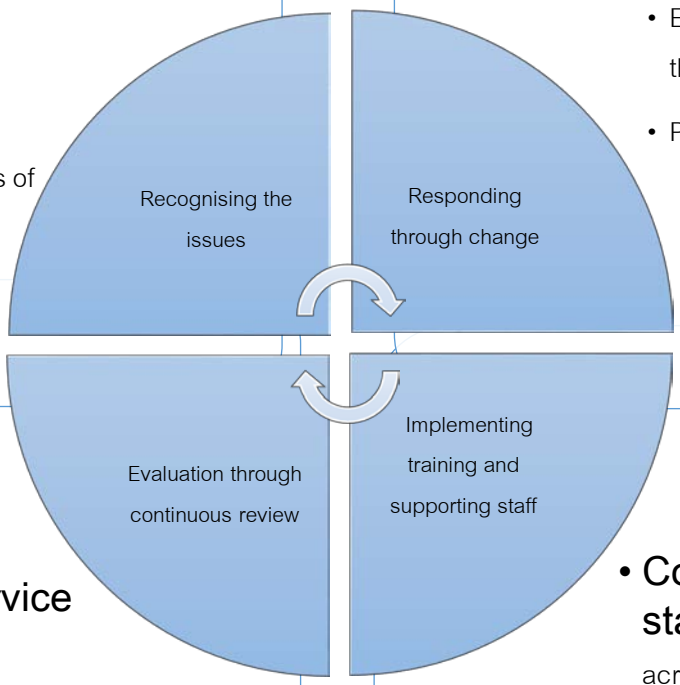
Combining the views of service users and service providers

These are the issues	Suggestions for best practice	Things to consider
Women who experience Gender-Based Violence (GBV) were referred onto specialist services, which delayed immediate support. Staff in some organisations report feeling reluctant to engage with women experiencing GBV. Staff highlight issues surrounding stigma from other workers towards women with substance use issues or experiencing GBV.	Staff across all sectors should receive training on how to deal with Gender-Based Violence. A specialist in gendered services could act as a consultant mainly to statutory services, with the option of consulting Third Sector organisations.	It is vital that services do not re-enact scenarios of control and allow women the freedom to make their own choices. Staff need to feel supported (e.g. reflective practice).
Women in employment may struggle to access services during opening hours or be subjected to high costs if they do not fit criteria .	Consider how services can be accessed by a range of women (alternative venues). Provide out-of-hours support options.	Continuity of care to build trust is key.
Women with children struggle to access services.	Improve childcare facilities and options to take children to appointments. Women report positive experiences of peer-support	Women with a history of experiencing GBV are often not comfortable leaving children with strangers.
Women are excluded from mainstream psychiatric services (e.g. because of substance use or an ongoing GBV court case)	Offer alternative services, such as workshops in existing support groups or courses on specific issues (e.g. managing anxiety). These approaches were valued by women. Extend trauma-informed practices across the sector and ensure correct advice is provided.	Women may well need formal mental health treatment, which suggests a need to reconsider current barriers to formal (NHS) mental health provision.

Women often experience increased vulnerability and exploitation when faced with mixed-sex temporary acoommodation.	Reduce vulnerability for homeless women by adopting different approaches to temporary housing need.	Increased vulnerability included experience of violence, sexual or drug-related exploitation.
Women with multiple complex needs require support from a range of specialists.	Promote partnerships and multi-agency collaborations to identify the best possible support for the women. Adopt person-centred/ "lead professional" approaches to take the specific needs of women and their wishes into consideration. Provide support from first contact.	Staff report tensions between organisations who were competing for funding. Service providers need to take joint ownership of risk. Staff also voice concerns about the guidelines on the mitigation of risk, which may hinder services being carried out on a person-centred basis. Services need to find a balance that does not prevent person-centred approaches.

Creating a positive cycle of change

- Women are being **stigmatised** and do not always receive appropriate care
- Women are being **subjected to dangerous situations** when they are vulnerable
- Recognise barriers of **conditionality**
- There are also examples of **good practice**



- Implement guidelines on **gender-responsive, trauma-informed and person-centred practice** and allow women to make their own **choices**
- Offer **alternative venues and opening hours** to overcome existing barriers
- Ensure **continuity of care** through a lead professional approach
- Provide **support from first contact**

- **Engage with service users** to hear their experiences and incorporate these into practice
- **Review evidence** and policy to ensure service delivery reflects ongoing issues
- Incorporate **reflective practice** to ensure best practice

- **Consult with specialist staff** to improve service provision across all sectors and taking joint ownership of risk rather than shifting responsibility (esp. on GBV) to specialist organisations
- Organisations **adopt guidelines into practice**
- Staff are supported through **counselling and training**

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1 Introduction and rationale

In recent years, research and policy have increasingly recognised the complex needs of women who access services for support in relation to gender-based violence (GBV), substance use and/or homelessness. However, the extent to which such gendered approaches to service design and delivery have been adopted into practice varies substantially. Studies repeatedly demonstrate that there can be multiple barriers to women accessing services, ranging from complex and fragmented service landscapes (Cameron *et al*., 2016) to lack of training and capacity in service organisations, concerns among service users about stigma and the implications of approach service organisations (Rose *et al*., 2010). Service organisations report that women with particularly complex needs can repeatedly present at multiple services at various crisis points, resulting in responses that may be largely ineffective in promoting long-term change and stability and are inefficient in terms of managing resources (Ceannt *et al.*, 2016). Issues such as gender-based violence (GBV)/ violence against women (VAW)[1], substance use and homelessness may not be effectively addressed, resulting in situations where women's experiences are 'hidden' and their needs are not fully understood or met (Mayock and Bretherton, 2016). Increasing focus is therefore being given to developing appropriate models of service delivery for this client group (Allcock and Smith, 2018).

Routes into and experiences of substance use and homelessness therefore have distinctive gender-specific aspects. Both are also highly linked to women's experiences of gender-based violence. Research in relation to substance use and drug related deaths has highlighted significant increases in the numbers and proportion of women among deaths related to substance use in Scotland (Tweed *et al*., 2018). Whilst fewer women make up official numbers of those who are homeless than men, research highlights that the route for women into and out of homelessness is significantly related to experiences of gender-based violence, experiences of abuse in childhood or other experiences of trauma (Moss and Singh, 2015) and that women's experiences of homelessness may remain relatively 'invisible' (Mayock *et al*., 2016).

Dundee faces specific challenges in relation to women with complex needs. Figures indicate that Dundee has the 2nd highest incidence of domestic abuse per 10,000 population, 40% higher than the rate across all of Scotland. Additionally, the ratio of male to female drug deaths is 59:41%, compared to a national average of 70:30% (Dundee Health and Social Care Partnership Implementation Plan 2019-2022). Meanwhile Dundee's current review of temporary housing and rapid rehousing recognises specific needs for women. These figures are confirmed by the experiences of local service organisations in Dundee which report women with multiple complex needs presenting at crisis point who have experienced repeated and diverse challenges and where

[1] The terms gender-based violence (GBV) and violence against women (VAW) are not identical, but they are used largely inter-changeably in this report due to their common usage among service users and service provision organisations involved in the research.

interventions are often ineffective. Service-providing organisations in Dundee are currently developing strategic planning around these service users, taking account of specific needs which may prevent them from accessing appropriate care and support, or, where they do engage with services, from their engagement being successful.

This research therefore aims to address the following two core questions:

- How can services better address the complex service needs of women with experiences of gender-based violence, substance use and/or homelessness in Dundee?
- What are the views of women who use these services and the staff who provide these services about how services could be improved?

Using qualitative methods in focus groups and interviews, the research explores

- The views of women who access services in relation to lived experiences of gender-based violence, substance use and/or homelessness.
- The views of managerial/strategic and front-line staff in relevant service organisations across the sector in Dundee.

We considered service users' experiences of different types of service provision, what would improve service provision for themselves or for others, and whether specific sub-groups of women might require consideration in service provision (Burman *et al.* 2004). We also examined barriers to successful engagement with services and identified positive attributes which encouraged engagement. Other aspects included the impact of stigma on accessing services (Kulesza *et al*., 2016) and the provision of 'safe' and 'more-than-safe' spaces for women to engage with services and support (Bowstead, 2019).

Service provider staff were asked about their organisations' approaches to service delivery and engagement with women service users, examples of good practice, key principles and practices which were relevant, and what training or staff development is required. Themes discussed with service providers included questions of understanding among staff of trauma-informed practice (NHS Education for Scotland, 2017) and gender-informed approaches to service provision, as well as the tensions or commonalities between different models and norms around interventions and service-user engagement (Salter and Breckenridge, 2014).

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2 Summary of literature review

This section presents a brief summary of key insights from the literature review of research and policy findings which can be found in the *Supplementary Report - Literature Review on Gendered Approaches to Service Provision.*

2.1 Why this research is important

Women's experiences of homelessness, substance use and domestic violence, while sharing some commonalities with those of men (Tweed et al, 2018) also show distinct differences. Social and economic inequalities, which affect women in particular, and their disproportionate experience of gender-based violence, as well as their responsibilities for children all contribute to distinctive experiences:

- Women are more likely to experience 'invisible homelessness' (Mayock *et al*., 2016);
- Women's experiences are more likely to be affected by abuse or gender-based violence in childhood or adulthood, which can have a severe impact on emotional wellbeing. There are also links to issues around substance use (Engender, 2017);
- Women are more likely to suffer a large loss of assets and income following a family breakdown (Warrener and Koivunen, 2014);
- Women are particularly at risk of becoming homeless after leaving an abusive partner (Scottish Government, 2018);
- At the same time many women may be unaware of the support available to them - 84% of women were not aware of their options after having experienced domestic violence and did not think staying at home would be an option to them (Scottish Women's Aid, 2015).

2.2 Why women need specialised service provision

Women are particularly disadvantaged in the following areas:

- contact with the criminal justice system,
- homelessness – including the intersection between homelessness and gender-based violence,
- sexual exploitation,
- mental health problems,
- drug and/or alcohol problems (McNeish and Scott, 2014).

Routes into substance use and challenges faced by women in accessing and maintaining recovery show some gender-specific characteristics:

- dependency caused by motherhood was viewed as a barrier to recovery by service providers;
- services often prioritised abstinence over the wellbeing of mother and child;

- punitive services, which targeted addiction through measures such as removing the children as part of the treatment plan, were implemented but ineffective as they did not take into consideration the complexity of the inequalities faced by the women and histories of abuse which heavily influenced their psychological state of mind (Fang et al., 2014).

2.3 Suggestions for best practice

- Comprehensive services which take into consideration individual counselling, housing, transport and childcare support options offer more effective solutions (Salter and Breckenbridge, 2014).
- When support workers are empathetic and provide continuous support, women are far more receptive to their support. Such support can also mitigate against and help women to negotiate the often-fragmented landscape of support found across these sectors (Cameron *et al.*, 2017).

Trauma-informed service provision is becoming increasingly recognised as a crucial component to providing support for individuals with a history of traumatic experiences (Tweed et al., 2018):

- Services which work "by the book" can be insensitive towards women who are experiencing abuse. Services which take into consideration the complex factors and individual history which affect life circumstances are viewed more positively (Salter and Breckenbridge, 2014; Rose *et al*., 2010).
- Women from chaotic backgrounds are highly likely to have experienced abuse in childhood or in adulthood, it is vital for services to take consideration of the emotional and psychological impact this has on the women who have experiences it. NHS Education Scotland (NHS Education for Scotland, 2017) have implemented a set of recommendations towards support services to adopt trauma-informed practice at all levels.

The Centre for Mental Health (2019) suggests that at a minimum trauma-informed practice with women should involve:

- Listening – enabling women to tell their stories in their own words
- Understanding – receiving women and their stories with insight and empathy
- Responding – offering women support this is timely, holistic and tailored to their individual needs
- Checking – ensuring that services are listening, understanding and responding in a meaningful way.

This chimes with the work of the Prison Reform Trust (2013) suggests that gender-responsive practice can be divided into five parts:

- Relational – building up relations over time (see also Rose *et al*. 2010),
- Strengths-based,

- Trauma-informed,
- Holistic,
- Culturally informed (taking diverse backgrounds into account (see Burman *et al*. 2004).

Women-only spaces have been found to be important in a number of ways:

- Women's refuges, for example, can provide a "more-than-safe space" for women – a secluded location, relationships built with workers and other residents facilitating places of support, recovery and acceptance (Bowstead, 2019).
- Appropriately supportive women-only spaces can also be important for women to be able to fully express emotions without fear of repercussions, and even engage in meaningful and constructive "conflict" or disagreement, providing a place where women can heal from trauma and learn to process their experiences in novel and transformative ways (Lewis *et al*., 2015).

Such research findings are reiterated in relevant policy documents such as those on:

- trauma-informed practice - NHS Education Scotland (2017) *Transforming Psychological Trauma. A knowledge and skills framework for the Scottish workforce,* see also Centre for Mental Health (2019))*;*
- housing first approaches - Women's Aid (2019) *No-where to Turn Project;*
- recovery-oriented approaches to substance use - Scottish Government (2018) *Rights, Respect and Recovery. Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths*;
- tackling gender-based violence - Scottish Government (2018) *Equally Safe. Scotland's strategy for preventing and eradicating violence against women and girls*.

3 Methodology – how the evidence was gathered and analysed

3.1 Who participated and how

The research aimed to conduct focus group discussions with participants in Dundee to understand:

- the views about service provision of adult women (aged 18 and over) with lived experience of one or more aspects of gender-based violence (GBV), homelessness, and/or substance use issues;
- the experience and views of staff from organisations which work to provide services to women in these three sectors. "Front-line" and managerial/strategic staff were included.

A total of 39 women who are service users and 53 service provider staff were involved in the research (a total of 92 participants). Figure 1 shows how we recruited participants.

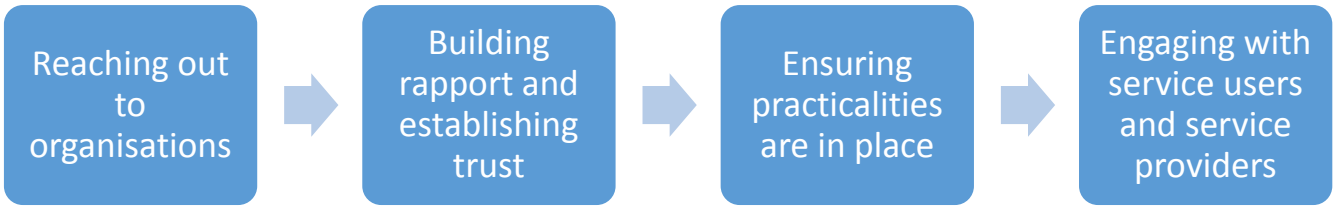


Figure 1 - Process of recruiting participants

We began by **reaching out to organisations** by approaching a range of service providing organisations in Dundee which supported women in one or more of the areas of service provision mentioned above. In order to **build rapport and establish trust** the process and purpose of the research was explained and initial information about what was being requested was outlined (see examples of information sheet provided in Appendix 1 and Appendix 2). Organisations were asked to help in two potential ways:

- to help facilitate the participation of women service users with lived experience in focus group discussions on their views about services in Dundee;
- to invite their own staff (front-line and/or managerial) to participate in staff focus groups.

Once organisations indicated they were able to participate in either way, **practicalities were put in place.** The researchers arranged for focus groups with women service users to take place in venues and at times that were suitable for the women, usually on the premises of the organisation with which they were familiar. Support workers from the service organisations were on hand in case issues should arise. Further ethical issues are outlined in section 3.2.

Focus groups with staff were arranged in accessible venues such as Dundee Women's Aid, University of Dundee and Dundee East Housing Office. Separate groups were arranged with managerial/strategic staff and those with direct 'front-line' service provision roles.

Engagement with service users and service providers was primarily through focus group discussions. Topics for the discussions with service users and with staff are listed in appendix 8 and appendix 9 respectively. Table 1 below provides an overview of the final number of participants who took part and the organisations through which they were recruited. Most participants took part in focus group discussion as planned, but a flexible approach was adopted which meant some participants engaged with the same questions in individual interviews. These were used to overcome practical barriers of setting up focus groups (e.g. arranging a suitable time) and to respond to requests from some participants for individual rather than group interviews.

Table 1 - Who participated in this research?

	Participant numbers	Focus groups	Individual interviews	Participating organisations
Service users	39	7	5	Dundee Women's Aid, Tayside Council for Alcohol (TCA), Addaction, Hillcrest (Housing Support), Dundee West Church (Making Dundee Home), Transform (Housing First), Barnardo's (Shine Project and Domestic Abuse Service), Whitfield Community Health
Staff	53 (17 managerial, 36 frontline)	4	4	Dundee Women's Aid, TCA, Integrated Substance Misuse Services (ISMS), Transform, Addaction, Hillcrest, Dundee Voluntary Action (DVA), Volunteer Dundee, Barnardo's, Link-Up Whitfield, Scottish Refugee Network, Amina Muslim Women's Centre, Penumbra, Citizen's Advice Bureau, Dundee Alcohol and Drug Partnership, WRASAC, Dundee City Council (Protecting People team, Housing department, Community Justice), NHS (ISMS, Keep Well team, Public Health), Tayside Police, Nurture Parents

Some challenges and limitations were encountered in the research:

- Establishing rapport with organisations sometimes took 3-4 weeks, in addition to time spent finding suitable times for focus groups, which pushed back the research timeline;
- Initially focussing on a smaller number of organisations limited the potential scope of women participating in the research and a wider range of organisations was approached;
- Women who required an interpreter (due to limited English, or need for BSL interpretation), though keen to participate, were in the end not able to participate in the limited time-frame of the research due to a lack of available interpreters. Future research to understand the views and experiences of these women would be an important addition to the findings reported here.

As figure 2 shows, service users who participated in the research sought support for a range of experiences, including GBV, homelessness and/or substance use. However, most participants had experienced a range of complex needs which could include financial and welfare issues, mental illness (and indeed other long-term health issues), experience of incarceration, or cultural and ethnic discrimination. All participants reported having experienced stigma from the general population and/or some service staff. Some reported adverse childhood experiences which affected them into adulthood. Whilst this was not the focus of this research, understanding the complex nature of women's backgrounds helps to contextualise the findings of this research.

Figure 2- Issues for which the service users sought support

3.2 Ethical considerations

This research follows the ethics procedures established by the University of Dundee through the School of Social Sciences Research Ethics Committee. The research was granted ethical approval under the application number UoD-SoSS-GEO-STAFF-2018-54.[2] Details of key ethical considerations are listed below.

3.2.1 Ethical issues related to service user participants

Several ethical considerations were put in place to ensure **anonymity and confidentiality** for the women who participated as service users. No names or personal details which would allow participants to be identified have been used in the report. Detailed participant information sheets were provided along with consent forms (appendix 3 and appendix 4) and these were explained verbally to any participants who asked for this to be done. These forms also set out measures in place to ensure the safety and wellbeing of the women involved. Measures adopted included the following:

- Participants were fully informed of the nature of the focus group discussion, which was **designed to focus solely on the women's experiences with services**. The women were encouraged to focus on these experiences so as to avoid dealing with difficult personal experiences in a group setting.
- Despite focussing on service provision, in practice, sometimes women talked about their own lived experiences, so **support staff were made available** at the time of each focus group in case additional support was required.
- To ensure protection of sensitive information, **researchers did not receive any personal contact details of the participants**. Consent forms were held securely by the participating organisations and were destroyed at the end of the research process. Audio-recordings were secured on password-protected devices and transcripts eliminated all identifying information. Women could also opt to have the participant information sheet retained at the service organisation if they did not wish to have it at home.
- Focus groups were **held in locations familiar to the women** to offer a comfortable environment. They were also generally held during times in which the women would be attending the services for a regular group session to avoid additional disruption to their schedule. Childcare was offered, although in the end no women asked for this.
- Women were offered **reimbursement of travel costs** to the location of the focus group and were also provided with a £10 Primark voucher as a thank you for taking part.

[2] Further information on the ethical approval procedure can be found on https://www.dundee.ac.uk/research/governance-policy/ethicsprocedures/ethics/.

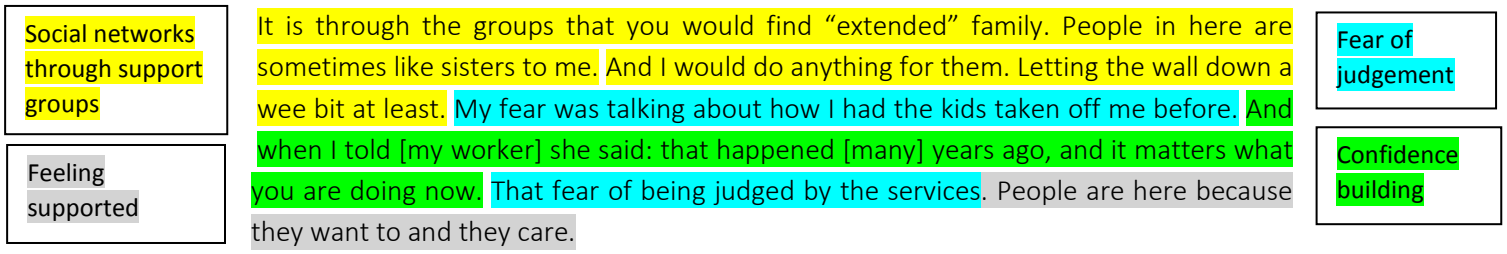
All above points were stated on the participant information sheet and were emphasised before each focus group, with the exception of the thank-you voucher which was provided at the end of the focus groups so as not to be viewed as an 'incentive' for participation.

3.2.2 Ethical issues related to service provider staff

Service provider staff were also assured of **anonymity and confidentiality**. Detailed participant information sheets were provided along with consent forms (appendix 5 and appendix 6). As well as including no names or personal details in the report, staff were also not identified in relation to the specific service organisation in which they were involved. This was to ensure that staff would be able to speak freely without feeling they were 'representing' a particular organisation. Furthermore, separate focus groups were carried out with 'front-line' staff and with managerial/strategic staff to avoid staff feeling they had to present a particular viewpoint in front of senior staff.

3.3 Analysis of the data

The focus groups and individual interviews were audio-recorded on password-protected devices. They were then transcribed into a written format, eliminating any information which could identify the participants (e.g. names, workplaces, family circumstances). Once transcribed, the fully anonymised documents were uploaded into the qualitative research software NVivo, which assists researchers in easily categorising data (Richards, 1999). This software is used by researchers to thematically analyse, or 'code' documents (Saldaña, 2009). As this research followed an evidence-led approach, an open coding approach was deemed most appropriate to analysing the data. During open coding, themes are identified and labelled within the text as they appear, rather than searching for a set of predetermined topics (or 'codes'). This allows themes which are of importance to the participants to emerge during the research (Corbin and Strauss, 2008). The sample below demonstrates how open coding is applied within NVivo to draw out topics from how the participants talked about them.



Once texts were fully coded, topics were categorised into broader overarching themes. The main themes to emerge were categorised as follows:

- Issues faced by women,
- Initial access to services and barriers to access,
- Service attributes (positive, negative, gender-specific needs and barriers to service provision)
- Suggestions for improvement and training needs identified.

The following sections of this report explore these themes. They used detailed extracts which document the views and experiences of participants to provide an evidence base about the experiences of women in Dundee with complex needs in accessing services around gender-based violence (GBV), substance use and/or homelessness, and the views of staff from the service organisations in these sectors. Section 4 assesses overall issues of access to services raised by the participants, drawing out examples of good practice and positive attributes as well as barriers to access and gaps in provision. Section 5 examines these themes in the three specific areas of gender-based violence (GBV), substance use and housing/homelessness. Section 6 identifies gaps in provision and suggestions from the participants on how to improve services in future. Finally section 7 summarises key findings, examples of good practice and key recommendations.

4 Accessing services – good practice and challenges

This section looks first at the initial ways women accessed services or experienced barriers to services (section 4.1) before going on to outline what emerged from the research as the key aspects contributing to good service provision (section 4.2) and the gender-specific needs which were identified in service provision (section 4.3). Finally section 4.4 outlines some of the main limitations in access to services which were identified. Throughout this section the voices of service users and service providers are highlighted and services which were identified by women service users as positive examples are indicated in 'Good Practice Boxes'.

4.1 Initial access and barriers to accessing services

The first element to understanding how women engage with services is understanding the steps they took to initially access a service. This can shed light on where barriers exist to service provision and how to overcome these in future. The most commonly mentioned route into service access was via a referral process. In many cases women had previous contact to statutory services, such as social workers, police officers or prison workers, who referred them onto other services.

In some cases women accessed services through self-referral when they were not happy with services they were involved with so sought out something more suitable to their needs. In other cases women were not previously engaged with services, but received information and advice about a service via word-of-mouth. This was generally when the women or someone close to them became concerned about a specific issue, such as GBV or substance use, and they sought support for that issue.

Several types of barriers to accessing services were identified:

Practical reasons: e.g. lack of childcare provision, too far to travel.

"My family don't know what happened with me, because I don't want them to know, don't want to pass on the burden. So I can't say, 'here could you look after the kids? I've got this thing on' and they'd be like 'well, what are you doing?' I don't want to say, so I don't want to ask anyone for help with the kids." – Service user

"There was here and there was another place up Albert Street that was mixed [for women and men]. I came here because where I stay is just behind here and I thought that's the nearest for me. I think if I had to get a bus for a couple of miles, I don't think I'd be here a lot, but because it's near my house [I am]." – Service user

Psychological and/or socially driven reasons: e.g. fear of losing children, fear of losing job, fear of repercussions from abusive partner, stigma about seeking support, misconceptions about services, bad experiences with services in the past, lack of trust in services, wanting to stay strong for children.

"I think I came with a fear at first. I didn't really know what Women's Aid was. I just knew that I needed someone to help with my situation. When I was first offered refuge, I absolutely caked it and ended up running back, because I was worried about being judged - would I be reported to anybody, would social work be involved for any of my children? I was frightened to speak to anybody. When I came here, that's when I learned." – Service user

Impacts of GBV: partner actively blocking access to support services, women afraid of losing income when leaving partner.

"I found in one particular case that the barrier was that the partner would hide out in the bathroom and pretend he wasn't there. I knew he was there. So sometimes [the service user] would engage [with us] and disengage when he was back on the scene and hiding in his bedroom." – Support worker

These barriers would often hinder women from having access to the support they required or delay access to support. Additionally, many women reported **requiring support when establishing initial contact** with a new service, reporting initial anxieties about reaching out to new services and valuing when a trusted worker was able to attend initial meetings alongside them. These anxieties were fuelled by psychological dispositions towards services. These are often driven by cultural and societal expectations and misconceptions, whilst others are based on individual experience or are heightened by structural weaknesses. The most commonly named barrier to seeking support was stigma. Women reported feeling ashamed of requiring support, particularly when seeking support for addiction- and GBV-related issues. Staff also referred to the difficulties of engaging individuals with complex needs, in particular referring to issues around initial engagement, continuity of care and mistrust. It is important to recognise these potential barriers when making contact with new service users.

GOOD PRACTICE BOX A - Continuity and comprehensive support

Good practice examples of continuous and comprehensive service provision, which had a significant effect on the wellbeing of the women accessing services.

There were many examples of good support workers, who were "always there" for their service users (i.e. whilst not necessarily immediately available for a face-to-face, were reachable via telephone and would respond to any calls for help), would arrange and come along to routine appointments (e.g. GPs, dentists), help with practical issues such as financial planning and food shopping, and help to arrange support from the wider service sector in Dundee. Some of the organisations mentioned by service users as providing this type of support were: Barnardo's (Shine Project and Domestic Abuse Service), Transform (Housing First), Positive Steps, and Hillcrest.

4.2 What constitutes good service provision?

4.2.1 Practicalities of good service provision

Good service provision was reported by women who were service users as encompassing a range of attributes. The most important elements to help their engagement with a service were the **outlook and attitudes** of the service provided and the continuity of care they received. In terms of outlook and attitude, the recognition of individual needs and person-centred approaches took precedence:

> "You might only know about one service, and they'll know about five other services that do the exact same thing but might be more helpful, because the one that you're seeing just now isn't helping. It's not that they're not good at it, but they just might not work for you. Everyone has different needs of things that would work for them. Some techniques might work for one person, but they don't work for somebody else. But it's finding that right balance." - Service user

As outlined above, women valued the benefit of **tailored referral** where they were referred onto an organisation by someone who evaluated and understood their needs and preferences and found a suitable organisation based on that information. Staff also recognised the benefits of conducting person-centred approaches (which may not always be standard procedure) if it has the potential of benefitting the person in question on a long-term basis. Some staff, on the other hand, were wary of the consequences this may have for the worker in case non-standard procedure may be viewed as misconduct.

Service users were very receptive to service provision when they were provided with **continuous care** by a **trusted worker** (see Good Practice Box A). Many women preferred this over having multiple different access points. Even when women were seeking support from multiple agencies, having the continuous support of their assigned and trusted worker was of great importance to the women. It was especially appreciated that staff were able to provide support and refer them on to different organisations when needed and to accompany them to diverse aspects of support:

> "My support worker comes to everything with me. To doctors, to appointment for drugs use, as I am on methadone. […] My support worker does everything though. Like today we were just baking and talking. It is a relaxed atmosphere. Since I got out of prison, I managed to build a good relationship with me support worker." – Service user

Help with practical arrangements was also strongly valued as it served to support women in their own choices and in gaining some sense of stability in their own situations:

> "They do everything - come to your house, take you to appointments, take you shopping […], do your budget, make sure that you get your shopping, gas, electric before anything else, so you're not struggling spending all your money on drugs or whatever. They are really, really good. It is an intense thing that some people need. I wouldn't have worked this intense with any other group. So they are definitely doing something right." – Service user

> "When you've been living with a guy for 15 years and they've been controlling every aspect of your life you have to think 'what am I doing?' I can't pay bills, paint walls, I can't decorate. […] You see I'm talking more about practical stuff like plugging in a washing machine or wiring in your cooker etc. you know what I mean things that are practical for when you start over. Do you know what I mean? When I got moved into my house about a year or so ago, when my housing officer found out she got me to the front of the queue and moved me. I moved into a house and I was like 'what am I doing', I didn't have a clue." – Service user

Women talked about the importance of such continuous support in beginning to be able to make their own choices and were clear about a key range of values which they found enabled them to do so, as the next sub-section demonstrates.

4.2.2 Organisational values which promoted positive service provision

The attributes which the service users favoured were shared across women of all backgrounds. Whether women were seeking support for GBV, substance use, homelessness, incarceration, or other issues, they valued the following attributes, many of which chime with the approaches supported by recommendations from the Centre for Mental Health (2019) on trauma-informed care for women:

Trust, which was established through continuity of care, people who were "always there for you", often in difficult circumstances.

"She always tells me I am putting myself down and she always tells me that I can do this. She helps even with my reading and writing, because I have been struggling. She helps me with anything I need and [is] supportive. She always says that if I need her she is there. She always listens to me and not many people do." – Service user

"I ended up in hospital from domestic abuse from my partner at the time. […] Went through that completely on my own, apart from support workers visiting me. They would wash my clothes. Things like family or a partner should be doing. They saved my life as well. I would not have went to hospital if they would not have said. They seen how poorly I was. They saved my life and helped me a lot." – Service user

Empowering, i.e. enabling women to make their own decisions and boosting their confidence to make independent choices.

"When I started coming here […] it was like I was getting my own choice to make my own decisions. Like they draw you into making your own decisions. Before I came, I couldn't think for myself, I couldn't make decisions for myself, I couldn't make appointments for myself, nothing, it was mental before I came here. […] I find it's the freedom as well. It helps because it made women feel like they were powerful again. You weren't underneath anybody." – Service user

"[…] at that time I was still drinking […], she'd say I can see you're going to do it and what she saw in me at that point that I didn't. […] What she saw in me I don't know. But since I've stopped drinking, I've come out of myself a lot." – Service user

Non-judgemental, i.e. not passing judgement for decisions which women might have felt uncomfortable about (e.g. relapsing, returning to an abusive partner).

"It's non-judgemental as well and I think that makes a big difference, when you are going to someone and they're not judging you on any of your background and are just asking the questions that need to be asked, but they are always the same, no matter what, when you see them and they're always in the same mood so you're not scared to approach them." – Service user

Treated with respect, which follows from the above-mentioned non-judgemental approach.

"[You] know they're willing to help you and put you in the right direction as well […] and you get the respect and everything that you should be getting anyway, but the Cairn Centre [community hub] has always done that, they really respect us and treat us just like everybody else." - Service user

Trauma-informed, i.e. understanding the relevance of past trauma on experiences in adulthood and also learning about discourse on trauma to make sense of experiences (although not all women used the specific terminology around 'trauma'.

"They just have a different persona [here] altogether. I just think the second I moved away from [my previous hometown] and came in here I was like this is just perfect. It is both professional and friendly. They just get it […] and they have such a good understanding of the mental health side of it. […] That's what we were talking about earlier, all the different layers to it with different support groups for different things and they base a lot of it on trauma and obviously at Women's Aid it's going to be dealing with trauma. So, it's good I like it here." – Service user

Peer workers, i.e. workers who 'have been through it themselves',

"[In] services, someone like a key worker as another woman who you can relate to as well and can then talk and relate to them. For example, I can relate to [my worker]. When [my worker] comes to me and talks to me about some kind of drug problem I can absolutely relate because I know where she's been, and I know how she feels because I've been there." – Service user

Staff further highlighted the potential benefits of providing person-centred care, but that at times this might go against some aspects of staff regulations and code of conduct. This raises the question of how staff might be able to compromise in these types of situations.

> "I think it is quite a lot about culture as well. The way the staff feel. A worker took a woman in her car to get her prescription, but that is not covered by the work insurance. She did what she needed for the woman, but that wasn't liked by everyone." – Frontline staff

The service users also shared some general positive attributes about a service. Women appreciated the provision of childcare facilities and additional support for children and other family members, particularly in GBV and substance use cases. The provision of out-of-hours support, i.e. services that are available outside of standard 9-5 weekday hours, was another element which was referenced as being helpful, in particular for women who were in employment or could not attend services during school holidays. These points will be elaborated further in section 4.3, which looks at gender-specific needs in service provision, as they are influenced heavily by the effects of the typical gender roles of women.

GOOD PRACTICE BOX B – Co-location

The Crescent (in Whitfield) was used as an example by both service users and frontline staff of the benefits of having a wide range of access points, such as GPs and dentists, in the same building as accessing more stigmatised types of services, such as substance use support or social workers. This also removed the barrier of attending a heavily stigmatised location, as the building can be accessed for a variety of reasons.

The location and environment also influenced the effectiveness of a service. Many women favoured proximity of a service to their home. If that was not possible, home visits or meetings in nearby public locations were also talked of favourably. Service users and staff recognised the benefits of a "one-stop shop", i.e. a building in which multiple services are co-located (see Good Practice Box B), particularly if not all the services were ones associated with 'stigma'.

Women commonly accessed female-only support groups for various types of recovery. Support groups were of great importance to women from a range of backgrounds. This was particularly the case for women seeking peer support for GBV and substance use. In peer-support contexts, the following were seen as important:

- Acceptance and non-judgement,
- Building a social network and overcoming isolation,
- Confidence building,
- Realising "it's not my fault" in cases of GBV,
- "You realise you're not alone",
- A feeling of safety.

Women also valued organisations that offered a variety of classes to choose from (e.g. crafts, arts, music). Women also highlighted the importance of getting support with practical and everyday tasks, e.g. managing finances, making appointments.

Emphasis was placed on the value of mental health support, whether that be in less formal sessions on mindfulness or overcoming anxiety, or in specific individual and group-based forms of tailored 'trauma-informed' practice and support (see Good Practice Box C).

GOOD PRACTICE BOX C – Mental health support

Mental health training sessions within existing support groups had a significant impact on the women attending the groups. The Dundee Women's Aid Freedom Project, the ASPEN project and Survive and Thrive groups were all noted by service users as examples of important mental health support, which allowed women to make sense of their experiences and vocalise them. Other less formal drop-ins, such as the women's group at the Whitfield Community Centre, had invited mental health experts to do individual sessions on topics such as "dealing with anxiety", which women again found useful.

Service providers were often aware of their desire to adopt or maintain the kinds of support mentioned above. Some of the existing strategies which their organisations sought to use to maintain/deliver such support (often in a context of facing a lack of resource) included:

- Prevention, i.e. preventing crises from happening from the onset,
- Rapid intervention (if possible), i.e. early invention in a crisis to prevent it from escalating,
- Prioritising cases, i.e. offering to be available via telephone to individuals who may be more stable whilst making appointments with those who are more vulnerable at the time,
- Flexibility in time and location of meeting the service users to prevent missed or cancelled appointments,
- Continuous review of service provision to ensure best practice at all times,
- Partnership-working to share resources and expertise amongst different agencies.

Partnership working was seen as beneficial for providing services for women with complex needs. However, this required staff to negotiate carefully between the requirements and operating approaches of different organisations (which will be elaborated in section 4.4). The benefits of this type of collaboration included enabling faster service provision to a wider range of services, sharing expertise and information sharing.

4.3 Gender-specific needs in service provision

4.3.1 The importance of gender considerations

Gender-specific needs were recognised by most women. Many based this on the fact that **women and men have different experiences** (although some aspects of support are common across men and women: Tweed *et al*., 2018) and so women require services that take these different experiences into account. This was recognised by both service users and many staff, but only a minority of staff participants were engaged in services which explicitly took these differences into consideration. Some staff argued that they did not provide a gendered angle, but they aimed to deliver services on an individualised basis regardless of gender.

> "Speaking for my service they are specific interventions, but from what I understand, we treat everyone the same. I think there are opportunities for more training for gender-specific interventions in my service that I have noticed. Just being more understanding on how women's needs can be more different from men." – Service manager

Service users reported the importance of **women-only spaces.** These were preferred by most women service-users, particularly when discussing sensitive matters, such as GBV, substance use or female medical issues. Some women initially stated having no preference for women-only spaces, but later specified that they would not feel comfortable discussing these kinds of sensitive issues around men and even feeling uncomfortable being in a mixed-gender environment. In some cases, this was culturally driven. Women from certain cultural backgrounds refused to talk about problems in front of men, or even speak at all. Women described these women-only spaces as "safe places". For some, these places offered opportunities to speak about issues "secret from family". This echoes findings from Bowstead (2019) on the importance of women-only spaces and is an aspect that raises a caution about the need to discuss carefully the balance between the need for such safe spaces and the potential benefits of co-location of multiple services mentioned above.

Indeed, some service users highlighted the dangers women could face in some mixed-gender spaces (e.g. hostels, drop-ins – see further details in section 5), particularly when women were in vulnerable situations (e.g. recovering from abuse or addiction, recently released from prison). Some reported becoming a target for men who were also using these spaces, being offered drugs, being vulnerable to sexual exploitation or assault, and reliving traumatic experiences in such mixed-gender spaces.

Concerns were expressed about the availability of drugs in some service locations (again especially in homeless hostels or drop-ins). Women reported being specifically targeted by men if it was known that they were in recovery or had just come out of prison.

> "With my drug addiction I find it very difficult, because there aren't many women. If you are a pretty average looking girl every guy in there wants…you know what I mean. When a

> new girl starts at a new school it is a very similar mentality. You constantly get drugs offered. It is really difficult. […] So, I came out of prison and was put into a mixed hostel and was not getting a moment of peace. Guys were coming and wanting something. So, I was staying at a friend, just because I was not playing the 'I am scared of men' part after an assault." – Service user

As well as the gender of other service users, the **gender of staff** at the organisation had an influence on women's wellbeing. The preference of gender in staff members was very individualised. This was not correlated with the experiences that women have had with men. Some women stated that they felt comfortable around a male worker, with one woman stating that "he's a professional and he can't really go about and disclose my information" and "they're there to help". Others expressed a preference for female workers and in some cases it went beyond solely being a preference but was rather a requirement. The reasons for preferring female staff ranged from not feeling comfortable to discuss sensitive issues with a man to having panic attacks when being alone with a man.

> "I prefer to have female workers, especially what has happened a few weeks ago. I am having panic attacks from men. […] If there is a guy near me, I start freaking out. I was getting over it, but because what is happening it is getting worse." – Service user

It is important therefore that women have the opportunity to make the decision about the gender of their worker if that is at all possible due to the distress it could cause if it is not considered.

As mentioned in section 4.2 and Good Practice Box A, **support with practicalities of everyday life** was highly valued by women. Women reported struggling to cope with arranging appointments and carrying out day-to-day tasks due to variety of reasons (e.g. financial control in an abusive relationship, incarceration, homelessness, dealing with addiction). Because of this, women appreciated initial support on how to book appointments (e.g. GP, dentist, hairdresser), how to manage routine tasks (e.g. weekly shopping) and manage finances/welfare, leading to eventual empowerment to do these tasks individually.

4.3.2 Consideration of children and other family members

In addition to managing the practicalities of everyday life, the **wellbeing of family members**, particularly children, was pertinent for women accessing services. Women would not engage with services if this would compromise the safety of their family members:

> "I was referred [to another service organisation] due to my anxiety around my kids and I think it was my third attempt and I thought I will stick it out this time. I was on the second meeting; she basically just threw child protection at me. She asked if I hit my kids, if I yelled at them. [… I feared that] she felt like she had no choice but to call CPS [child protection

> services], I just ran out crying and refused to come back. It made my anxiety ten times worse. I thought someone was going to come and take my kids. You feel like you are going to these places to get help and even at the second meeting it was still just paperwork. It has taken me ages to build the confidence up to go back." – Service user

The fear of losing children was a common theme throughout the focus groups, particularly with women who had experienced GBV.

At the same time provision of childcare was frequently mentioned by women as being an essential component to accessing services. Childcare was typically provided by those organisations that were drive by a gender-focus, such as women-only support groups. Whilst some other services did allow the women to take their children, other cases presented significant challenges for the women. In the most extreme case, a woman was prevented from accessing a service she had been accessing on a long-term basis (taking her children with her to appointments) as the premises had started engaging with a registered sex offender, meaning that as it expanded its services to another client group it thereby excluded the woman who had already been a service user. Some services provided childcare facilities, such as a creche. This was provided in services which had already integrated a gendered approach. However, even when childcare provisions were available, mothers did not necessarily feel comfortable leaving their children with people they were not familiar with. Women also spoke of difficulties accessing services without childcare provisions. One service user mentioned that this was particularly difficult for single parents, as "[a] lot of people that have been through abuse to tend to be single parents". These responses highlight the importance of finding flexible solutions to this on a short-term basis whilst establishing a trusting relationship through continuous care. This might involve consideration of formal childcare, but as one woman suggested, providing a play area may be enough to include families.

> "Might be good to make it baby friendly as well, as there a few, including me who have kids. Easy enough to work around that. Put toys in the corner and then there is no barriers for people to come. That a lot of times you can't go to this group or that, because we can't take the kids. Families and people with kids also get hungry and can also feel isolated." – Service user

Services with options of support for family members, such as counselling for children and partners, received positive feedback. This removed the matter of feeling isolated through addiction (see Good Practice Box D) or through other issues as it gave the women the feeling of tackling it together with their family.

GOOD PRACTICE BOX D – Support for family members

Tayside Council for Alcohol provide a counselling service for family members of individuals struggling with alcoholism. This received positive feedback by women in Dundee.

4.3.3 Trauma-informed service provision

Trauma-informed service provision is increasingly recognised as a vital element to providing services across all sectors as the inter-connections between different aspects of complex needs are highlighted. Women who have experienced domestic and sexual abuse are 3 times more likely to be substance-dependent than non-abused women (Rees *et al*., 2011). The *Engender submission of evidence on homelessness to Scottish Parliament Local Government and Communities Committee* in 2017 states that women's experiences are more likely to be affected by abuse in childhood or adulthood, which can have a severe impact on emotional wellbeing and carry on into adulthood (see also Mayock and Bretherton, 2016; McClenne *et al*., 2017). Whilst the term "trauma-informed" was only used by some service users, many of the characteristics of trauma-informed service were mentioned in what were desired attributes for staff and support organisations. The recommendations as set out in the *Transforming Psychological Trauma* framework by NHS Scotland (NES, 2017) suggest an approach which has features common to those identified in section 4.2.2 of this report as being valued by the women service-users in this study, such as empathetic conduct, empowering individuals to make their own decisions, and taking into consideration that trauma and abuse may cause individuals to make decisions differently. In this research, women emphasised the importance of staff understanding the psychological effects of having experienced trauma. This included providing non-judgemental support despite service users making decisions which may go against the advice of the support worker, e.g. allowing perpetrators to have supervised contact to children, relapsing, returning to the home of the perpetrator.

Overall, trauma-informed practice was generally recognised as being a positive development, but one service user and two frontline staff were wary that its adoption could lead to more "clinical" approaches, or the challenge if staff are not suitably trained:

> "They were trauma-informed carers, but there are so many people who don't have a clue what that means. I remember being at one of the centres in the [mental hospital] and I tried to explain to them what was in my head, saying it is to do with trauma and I'd like to deactivate that. I was thinking if I just explain to them. The doctor said in this case, 'oh yeah I know about trauma'. It was just like a brick wall. 'I know you've experienced trauma. Your diagnosis is Borderline Personality Disorder. This is part of your symptoms. You are a group of many people who are going through the same. You're experiencing this not because of trauma, but because of your BPD.' I'm like this isn't about BPD, this is literally about a specific thing that happened to me, which brings up certain feelings, my head gets muddled up, my feelings get muddled up and everything feels the same. In her mind she thought she understood me, 'Yeah your trauma is what caused your BPD', and the kind of

> people that say they are trauma-informed think like that. So where do you go with that?" – Service user

This experience highlights the importance of understanding trauma-informed practice as a holistic and person-centred approach rather than a rigid set of guidelines and the need for careful training where such approaches might be implemented. The example also raises some of the tensions which can emerge between wider support and specialist mental health provision (see section 5 on aspects which also limited women's access to mental health support).

4.4 Limitations and challenges in service provision

Several challenges presented themselves to effective service provision, some being integral parts of the structure of service provision whilst others were caused by external factors. One of the largest limitations recognised by both staff and service users was the provision of **generalised, non-tailored service provision.** The rigidity of guidelines and only playing "by the book" meant that situations arose where personal circumstances were not taken into consideration:

> "I think it's generalised. It's like traumatic women this way, and psychotic women this way, you all get lumped into a group. Trauma could be anything, not necessarily abusive. It could be a car accident. I mean physical, mental and sexual abuse is all different. I mean, a sexual predator uses some mental abuse, and sexual abuse is also physical, but the trauma is all different." – Service user

> "We have been discussing recently the aspects around drug addiction and the specific vulnerabilities that women have. Our general services in response to substance abuse is a kind of a prescriptive standard response. It is not recognizing there is a whole other part to the particular vulnerability." – Managerial staff

Conditions attached to accessing services presented some barriers to women. One example is that means-testing may affect access to services. For example, one service user reported not being able to access a homeless shelter after leaving an abusive partner as she was in employment. As she couldn't afford the cost of the accommodation, she resolved to stay at her friend's house until she found another home. This echoes findings by previous researchers on "invisible homelessness" among women (Maycock *et al.*, 2016). Women seeking support for substance use issues reported being refused support until they met certain criteria was also reported (for example, one woman being refused engagement with a substance use support group as she had recently relapsed.)

As mentioned above, **not being available 'out-of-hours' and not having flexible hours** affected how

individuals who have other responsibilities, such as children and employment, were able to access services. This also affected any women who might experience crisis outside of access hours.

Whilst not mentioned by staff, service users referred to a lack of outreach by services. They stated that they had not heard of many services prior to being actively engaged within the service network through the process of referral mentioned in section 4.1 Referrals can open doors to new types of support, but it is important that they are carried out suitably. Women reported being afraid of accessing a new service and sometimes refused to do so without the support of a worker they were familiar with.

Slow or bureaucratic processes of referral to other services were also listed as a deterrent for women to engage with a service. This was an issue that was also recognised by frontline staff, and something that organisational procedures could in fact make more difficult:

> "Referral-wise, things are quite different. […] You used to be able to just pick up the phone but now everything's got to be on paper. Sometimes that's frustrating. When you're dealing with a crisis you have someone needing support there and then, but we try to get around that and doing the phone calls. But sometimes I'm just like, come on! Judge our expertise that this is what this person is requiring. I just used to pick up the phone all the time." – Frontline worker

Where formal processes of referral and partnership working do exist, the way information is shared can help to facilitate the process, but women also reported examples of where this process of inappropriately-handled information-sharing. One the one hand, some service users reported situations where information had not been shared and they had to "[bring] it back up again and again", revisiting traumatic experienced. On the other hand, oversharing sensitive information between services and inappropriate attitudes from service staff could undermine service users' trust in confidential and professional conduct. This latter point was raised when a service user reported being repeatedly interrupted by a member of staff of a new organisation to which she had been referred, stating that the previous support worker had already told her that:

> "You expect places to keep records on you, but you don't expect every little gory detail to be common knowledge. I went to the organisation and she kept interrupting saying '[your worker] said, [your worker] said', and I'm like, 'do you want me to tell you my story? You're just saying [your worker] said. If you know already, why are you even asking?'" – Service user

These examples highlight the importance of finding a balance between sharing information, whilst

still allowing service users to tell their own life stories on the one hand, and not creating situations which are re-traumatising on the other.

The largest barrier reported by service providing organisations seeking to carry out services to the best of their ability is the lack of financial resources and the battle to secure funding. Competing for funding was reported as creating a lack of trust between services and could cause friction when working in partnership with one another. Lack of funding also meant that staff were often overstretched, which can lead to heightened stress levels and subsequently reduce the quality of service provision. Time limitations for contact (e.g. a short-term contracts or rationed contact time per client) meant that in some cases service users did not receive continuous care. There were examples of services which were reported having been beneficial being lost when funding was cut. Finally, some organisations did not have suitable premises for contacting their service users.

Despite the focus of this research being GBV, homelessness and substance use, one of the most significant findings to come from this research is the lack of mental health services for women with the complex needs outlined here. Service reported that if they had received mental health support at the beginning of their "journeys", they may not have had required additional support later in life. Staff also recognised that mental health support was greatly lacking in Dundee. The following groups particularly struggled to access mental health services:

- Children of women battling addiction or experiencing GBV;
- GBV survivors, as some women reported being advised not to access psychiatric services due to an ongoing legal case;
- Individuals battling addiction who frequently reported being refused access to psychiatric services until they had stopped taking substances or having support suspended if they relapsed;
- Some women reported being denied access to psychiatric services while pregnant after a history of substance use issues.

There were location attributes shared by the service users which exacerbated their experiences. Reportedly "sterile" environments made service users feel uncomfortable and unwelcome. This was reported as window-less and cold rooms. However, these attributes were only highlighted in organisations which the women already felt apprehensive about attending and had overall negative experiences. In a mirror opposite to the positive attributes mentioned in section 4.2.1, the service users reported being hesitant about accessing services which were located too far from their homes. They also felt wary about accessing services in locations which had a high level of stigma attached to them.

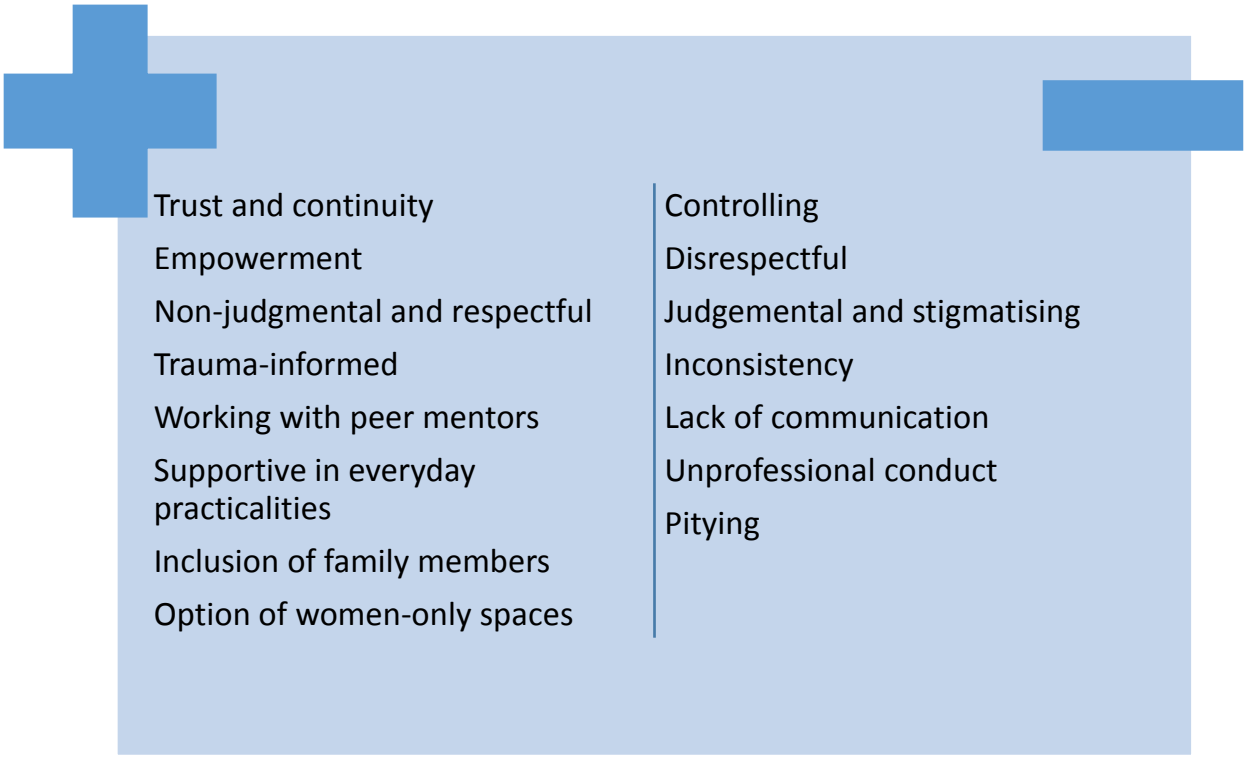


Figure 3 Service attributes viewed by service users as positive or negative

Figure 3 compares the **positive service attributes** which already outlined in section 4.2.1 with **attributes which were viewed negatively by the service users**, irrespective of what type of services they sought to access. The negative attributes are explained further below with specific examples:

Controlling, i.e. didn't allow service users to be involved in the decision-making processes,
"When they were speaking about budgeting your money, they were much more controlling. […] You feel as though it's Big Brother is watching you." – Service user

Disrespectful, judgemental and stigmatising.
"My drug worker is not that good. She makes me feel a bit small. She just brings me down and speaks to me like a child. Makes me feel horrible. Just can't work with her. I have to until I get a new worker. She is not a nice person and I have heard a few people complaining about her." – Service user

Not believing service users' account of events.
"[My new support worker] says there's a few clients that the team leader has made to feel like that, like I'm going off ma head. Saying that I was oot ma face and imagined that phone call." – Service user

Inconsistency in advice given, which was heightened when there was a high turnover of workers.

"It's hard, you get to know one person, then you're onto another and you've got to get to know them." – Service user

Lack of communication between staff and service users, meaning that the women are not fully informed of the procedures in place.

"I filled out a form to get this support for something, and I didn't know what they were doing. I didn't know what I was asking or requesting or what was going on." – Service user

Unprofessional and non-confidential conduct, i.e. discussing information in front of others.

"When I got out of prison, I seen [a worker] and she was quite unprofessional. I could have been embarrassed, but I wasn't. She was saying [in the past] I was showing her how to dance, but I must have been under the influence. We were going through the forms and she was saying that she could have signed it without me being there. I was thinking: 'That was so many years ago, I am a woman now'. That back when I was a teenager and I have changed." - Service user

"[A worker from another organisation] was meant to do a house visit tomorrow but it changed. Any service isn't allowed to come up to my house, because they could be at risk, if there is any fighting [because of a history of domestic violence]. Although she totally went over my support worker's head. They phoned me and said they were coming to my house tomorrow. I phoned my support worker and said that I didn't like it and she was being too over-familiar. I want to concentrate on the matter at hand and not being talked to like mates." - Service user

Pitying attitude, rather than empathising and providing constructive support.

"I went in and totally opened up and the woman just feel so sorry for me, but that was not what I was there for. I don't want you to feel sorry for me, I want you to help me, so I just never went back. Just makes you feel funny." – Service user.

Many of these points raised by women service users go against recommendations as set out by policy and reports, such as the guidelines by NHS Education for Scotland on *Transforming psychological trauma* in 2017 for working with individuals with a history of trauma and the Dundee Fairness Commission report *A Fair Way to Go* for local services working with individuals from disadvantaged backgrounds The examples named here demonstrate that there are ongoing issues with staff conduct towards service users, which need to be managed appropriately, and that further training and guidance is required.

On a final note, staff noted the mitigation of risks, whilst deemed absolutely necessary, was a potential barrier to carrying out services to the best of their abilities. Some staff had experienced violence at the hand of service users, and this affected the way in which they carried out their service provision. On a structural level, it resulted in an increase of security protocol. On a personal level, it resulted in a level of caution when approaching new service users, which could hinder the establishment of a trusting relationship. This highlights the need for staff support throughout their work, including after encountering these types of incidents. Furthermore, as mentioned above risks associated with non-standard procedure meant that staff were reluctant to provide support which may have been beneficial at the time due to the fear of being questioned about their conduct in retrospect, and potentially facing disciplinary action. This highlights that in practice, applying a person-centred approach can cause difficulties in terms of norms around professional practice and needs to be considered carefully when being adopted by service organisations.

In the following section (section 5) the report goes on to look in turn at specific issues around services related to the GBV, substance use and homelessness sectors.

5 Challenges related to specific types of services

5.1 Gender-Based Violence (GBV)

Service managers recognised the issues posed by the compartmentalisation of women's services. Managers reported workers deferring responsibility of a GBV case to traditional women's services, such as Women's Aid, instead of engaging with the issue themselves. There were some reports of workers overlooking signs of GBV because of a lack of training in the area which then delayed intervention. Changing work cultures and staff attitudes was presented as a major barrier even when training was being undertaken:

> "I imagine in this room in we are well-endowed with common sense and rationality, so if we were to face with certain circumstances we would do "this", whereas a victim would do "that". It is the judgementalism that comes behind it. "Why does she stay with him?" We did this study on the staff where we presented a very scarring video of domestic abuse, and one of the things I was really interested in was people's attitudes towards vulnerability and attitudes to victims. We had long conversation about prejudices and the things they thought about. We then showed them the video and discussed their empathy for the victim. Note the victim was getting beat within an inch of their life in front of them. Suddenly children were introduced, and she ignored the children and almost then ran away from them and we discussed why she might have done that. What was really interesting was the empathy of the people watching completely fell away. Particularly amongst women, because they clearly had the empathy of the child and the woman's action was then being judged by this outsider view of rationality. If you apply that then to service provision [... we see] that prejudice that we have inherently, where we try to apply our own logic to the behaviour of a victim." – Service manager

> "I think that is a really important point around domestic abuse specifically, because we know that victims behave, in order to protect themselves and their children, what appears as totally irrational. In the past people have been judged on that. There is now evidence everywhere that could give our frontline enough understanding of the dynamics. We are not doing enough with that for sure." – Service manager

This raises the importance of training staff in treating service users with respect and empathy, taking a **trauma-informed approach** to understanding individual circumstances and understanding behaviour which might appear 'irrational'. Service users, frontline staff and managers highlighted the importance of a person-centred approach in this case:

> "Even if a woman is with Women's Aid and staying in a flat, [the woman] might still let the perpetrator into the flat, even though they know they are not allowed to do that. They [also] know if they don't do it, it might be incredibly dangerous to them. They will allow a perpetrator to spend time with their children, even though they know he is dodgy, because

> they know if they don't, the consequences will be phenomenal. It is different. A person-centred approach needs to focus on what appears irrational and crazy sometimes, but actually works in keeping a family safe sometimes." – Service manager

Organisations such as Dundee Women's Aid and WRASAC were widely recognised as "women's organisations" in Dundee. However, a manager referred to what they called the issue with the **"compartmentalisation" of women's services** in the City. One of the biggest questions surrounding gendered service provision was whether to introduce a gendered perspective across all sectors and how the balance could be found between the need for specialist support and gender-mainstreaming.

Long waiting lists were the main concern about specialist organisations which dealt with GBV. This was an issue mentioned by both service users and staff. Staff stated that the specialist GBV services are greatly overstretched, while service users felt that there was no "immediate help" for some women's issues when they raised issues about GBV in particular with non-specialist organisations. This could be attributed to other organisations feeling reluctant to provide support for GBV-related issues. Staff from non-GBV services reported instances of colleagues withholding care for a GBV-related issue as they said **"that's a Women's Aid issue"**:

> "My agency's legacy has always been compartmentalised with women's issues falling in to the domestic and sexual violence. […] You have all these different departments and think: "that's a woman issue". To me it really undermines the kind of holistic service that we all aspire to deliver. Whether it is aspects of women as a mother or women as a particularly vulnerable victim. We have been discussing recently the aspects around drug addiction and the specific vulnerabilities that women have. […] An aspiration of mine, and I know that's reflected here, is that we could actually integrate that into all our services. I am not convinced that my organisation is quite ready." – Service manager

Such discussions lead to the recognition of **gaps in GBV training across the wider service sector in Dundee**. Staff and service users recognised that there was a lack of GBV staff across the city and recognised a need for a different approach on the matter. Some staff felt that there was lack of appropriate guidelines for workers to identify and deal with signs of GBV. Because of this, some workers overlooked signs of GBV, which they referred to as "obvious in hindsight". This highlights the need for further training for staff across non-specialist services towards understanding and interpreting the signs of GBV and how to act when they have been identified.

The issue of **confidentiality of sensitive information** (not sharing information unless agreed with the service user) was highlighted as being vital in relation to GBV and the trust of service users towards support organisations. An example of good practice was mentioned in which the police approached an organisation for information on a service user, but this was discussed and agreed with the service user before any information was shared. The service user stated that this is one of the reasons she placed a high level of trust in the organisation that she was attending and that she would likely not be using their services if she did not have that level of trust.

GOOD PRACTICE BOX E – Confidentiality and empowerment

Dundee Women's Aid liaises with service users prior to releasing personal information. This allows the service users to make informed decisions and gives them the freedom to act independently. This is a particularly valuable attribute to allow survivors of GBV to be empowered to make independent choices.

> "I think the confidentiality of [a GBV organisation] is one of its greatest attributes. […] One of the things my workers told me once is that the police were asking for my address, because they wanted to [speak to me]. […] They are asking for my address and she said we won't give it if you don't want us to. You feel like they're saying a friendly thing, but it's a professional thing too." – Service user

In terms of the types of support which were accessed and praised by women seeking support for GBV, women valued organisations which empowered them and helped them make sense of their experiences, including a whole range of practical support and trauma-informed practice, both in one-on-one forms and through support groups and courses (as mentioned in section 4.2 above). Women also valued empowering, non-judgemental support workers. The attributes for these are shared amongst women who were accessing support for GBV and those who sought support for substance use.

Finally, some significant **legal and housing concerns** were raised by victims of GBV and the staff who engaged with them (see further issues around homelessness in section 5.3). Serious concerns were raised about tenancy regulations which protect a perpetrator as a co-tenant, usually resulting in the relocation of the victim rather than perpetrator. This results in the women having to leave a familiar and comfortable environment and having to seek refuge in temporary homeless accommodation. Whilst some programmes are in place to help the women find supported accommodation, there was a lack of immediately available and suitable accommodation. Long waiting lists meant that women often returned to the perpetrator. Many women also reported having no physical protection from their perpetrator, leaving them to feel extremely vulnerable and fearing for their lives. In some cases, this also resulted in returning to the shared home with the perpetrator, as they felt more exposed being alone than in their shared home. These are serious issues which affect the safety of the women involved in these types of situations. Finally,

some women reported that the actions of the Police or their experience of the criminal justice system could place them in difficult positions (for example, the Police demanding entrance because of reports of disturbance when this was part of a pattern of harassment by a GBV perpetrator; or being advised by lawyers not to seek mental health support for the effects of GBV during a pending court case due to the potential impact on the legal case).

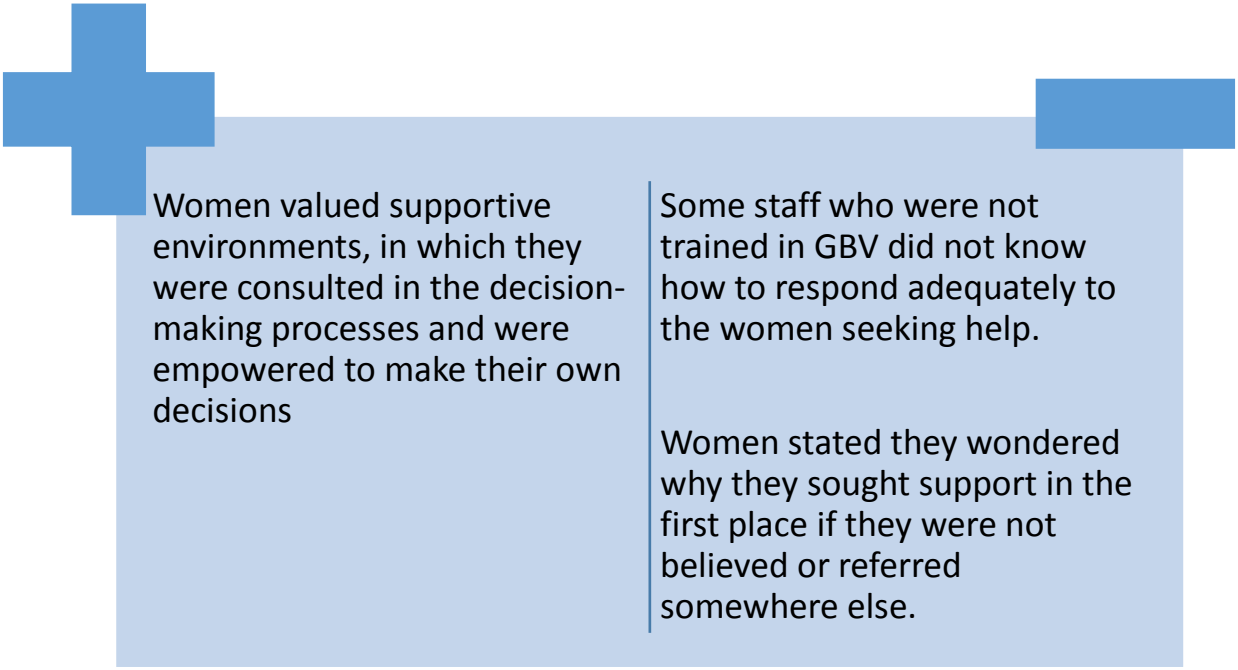


Figure 4 Positive and negative experiences with services accessed for GBV-related needs (as shared by service users)

Figure 4 summarises key points articulated in relation to GBV. This section demonstrates that agencies who are not trained in GBV are reluctant to engage with women who are experiencing violence and even where training is undertaken, staff need on-going support. Lack of training or staff feeling they lack the skills and knowledge (or support) can lead to cases being overlooked or to women disengaging from services. The findings indicate that GBV training is required across all sectors in Dundee. In particular, findings of this research and previous studies which highlight that GBV is commonly interlinked with substance use and homelessness as well as other aspects of complex needs point to the need to tackle stigma towards women who experience GBV and to support and train staff across support services.

5.2 Substance use

Among women service users with diverse experiences of substance use (both drugs and alcohol-related), support groups offered by different organisations were seen as positive coping mechanisms. Women also valued empowering, non-judgemental support workers. The attributes for these are shared between women accessing support for GBV and for substance use and were already mentioned in sections 4.2 and 4.3 above.

5.2.1 Challenges in relation to substance use services

Some of the specific issues mentioned in relation to substance use services are:

- **Stigmatised buildings** which deterred individuals from accessing services, something which was also recognised by staff offering services (particularly those in what was previously the DPC (Drug Problem Centre) and is now the Integrated Substance Misuse Service (ISMS) in Dundee, although most service users did not use that term):

> "The high stigma that comes with the DPC. It doesn't matter how many name changes you have, people going in there will know what people are there for." - Service user

> "The building as well. A lot of us have started doing the clinics out with the building and just do things like go to a GP practice to meet their substance abuse nurse and their social worker, their chemist or just something that would be normal for them to go to an appointment to and not coming into that dreaded building. And we're working to get more of us doing that as well on a regular basis." - Staff member

- Service users also reported that some buildings themselves were not conducive to positive experiences, with 'sterile' environments and an intimidating experience which could **affect their mental resilience and willingness to engage with services**:

> "My anxiety is bad. I had to go to the DPC once. You sit in this quiet room across from somebody you don't know, it's all dark and sterile, and they ask you all these things. It is horrible. I got exhausted." – Service user

- **Rigid service provision**, i.e. standard procedure and rather than person-centred approaches:

> "Every individual has different needs. Although people have went through similar stuff, people deal with it differently and get different things from different people. That's what other services need to realise. Every person coming through that door,

> just because someone else has experienced something similar doesn't mean they need the same thing as them. Every individual has their own individual needs." – Service user

The issue of person-centred approaches was also noted by staff who expressed frustration that insights from previous policies and reports, for example on access to mental health services for people dealing with substance use, had not been implemented in relation to services applying more flexible approaches to eligibility criteria. For example, it was noted that service users could lose access to mental health services when they relapsed in relation to substance use, contrary to previous policy guidance, and that as a result forms of 'self-medication' had become prominent in some cases (however, see the debates in section 5.2.2 below about different approaches to thresholds for access to mental health support):

> "A lot more people have been self-medicating recently, because they didn't meet with mental health services or they didn't meet the criteria. There was a report written about ten years ago, which is called Mind the Gap[3]. It is about mental health support and substance abuse and how to get it right. A lot if these things we haven't particularly been acted upon." - Staff member

Below is one particular example of how access to a variety of services for a service user could be impacted as personal circumstances changed (e.g. becoming pregnant) and as shifting criteria for access to services (or shifts in which agency seemed to be responsible for support) at times could leave a woman who was in need of multiple forms of support without any continuity of care or, in the worst case, losing access to support:

> "Just before I found out I was pregnant, I waited 4 years until I seen a psychologist. Then I finally got one and they said that they do a six-week assessment period. The six weeks turned into a year. They said it was an extremely hard case and that it was going to be quite difficult to break down. They said something like I spent my whole life building up walls. She finally said she was going to start treating me and at this point it has been a year. I seen her every fortnight for a year. I found out I was pregnant and she [the NHS psychologist] said "I can't see you anymore", which is a joke. Not only can you not access any NHS mental health services, now nobody else will talk to you at the DPC [now the ISMS] either [because of the pregnancy]. So, I had to go through my whole pregnancy alone and

[3] Participant refers to a mental health document released by the Scottish Government in 2003 named "*MIND THE GAPS -Meeting the needs of people with co-occurring substance use and mental health problems".* Similar issues were raised in 2019 in the Dundee Drugs Commission Report.

> up until he was a year old, I had no mental health help, no help for the drugs, even though my mental health was really bad." - Service user

This example repeats the crucial finding that access to diverse forms of inter-related support (in this case around mental health services, substance use, pregnancy and parenthood) can be hugely problematic for women to negotiate as they try to engage with diverse services and that perversely these processes can be even more difficult when they are dealing with complex situations. Finally, the example reiterates the importance of questions of access to statutory services provided via the NHS (mental health treatment, substance use services) for many of the service users in this study, as is explored in the next sub-section.

5.2.2 Specific issues in relation to accessing mental health services and substance use

A common concern among many women who had lived experiences of substance use was that access to NHS mental health services could be disrupted or restricted among those with addiction issues. Service users viewed this as a counter-productive and frustrating experience and made these arguments in relation to wider debates about the inter-connectedness of mental health and substance use in personal experience, in the experience of family and friends, and in current debates in Dundee related to the work of the Dundee Drugs Commission:

> "Mental Health. There is a massive gap for mental health if you have addiction. If you don't, you can go to the doctor and access all these different things. For people like me [dealing with substance use] there is nothing." - Service user

> "The thing that annoys me […] is that it has been proven that most addicts have mental health issues and they [NHS mental health services] act as if the mental health issues have been caused by drugs. In my opinion most people have mental health issues before they went on drugs. That's why they are using, and they don't seem to get that. What is even worse is that their mental health care is absolutely shocking. What is even worse than that is, that when you are on a methadone programme you can't access NHS Mental Health." - Service user

> "I have very close friends and family who have all committed suicide. The mental health treatment just was not there for them. Dundee is now the European drug death capital or whatever. Now they are focusing a lot on this administration where they are going to be changing this and that. I still think that they are still lacking mental health." - Service user

In particular, the issue of feeling like they were in an un-resolvable situation between the criteria for access to different services meant some women reported feeling that they found it very difficult to envisage any route towards recovery or stability since the issues that they identified as causing mental health issues (such as loss of children, or family bereavements related to drug use in the example below) were not something that would be resolved without access to simultaneous

support in relation to mental health treatment and substance use:

> "I work with another service with my addiction, so my mental health I am not getting any help with. I keep getting told from my worker that I need to be stable, but I have been stable. It is just taking ages. If my mental health is like that, I don't think I will be ever able to stop taking drugs. I have lost [children through social services/relationship breakdown]. [One of my parents] overdosed and died. Those are voids in my life that I can't fill with no partner or no drug. There are many other issues such as assaults and things I have done. That's why I take drugs to numb. When you are off drugs that raw emotion comes back. When you have been on drugs for years it is a break from feeling. When you have been on drugs for years it is normal. I have not had those emotions [for a long time]. You don't know what to do when you are feeling like that. I just can't stay clean, because stuff becomes too real. That's why I need the help with the mental health. That's the only thing that Dundee services are letting people down. I mean they are quick to dish out methadone, but that's not the answer. There is so many months they say you need to be stable before they look at you. I think it should go hand in hand. While you are on your methadone and you're managing to stay stable that should be enough. If you have relapses all the time they shouldn't say: "not until you have sorted yourself out again, we'll pick it back up". I want so much to make my life better for myself. I am at that age now where something has got to give. Compared to where I was [earlier in life] where I was overdosed, compared to where I am now I still can't get help for my mental health. It is breaking my spirit a bit. That's kind of setting me back." - Service user

In this example, instead of services going "hand in hand" (as the service user argues), the repeated loss of access to services meant that this woman's mental wellbeing and sense of any progress towards recovery was being undermined – **"it is breaking my spirit a bit. That's kind of setting me back."**

Some service provider staff did argue that those accessing psychological services needed to be "stable enough" to engage, including people with complex support needs. They also pointed to the logistical limitations of staffing available to support substance use service users in relation to psychological help and how working with other professionals in the support team might help to mitigate that:

> "Implementing especially with trauma we have psychologists that are always in the building and a 2-day course regarding trauma. Psychologists are able to do formulation with people to develop support with people who need it. People have high complex needs. Formulation is a psychological process where, ehm… We have [few] psychologists working with this service and [a very large number] people coming to this service excluding social work cases. There isn't enough psychology to go around, but what psychologists try and

> do is be part of a disciplinary meeting or work with social workers to support that worker. They also help with a plan to support their needs. They help develop a plan with the specific needs, which then can be acted upon by the social worker and other workers. A lot of the people we work with are actually not stable enough to work with the psychologists. They are not able to start scratching away at the surface. It is a different way of doing things." – Service manager

Following this quote, it would be pertinent to emphasise the importance of applying a trauma-informed approach across all sectors to mitigate the need for psychological intervention. The Dundee Drugs Commission report in 2019 likewise highlights the need for trauma-informed approaches in substance use services. Sections 6.2 and 6.3 provide some suggestions that were identified in the research on how to implement this, with final recommendations in section 7.

While access to formal mental health services emerged as a particular issue for many service users seeking support for substance use, there was also mention that a range of mental-health related support activities could be important for service users (as mentioned in section 4.2), but these were still seen as being insufficient in the face of the limitations on access to formal mental health provision:

> "If you are not doing the side of mental health you can go to many of these "my recovery" things, but if you are not feeling great up there [pointing to head] then it doesn't matter what you do. It is like putting a band-aid on something and then taking it off at night when you go home. Everything else they are doing is great. They need to employ more CPN's [Community Psychiatric Nurses]. That is what they should be looking at. There was times where I thought about going to the local MP and bringing him the paper [with the Dundee Drugs Report] and never mind what is going on my whole life." - Service user

> "They are building new signposts [to services] and have all these group works on. That's great and builds your confidence up. But when you come home at night you still have what is going on inside your head." - Service user

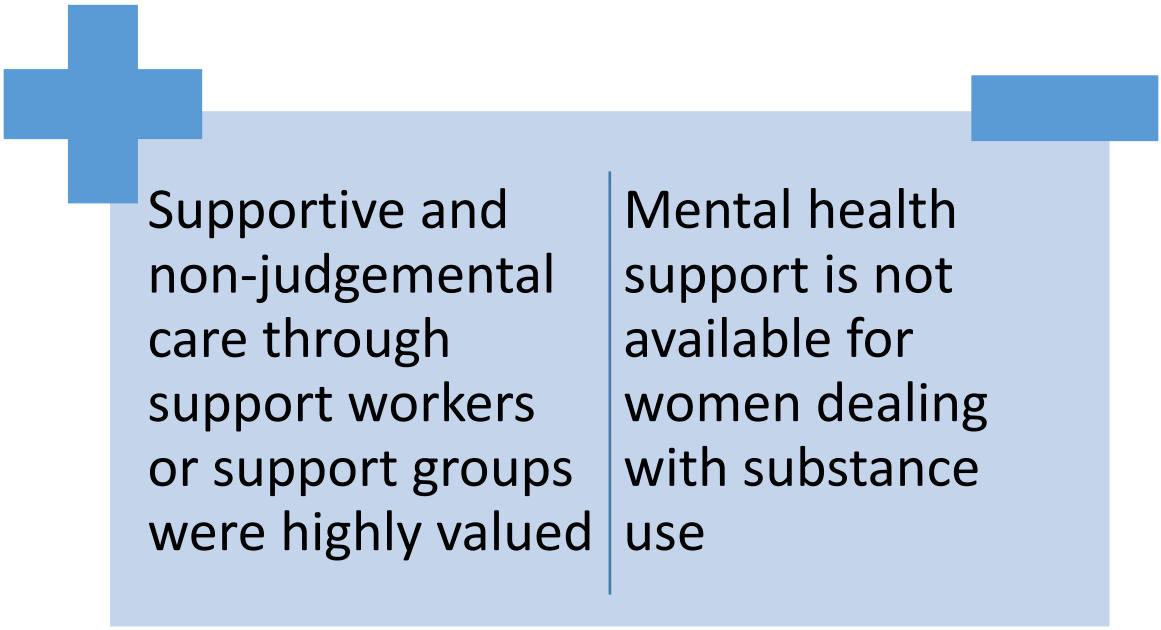


Figure 5 Positive vs negative experiences with substance use services (as shared by service users)

Findings in this section echo those of both the Dundee Drugs Commission 2019, and the Evaluation of Dundee Community Hubs 2019 (Jupp Kina *et al.*, 2019) in terms of highlighting challenges for women with complex needs around substance use. They also point to some contradictions between stated policy priorities at the national level in Scotland around 'Recovery-Oriented Systems of Care' (Scottish Government 2018) and Trauma-Informed Practice (NES 2017) on the one hand, and how such approaches are implemented in differing agencies and services in ways which might have contradictory outcomes for women with complex needs. Questions of how services provide a range of approaches supporting women's recovery, using different models of practice, and working with constrained resources, while ensuring that women experience such approaches as complementary, rather than being in conflict with each other, are ones which need to be addressed further to avoid situations where the barriers reported here leave women to feel services are frustrating their attempts to work towards recovery, rather than supporting them.

5.3 Homelessness and housing

One of the biggest concerns shared by staff and service users was **the lack of adequate and appropriate housing around the City, particularly when immediate entry was required (e.g. when leaving an abusive relationship, or when exiting prison).** This is particularly problematic because having their 'own space' was described by service users who had experienced homelessness of various kinds as being a vital element to feeling safe. (Research on homelessness reports impacts including poor emotional and physical wellbeing, disruption to social relationships, absence of privacy and security and a diminished sense of control; Cloke *et al*., 2008). There were instances where suitable accommodation was provided, in turn creating positive outcomes for the women involved:

> "When I left my partner, all services I worked with were there and they got me a safe flat instantly. They made the situation easier. A lot easier than you'd think. It was Housing that got me the flat. It was Social [Work] and Barnardo's that helped me get it. […] Me and my daughter now have a life. Everything we want to do, no one's there to stop us." – Service user

However, most women with experience of homelessness reported facing long waiting lists and living in temporary accommodation prior to being allocated accommodation. Problems with access to suitable accommodation had wider implications in terms of disrupting people's process of working towards different types of recovery from trauma (such as GBV) or substance use:

> "To be honest [being homeless] has kind of stopped the process [of recovery]. I done so well compared to when I lived somewhere else. I really need to get my own flat, but I don't want to go to a hostel environment. I am hoping for Housing First or Positive Steps to get something. That is what I need, my own flat. Do my thing." - Service user

> "So, I think they put it down as if I was on something else [drug use] and that's why I have left [my previous accommodation]. I am here again back to the start to get a house. It is hard to stay stable and drug free when you are not in your own home. If you're in someone's house and they are taking one thing it is hard. By Christmas my money will be sorted out properly. I should have my own flat. I need my own space. That is what is keeping me going." - Service user

The second quotation indicates the challenge of providing housing services for women with complex needs who may, for example, lose a tenancy due to drugs use, which in turn leaves them vulnerable in relation to the limited social housing supply. Problems faced by women in hostel accommodation emerged strongly (section 5.3.1) as did wider issues with access to social housing (section 5.3.2).

5.3.1 Hostels

Hostels were considered to be very dangerous environments, particularly for women. Many women who were service users reported being harassed by men in mixed-sex hostels, whilst some reported cases of sexual violence, theft and other crimes, or were unsettled by witnessing upsetting situations around them:

> "I had a large sum of money stolen out of my bank account. From somebody I thought I could trust [in the hostel]. We went to the police and they only got half back. They know who did it, but I have not heard anything about it." - Service user

> "I was seeing a guy in the hostel. He beat me up. So, I did not want to be in the hostel, so I went and slept on the floorboards [in my new accommodation]. Housing First gave me a fold-up bed and a duvet and stuff until I got my furniture." - Service user

> "When I was in there [in the hostel] I saw some things. Someone was overdosing and died. That freaked me out. I wouldn't go back there." - Service user

Women who had experienced hostels also reported impacts on their physical and mental health of the **availability of drugs** within the hostels (and the example below also indicates the additional vulnerability of women who have been in prison):

> "That's what I was saying if they could change the system for people getting out of jail and prevent them from going into hostels. Because they're clean when they go in, but then they end up on something. […] The amount of drug dealers in hostels. It's like they turn a blind eye to it as it's happening right under their eyes." - Service user

As already mentioned in section 4.3.1, women also reported the ways in which drug use could be utilised by men in the hostels, along with sexual harassment, to try to draw women into **exploitative relationships**. The problem of placing women in hostel accommodation was also raised by a number of staff who saw hostels as spaces where women who were already experiencing vulnerability (leaving prison, exiting prostitution) would be drawn into areas such as drug use and further sexual exploitation in **"a revolving door"**:

> "If people have got an addiction the last place they want to be is in a hostel, and the last place you want to be if you're coming out of prison is a hostel. It's a revolving door kind of thing. We need to have somewhere people can go to when they come out of prison, so they're not getting straight back into the drugs and that. Unfortunately, there's nothing. […] You're like oh my god if they are going to get depression it will be now because they're

> amongst lots of drug users and it's just awful. So when we are talking about prevention, it's just not happening." - Staff Member

> "When went into the hostel and we knew they were involved in prostitution they were almost targeted by men, because they were seen as earners. They would be a guaranteed source of income, so people would buy their drugs to begin with and then quickly turn in to them going out and having to pay their debt. That kind of process was involved and their ability to get away for an appointment was really difficult." – Frontline staff

Staff expressed major frustrations with such situations. As noted above this was felt to create a 'revolving door' for many service users, which created new vulnerabilities and furthermore caused difficulties for those seeking to continue with other aspects of their recovery (e.g. by missing appointments).

Staff in organisations that provided accommodation for women recognised the particular challenges of providing specialist accommodation for those with complex needs which may clash with the needs of other service users which until now might have led to women with complex needs being referred to hostels:

> "I think that is a big problem everyone has pressure on the services, and you can feel it from other people. It's a political thing, really. From our point of view we only have a certain amount of refuge spaces [for women experiencing GBV], and refuge isn't always suitable for every woman because we do have certain rules and I know that means that certain women don't have any choice and have to go to hostels and I know that it's all going to be changing […], I know it's obviously really a really difficult environment for a woman who's on her own with mental health issues and a past of substance use to live somewhere like a hostel which can be a scary place." – Frontline staff

Challenges with providing such specialist and supported accommodation have been found elsewhere (Women's Aid *Nowhere to Turn 2019* report) and there are moves within Dundee to review the approach taken to temporary accommodation, including taking in to account the challenges of those with complex needs (both women and men):

> "We are reviewing temporary accommodation in Dundee. I would agree that some hostel accommodation can be toxic for individuals coming, whether that is male or female. Bringing 20 people together with similar problems highlights some of those problems about exploitation. All this in the one place. We are looking at how we can manage accommodation in a much more sympathetic way and giving people the opportunity, instead of getting them trapped in this cycle."- Service Manager

Attention to challenges in relation to temporary accommodation were situated within the wider challenges of access to social housing, as outlined in the next section.

5.3.2 Challenges of access to social housing

As reported by staff and by women who had experienced housing need, the main issue was that despite service organisations working with diverse housing providers in the city, there was limited availability of housing. Limitations were noted in terms of **when accommodation was most urgently needed**:

> "So, they were trying to work with Housing First. They did not have any places available. We then went to Positive Steps. So, my support worker picked me up from prison and we went back and done everything I needed to do. She took me to a hostel first." - Service user

Also, in terms of the type of accommodating being suitable for a **range of different needs**, including women in vulnerable situations. Limited availability and long waiting lists meant that women (and their children) could find themselves with a long wait even where housing providers worked hard to find suitable accommodation. Others ended up in hostel accommodation (as outlined above), or as a rough sleeper:

> "I do know that Housing [Department] will always look at options, and I do know they try their best not to put vulnerable people into vulnerable situations. Unfortunately, as you say, there are only so many hostels and so many beds and flats. But they do try to get them to have somewhere safe. It's also difficult to convince people to keep a flat if they get offered one they don't want, there's someone on the streets tonight because she's been offered a flat that she doesn't want. She is vulnerable, and they do try their best not to do that." - Staff member

> "Talking from a housing and rehousing point of view it's having the stock. Especially when you're talking about kids. ´Cause trying to get a 3 or 4 bedroom house nowadays can be an absolute headache […] without waiting months and months and months to find a suitable property and it's really frustrating because one of the cases I was working with lately was looking to get a flat and then a house. But then you get a conscience about moving a family twice because you´ve got other things to think about like schools and GPs and everything else and it's just a nightmare. With the lack of stock potentially for some of these families." - Staff member

There are examples of tailored projects in Dundee seeking to support clients with complex needs through housing-based approaches (e.g. Housing First (Transform), Positive Steps, and Dundee Women's Aid refuge were examples cited by service users). However, wider issues of housing supply and capacity to respond to immediate need remain challenging for service providers, given the limited housing stock available:

> "The Housing First project, to put vulnerable people straight into their own tenancy with all their support in there, so they don't have to go around [is good]. But there are not enough one-bedroom places to house these people, and it's all well and good the minister saying that the idea is there, but they are not building properties to back that up. Plus they still have to be assessed for that and have certain needs. In principle, though it does make sense with everyone coming to you rather than you having to go to everyone else, it's getting the properties to put people into. Our waiting list is our biggest problem." - Staff member

GOOD PRACTICE BOX F – Housing First approach

Housing First is an approach (e.g. from Transform in Dundee) which provides a service in which service users receive a well-maintained property with functioning utilities and regular maintenance. Support workers also provide the comprehensive care as described in Good Practice Box A. Service users have the option to contact their workers via telephone at any time and generally work with the same member of staff.

Despite waiting lists, the feedback from service users on supported housing was overwhelmingly positive. Women reported being severely isolated previously, but that their support workers provided them with a feeling of safety and support:

> "I had to wait about ten or eleven weeks on my house, but that can't be helped. Housing First have to wait till they got offered the house. It is hard to go into hostels when you are just out of jail, because as soon as someone puts a drug in front of you and you are feeling down, you will take it. That's what I ended up doing. It nearly killed me being in hostels. If it was not for my support worker and the worker from Housing First, I wouldn't be sitting here." – Service user

Staff members in GBV services also reported problems of stigma or unsympathetic views which could be encountered among other agencies when service users were dealing with housing needs:

> "I kind of see it here as well. I suppose we think what we deal with when women come to us as a domestic abuse service, that usually homelessness is a big thing for us. The threat of homelessness for women wanting to leave [their abusive partner] is big. Some of the things they have struggled with when they presented themselves as homeless is that the attitude is that 'you should be grateful for what you get. If you are homeless you should be

> happy with anything you get'. But the women were saying that they didn't want to be homeless. They just didn't want abuse." - Staff member

There were also suggestions of the need to recognise the **emotional and social challenge** of moving to new accommodation which might be faced particularly by women who have experienced multiple issues and who may find it difficult to form trusting relationships:

> "I would like to say in crisis accommodation. I know we got housing, but I know we are busy all the time. Sometimes the women we work with are unstable and they sometimes struggle with housing with other women and their kids and that can sometimes be a struggle. A lot of these people have never experienced a positive relationship in all their lives, and we treat them differently and stick them in houses they don't fit in to." - Staff member

In contrast, what might be needed is a potentially less challenging environment, one with what one staff member called a **'low threshold'**:

> "Something that has a really low threshold, 24-hour accommodation so we can go 'right we can help you right now'. So, we can be there for safety and stabilization. Remove the initial threat."- Staff member

Problems of finding **affordable accommodation** for their organisation or their client was also reported as being a key issue. Rising housing prices in Dundee, particularly in the rental sector, were listed as reasons for organisations not being able to secure housing and for service users declining the offer of entry into a new home. This includes service users in employment who were seeking access to temporary accommodation, or social housing (for example after leaving an abusive relationship) being subject to unrealistically expensive charges for such housing. If women then refused the 'one reasonable offer' of accommodation made to them, they would then be reprimanded for refusing entry and be returned to the bottom of housing waiting lists. If they did accept such tenancies, despite being seen to be 'secure', the financial pressures could be problematic for many clients:

> "Again, it's affordability, whether it's their benefits or their age. It's hard to house somebody, and at the moment the rental prices have rocketed in Dundee." - Staff member

> "Housing here is a big impediment as well, the housing being built is mid-market, and the people we are dealing with cannot afford to be in these mid-market renters. But they're all in them, and we have so many people on benefits wanting out of them because they cannot afford to pay the rent and they are meant to be secure tenancies, but they're not because people cannot afford to pay the rents. It's just a vicious circle." - Staff member

> "If you are trying to get on your feet, the last thing you want to do is put someone in financial difficulty straight away because that adds to more pressure and especially if you've got a young family or other reasons." - Staff member

One practical barrier faced by staff in ensuring their clients could access suitable housing was the extent to which issues of **confidentiality and data protection laws (GDPR) were perceived to mean that they could not get housing services to understand the urgency of the needs of their client**:

> "I think sometimes sharing the reason why you need something done might be a bit awkward. […] Sometimes we'll get [services] out to do evaluation and they´ll just put it on the waiting list. [But …] it's not just a regular case. It's urgent. So obviously if the GDPR [means I] can´t explain why she needs it done urgently then it gets put in a waiting list." - Staff member

Figure 6 summarises key findings on issues related to housing and homelessness. Alongside the practical challenges of access to a limited housing supply, high cost, and issues of the lack of suitable short-term and longer-term accommodation, there are clearly specific issues which face women in the housing context. In particularly interconnections of gender-based violence and sexual exploitation, substance use and homelessness (including amongst women released from prison) mean that women and the services working to support them can struggle to be able to address complex needs. It also demonstrates that there are positive examples of approaches to supporting women in housing need and that there is a willingness to develop suitable services, but that these face considerable challenges (see section 6 for recommendations).

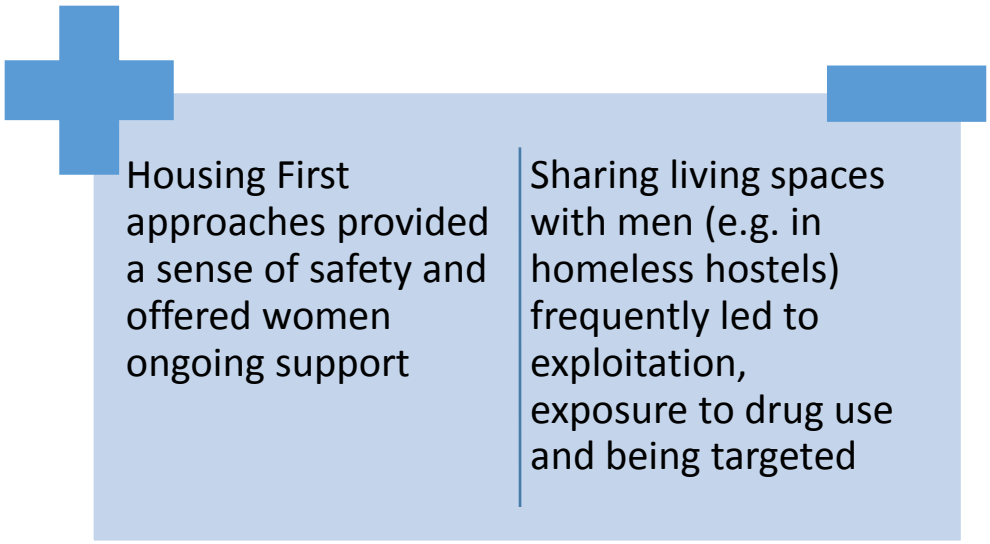


Figure 6 Positive vs negative experiences with housing services (as shared by service users)

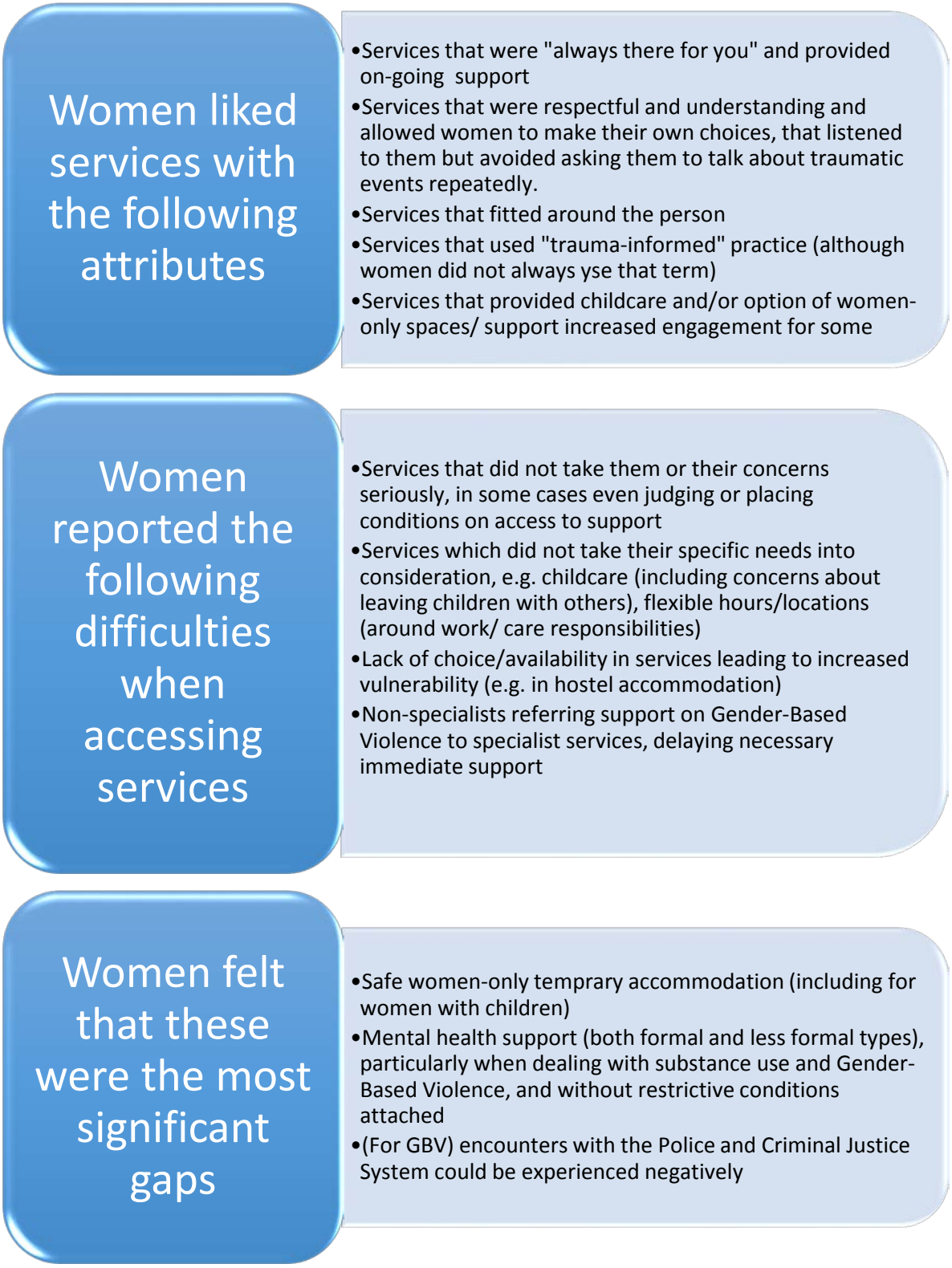


Figure 7 Summary of women's experiences with services

6 Gaps and moving forward to improve services

6.1 Overcoming common barriers across sectors

This section presents suggestions made by the participants about existing gaps in Dundee's service network in relation to the service user groups who are the focus of the research and ideas about how to improve services for women in Dundee.

As mentioned in sections 4.1 and 4.2, location played a role in how service users engaged with a service. A key consideration is to offer **co-location of services in non-stigmatised buildings**. This could potentially remove the shame attached to the stigma of some services and could potentially widen the target group of clients and remove barriers to access. Another aspects of service location worth considering are that with the important exception of most women who accessed GBV services, those who sought support in other areas (such as housing, financial advice, and substance use) appreciated opportunities for **home visits or meeting in a public space close to their homes with which they were familiar and in which they felt comfortable**. On a structural level, some members of staff suggested that service providers could assign staff to **focus on smaller geographical areas** wherever possible. This could stimulate a better understanding of neighbourhood characteristics and overcome some of the barriers caused by offering services on a city-wide basis, such as travel distances for service users.

Service users in particular requested a greater **outreach and awareness** about services, as they felt as though they could have prevented the onset of a crisis had they been aware about a particular service at that time. Service users and staff made several suggestions of how they would promote services leading to earlier engagement with service users:

> "But it would have been more helpful if a key worker had sat me down and told me this is what's on offer for the recovery side of things. It would have been much easier, but I kind of had to navigate all of that myself. So that would have helped." – Service user

> "It would be good just having a session [at drop-ins and community centres] where all the people are there, and someone introduces them and says what they do and then we can go speak to them or put our name down." – Service user

> "Think the different agencies need to be more visible to the public. On social media and whatnot. Dundee City Council has the 'in your neighbourhood' Facebook page and I like areas that I cover and it is really informative. So, when I am out visiting someone I can say this is happening in your areas in a couple of weeks." – Frontline staff

In reference to the challenges discussed in section 4.4, suggestions were also made on implementing continuity of care, out-of-hours options (outside standard 9-5 hours on weekdays),

and options of childcare provisions for women with children.

In terms of approaches to working, and despite issues around inter-organisational competition and tensions, most staff spoke positively of a **greater promotion of partnership working.** The benefits of sharing expertise and the importance of overcoming competition between organisations were highlighted:

> "Everyone is thinking how I can save my budget. If we are saving for the police, fire service, ambulance how can all that money be redistributed, because the work we are doing is saving other organisations or services money. How can that be looked at as a one rather than all these different pots of money." – Frontline staff

> "I wouldn't say one service could fit everything. There needs to be a range of services with a range of specialities who can all work together and share their knowledge. If you get someone with domestic abuse, they night have been in prison, they might have been homeless, they might have used or are using substances to help cope, they might have mental illness. It goes for other services too. It's all interlinked. More and more services are trying to capture families that have been impacted by domestics because it's coming more to the forefront that families that have been presented with different kinds of problems. There's a domestic element behind that. It's huge." – Service manager

The question of the **joint ownership of risk** was raised as an issue is overcoming competition and achieving communal goals in such partnership working:

> "I think we are on the journey. There is no simple answer. I think it has to be the principal of sharing. […] It is about our own staff; it is about society and the key thing is about how our partners work together. Getting a commonality about how we approach those problems. I can't think of a single incident that nowadays is only a [single] incident. It always has an impact on the community and partners. Without them being involved the outcomes are worse. I still see this high-level compartmentalisation. For me it has to come from the top, we have to start looking at how to achieve this broader goal. Not to do it quickly. It has to do with all of us. We all own this risk. Whereas you think of all these public disasters there is often this blame culture. You will end up often with small teams of staff. There are all these organisations that carry this high level of risk and make the decisions. They then end up where they see the worst of it and their tolerance levels go up and they see the victims for their exposures and the worst child abusers. We have seen that so many times. Social workers being exposed. What I would really like to see is us moving to a joined up ownership of risk. We in this room reflect a number of partnerships and if anything, we

> have to take ownership and the chief executives have to take ownership of risk. If there is a problem with NHS Tayside for example it is not their problem, it is our problem. It affects us [all].” – Service manager

Other members of staff highlighted the importance of putting differences between different agencies aside and focusing on the needs of service users:

> “I think that is getting better. I think sometimes we need to put our egos aside. I don’t think it’s about who has the right qualification, it is about who is the right person to engage with the person. Whoever can best support them. That is what we should be really pushing.” – Service manager

Sharing expertise between services with the aim of providing the best possible support for service users could have wide-reaching positive effects for those with complex needs. However, as examples from earlier sections have illustrated, this also requires that staff be supported and that decisions which affect service users are made with their understanding.

6.2 Developing a gendered approach across all sectors

Improving the potential for women to access **women-only services** is one aspect of taking a gendered approach. The need for women-only spaces, particularly for women who have experienced trauma, was highlighted in section 4.3.1. These spaces provide a place of acceptance and safety, which was agreed upon by women from a mix of backgrounds. Whilst some women attended drop-ins, others were not aware of any female-only drop-in support groups. For those that existed, the women suggested the following changes:

- More flexible hours to take responsibilities of parents and working women into consideration,
- Higher frequency of activities,
- More variety of activities.

Overall, these suggestions point towards a **higher allocation of resources towards women-only groups**. Service users additionally wished for a higher focus on empowerment and training of more peer support workers.

There was also a mention of gaps for women-only services in the following areas:

- Hostels, as discussed in section 5.3.1,
- Crisis hotline, in which women can speak to trained women about issues they may be facing.

The option of being able to have a woman support worker/ staff member to work with was also important for some women, and for most women in relation to specific themes (such as GBV, or sensitive medical issues).

Section 5.1 highlighted the severity of existing stigma amongst some service provider staff in relation to women with complex needs and in some cases despite previous staff training. Some managers expressed concerns about the time it would take to implement further changes to attitudes among staff:

> "The Safe and Together approach which is on child protection and domestic abuse is having an impact, but again culture change takes a long time. Think about smoking and how unacceptable it is now, there's a real stigma about being a smoker now whereas before there wasn't at all and people out in that office could be sat smoking at their desks. It was a change in the view of the population and a whole systems approach to changing that culture and I think that it probably what it's going to come down to." – Service manager

To combat this, it was suggested that services adopt gendered approaches across all sectors in a whole systems approach and not only expect that the 'gender' services (such as Dundee Women's Aid or WRASAC) would somehow provide all such cover (although their expertise could clearly have a role in such developments):

> "What I would like to throw in is that historically what we have always done when we wanted to improve our responses to the issues affecting women, is that we wanted to have more funding for Women's Aid. In my view that is a mistake. What we need to have is a whole system approach that accepts gender. […] I think now we have opportunities to do that, because there is things going on around the city. We have an opportunity to do that, but I would say that is also a challenge to women's services." – Service manager

Some staff admitted to increasingly recognising that women's needs may be different from those of men, despite their service not (yet) taking a gendered approach:

> "Speaking for my service there are specific interventions, but from what I understand, we treat everyone the same. I think there are opportunities for more training for gender-specific interventions in my service, that I have noticed and I've just been more understanding on how women's needs can be more different from men." – Frontline staff

There was a consensus amongst staff that there is a strong need for training on GBV across all sectors, opening discussion amongst the workforce about how to tackle issues and listening to the

views of the women and families affected by GBV in the discussion:

> "We do spend a lot of time to say how we as services respond, but we don't spend enough time being engaged with those people using the services. They could tell us what they felt like and what are deficiencies are. That is challenging and in crisis points we can't always expect that. I think we are liable to be a bit stoic in that. […] It is a basic problem-solving approach that listens to the people you are there to serve. The insights it gives about why people to things we wouldn't understand. That could be in a wide interest, looking and friends and family. We tend to often talk about what our service response is. I think that is a bit narrow. […] we just need to do workforce development and talk about these issues. Talk about them in every context. […] It is a cross-cutting issue." – Service manager

There was an overall consensus about providing training to staff across all sectors, rather than increasing funding for the "compartmentalised" services as mentioned in section 5.1. Some staff suggested organisations that specialise in GBV should provide training sessions or materials for other organisations. In one focus group, the discussion arose of GBV specialists providing consultation via telephone to other services when requiring advice on a GBV case (including on specific aspects such as trafficking or prostitution):

> "I think specialist services need to be able to provide consultation as well, so there's training and upscaling stuff, but there's ongoing support that specialist agencies could give. I think that, well I mean in my head I had this idea that we could have a kind of direct access type thing for violence against women generally, but also including trafficking and prostitution and everything that comes under that umbrella. They would be the initial point of contact and would be able to give people information, options and advice if that's all they needed at that point. They could do an early screening and risk assessment and see where is the best place for this person to go. But they could also provide consultation for services, so ISMS could call and say we've got [a woman here], she's involved with prostitution, she's got PTSD as a result of a rape that happened two years ago, what is the best thing for us to do? Rather than just firing it straight over to Women's Aid, they are then able to tackle it in a much better way and therefore takes the pressure off of the specialist services. But how you get that set up without additional resources I have no idea." – Service manager

Some staff suggested early intervention, e.g. police or social workers identifying cases early and offering support to the women if desired. In practice, however, it is possible that women are not ready to engage with services and/or the perpetrator still poses a significant risk to the victim, so it may not be possible to enforce such a strategy under current legislation. Another member of staff suggested providing education for children in school, to learn about signs of GBV and how to

safely seek support as a means of early intervention and raising awareness from an early age (in line with the 'prevention' aspect of the Scottish Government's *Equally Safe* strategy). These ideas could potentially offer starting points for a discussion on raising wider public awareness on GBV.

Some members of staff voiced their concerns about the availability of support and counselling for staff working with traumatic cases (whether that be related to GBV or other issues). The wellbeing of staff members when dealing with crises is pertinent to ensuring the services operate holistically:

> "I think as a worker as well, it is about support for us too. I had a few people tell me their story and it is heart-breaking. I had a woman that showed me pictures of her domestic violence towards her and I can't stop thinking about it. It is confidential so who do I speak to about it? That is the thing, we are expected to just get on with it. A lot of workers get PTSD and it is living that person's experience yourself. You live stories you have seen." – Frontline staff

This staff member was not working in a specialist GBV service and did not have any resources to fall back on or was not aware of any procedures in place. In contrast, other staff spoke of their organisation having a monthly drop-in for workers to attend for counselling issues, whilst others had the opportunity to speak to an occupational therapist. The concerns expressed by the member of staff above, however, emphasise the need to implement support for all staff working with vulnerable groups, to ensure they are aware of options available to them and to develop reflective practices within service organisations.

There was also discussion of the importance of promoting more female leadership in the sector, as one service manager highlighted:

> "There is one element that I think would accelerate some of the change I think that is the leadership in the sense of the female leadership. I don't mean that in a compartmentalised kind of way. Getting truly balanced leadership, where a mix of gender is driving the agenda to me is essential. I can only speak anecdotally in my own organisation; it is very evident to be pre-dominantly male. A woman waits until she is 110% certain to move on the next hurdle or challenging task, whereas a male will fly more by the seat of their pants to try more when they are only 50% ready. What that creates, I see it in my own organisation […], which naturally creates a gap. It ends up with fairly good balance at a lower level of an organisation, but you get total distorting at the top. It is lack of balance of that level that really impacts the culture and what we need to change. I set up a place where I tried to achieve a 50-50 leadership and the quality of leadership went through the roof. I could see the quality of leadership change." – Service manager

In line with providing gender considerations across all sectors, mainstreaming trauma-informed approaches to services is a pertinent issue to avoid re-traumatising women and allow them to establish feelings of trust towards a service they are engaging with, but it also requires careful implementation as women have highlighted the detrimental effects of engaging with workers who were not trained in trauma-informed approaches:

> "When they've got an understanding of how the actual trauma works [that's good]. Even males are dealing with trauma. That's my biggest problem as well. I think a lot of the organisations definitely [need] new training with the trauma things. [Workers who weren't trained in this way] came out to me, and yeah it was just over a threat [from a violent partner], they were like "why are you shaking? You seem awful nervous". I said I'm petrified. "He's not even come near your door" [they said]. And you feel more anxious, like you're doing something wrong. "Yeah he might be sending you those [threatening] messages, but he's not stepped along that path". It's worse that they come to you and tell you that than if they don't come at all. Automatically they said you're doing something wrong because you're shaking. That's why I think that [they] need all this training." - Service user

In line with national on trauma-informed approaches, it is imperative to consider implementing person-centred service provision, which requires discussion about negotiating professional norms when dealing with women with complex needs (including aspects of trauma):

> "I find that kind of difficult that we can't stop and see what are the person's needs. How do we meet them? Instead of these cant's what can we do? We can do things. There are shining lights in there and agencies that are willing to try and even when it is unsuccessful. I think that is a culture shift. I understand that services are generally feeling overwhelmed, so I get it. Whilst this is all going on you have a human in crisis with needs. That is often lost. We step away from that, because it is too hard. How do we change? What are the needs? What can we bring, instead of the just the standard?" – Service Manager

Finally, staff highlighted the importance of implementing policy in practice, particularly around the previous points, as many of these proposals have already been circulated in national and local reports and policies. Throughout any such implementation it is essential to listen to service user feedback when implementing these policies in practice to ensure their efficacy for those affected by them and to provide support and training for staff who are being asked to implement them.

Taking these findings into consideration and providing services in which the needs of women are

valued and reflected could make consequential impact on women's engagement with services and the effects that are derived from them. It is vital to ensure that these findings are considered in practice with all services that engage with women who experience GBV, homelessness and substance use issues as well as other complex needs.

6.3 Overcoming gaps in mental health services

As discussed in section 4.4, research participants (both service users and service providers) noted a significant gap in the mental health services provided in Dundee and specific barriers which some women with complex needs faced in accessing them. Some suggestions were made to overcome the issues presented by mainstream mental health services. Most of these suggestions already exist within the City, but they could act as guidelines for developing and expanding services. Partnership working and providing referrals to suitable alternative services (e.g. support groups) could assist in providing part of range of mental health support options.

In section 4.2.2 and the Good Practice box C, service users spoke highly of **mental health workshops and training within existing services by professionals**. This allowed women to learn coping strategies in a familiar environment. Some of these were more low-threshold types of support:

> "I think mindfulness, meditation and that. That really helps. Even schools are putting out meditation instead of detention and apparently that has had dramatic results. I think that could be something to do." – Service user

Service users also spoke highly of mental health support (such as the ASPEN project or Survive and Thrive, both offered through Dundee Women's Aid) provided through existing support groups. This allowed the women to engage with the topic in a comfortable and familiar environment, without the barriers presented by traditional mental health services.

There were also suggestions of more **person-centred approaches** and fewer diagnoses, as there were concerns about the stigma attached to a medical diagnosis

> "It's not even some much about the diagnoses, it's more about pulling that person's story together. So that it makes sense to only to professionals but to the person themselves. They don't feel like they are going crazy, that's what I would I hope I can bring, telling them what they are feeling and experiencing, the behaviours that have occurred because of your whole story. Sometimes always you get a diagnosis which it great you have had access to that but there is not always immediate follow up care. So, you might get someone with a diagnosis that is stigmatised. So, schizophrenia, borderline personality disorder in particular where there is not really any help. They will look it up and go 'god I am a psychopath and I will never love again'. That can get spiral them off into terrible scary

> thoughts because you don't have anyone you can talk to it about." – Frontline staff

Some suggested more immediate accessibility to support when needed, such as an **out-of-hours walk-in centre** to access immediate support. This was a suggestion that was made frequently, both by staff and service users.

> "That's what I'd like to see, some form of 24 hour crisis centre for mental health or everything. So, if that day you got turned away there's another option, and you can go to the crisis centre." - Service user

A manager mentioned that there were plans to implement a 24/7 crisis centre, despite not having a concrete strategy in place.

> "[It] is maybe worth noting that there is a bit of work going on in Dundee at the moment where the Mental Health and Wellbeing strategic planning group is looking at a provision, in regard to responding to the stress. To get something that is available 24/7 and a crisis response to alleviate the issues you are talking about. Police are saying that is such a huge issue at the moment. So, there has been an improvement advisor appointed to work forward. How it is going to look is not clear, but there will be 24/7 crisis type response." – Service manager

Despite initial costs to implement this, this could have long-term effects for a wide population group, including many of the women with complex needs who contributed to this research. These findings signify a clear need for addressing access to mental health support in a range of forms. It also raises, particularly in relation to women with substance use issues, questions about how to overcome specific conditions attached to accessing mainstream NHS Psychiatric Services (as outlined in section 5.2.2.

7 Conclusions and recommendations

Key findings and areas for action are grouped here under five broad headings which emerge strongly from the report:

- **Mainstreaming gender-informed practice** (section 7.1.1)
- **Trauma-informed and supportive practice** (section 7.1.2)
- **Placing the person at the centre of addressing multiple and complex needs for women** (section 7.13)
- **Addressing the fragmented landscape of service provision and barriers to services** (section 7.2)
- **Supporting staff and building their capacity** (section 7.3)

Each section:

- Identifies **key issues** raised in the report
- Gives examples of **good practice** (or progress towards this)
- Recommends **areas for action**.

Two key approaches underpin all of these recommendations:

- Listening to the **voices of women with lived experiences** of gender-based violence, homelessness, and /or substance use and related issues.
- Listening to and supporting staff to help **share good practice** and develop **services which take complex needs into account** and align clearly with national policies.

Finally, section 7.4 provides:

- A summary of core recommendations along with issues that should be considered when taking these points forwards.
- How these might be developed into a positive cycle of change across Dundee.

7.1 Taking forward gender- and trauma-informed practice

7.1.1 Mainstreaming gender-informed practice

There is a need for services to implement an understanding of gender differences in life experiences and integrate this into service provision, particularly for women with complex needs.

Key issues:

- **Stigma and a lack of understanding** of the issues women are facing can lead to inappropriate and sometimes damaging responses when women seek support.
- **A lack of a gendered approach in some areas can cause women to face more vulnerabilities, e.g. in mixed-sex hostel accommodation.**
- Women reported cases of being **re-traumatised by procedures** which re-enacted processes they experienced previously, such as an invasion of privacy and not having control over their situation, or facing further trauma, e.g. through becoming homeless or losing income.

Current examples of good practice:

- A range of organisations incorporate the wishes of women in their service delivery e.g. Dundee Women's Aid.
- Some services in Dundee (e.g. TCA, Hillcrest) offer **women-only groups**, which offer a place of "more than safety" for the women who attend.
- Housing First and other supported approaches to temporary housing offer positive models for **safe spaces for women facing housing need.**
- Service organisations offer **flexible approaches to childcare** – e.g. Whitfield Community Health offer a creche to the women attending their services, but also allow the option of taking children into groups.

Examples of good practice in development:

- The Pathways group in Dundee is an oversight group consisting of the Violence against Women Partnership, which aims to provide guidelines for services in Dundee to provide gendered approaches to service provision.
- The Integrated Substance Misuse Service (ISMS) are adopting a plan to develop women-only spaces at non-stigmatised locations, such as GPs, community centres, and other venues. It is also considering having designated women-only times for access to ISMS services and well as creating more women-only spaces and introducing facilities to support women's children attending their appointments.

Areas for action
- **Build capacity to understand GBV within the workforce and implement this through training**. This is necessary across a wide range of services, not only in GBV specialist services. - Fund **a worker who specialises in gender-informed practice to collaborate mainly with statutory services**, with the option of working with Third Sector services on request, to provide training and consultation for adopting gendered approaches to service provision. Organisations receiving funding must ensure to incorporate this into their practice and guidelines. - Develop **alternative approaches to temporary and rapid accommodation to existing hostels, providing safe spaces for women (and their children).** - Offer the **option of female support workers** for service users. - Provide **support for family members** through individual services, but also through wider statutory support (e.g. GBV support for children through schools) as it targets isolation and provides a support/safety network for women with complex needs. - **Increase in female leadership** in the sector to help tackle gender inequality and aide in the implementation of gendered policies.

7.1.2 Implementing trauma-informed and supportive practice

There is a need for services to understand the effects of traumatic life events on the women who seek support and to recognise the extent to which trauma is implicated in a wide range of complex needs that women face. At its basis are needs to follow key approaches to listening, understanding, responding and checking with women who are at the focus of service provision (Centre for Mental Health, 2019).

Key issues:

- **Women can experience stigma, judgement or incomprehension** from some services when their behaviour in relation to aspects of trauma such as GBV appears potentially counter-productive or irrational.
- Lack of understanding of how trauma and complex needs may be affecting service users can lead to service users facing **unnecessary barriers to support, disengagement from support or repeated cycles of vulnerability and further trauma**.
- The lack of **access to mental health services** was a significant finding, echoing findings of other recent research and reports in Dundee. Many women clearly saw their mental health was linked with other issues for which they sought support (e.g. GBV, substance use, homelessness).

Current good practice:

- Dundee Women's Aid currently practice an **evaluation for trauma during initial contact.**
- There is a range of examples of one-to-one support, groups and courses which **support women in with their mental health** (e.g. anxiety workshops in Whitfield Community Health drop-ins) and specifically trauma-informed approaches (e.g. Survive and Thrive, Aspen programme – Dundee Women's Aid), all of which are highly valued by the women who have used them.

Areas for action:
- Services which do not specialise in psychologically informed approaches to service provision could consider starting by **taking other elements of trauma-informed practice into consideration**, such as the provision of a safe environment and providing empathetic and person-centred care (following NES 2017 guidelines). - **Alternative options to statutory mental health services** should be in place, to offer women options for psychological support when they cannot access mainstream services and in formats which are 'low threshold'. - **Barriers to access to NHS mental health services** such as conditions in relation to substance use should be addressed in the wider integration of health and social care in Dundee.

7.1.3 Placing the person at the centre of addressing multiple and complex needs for women

The difficulties of dealing with **multiple complex needs** are heightened when multi-agency approaches are restricted due to the participants being excluded through conditional service provision. In contrast, a **person-centred approach**, supported by implementation of the **lead professional** model, offers potential to support service users in flexible needs while **maintaining the attributes which women value and which lead them to engage with services**.

Key issues

- Dealing with one type of vulnerability can lead to **women being subjected to vulnerability in multiple contexts** (the case of homeless hostel accommodation was particularly noted).
- **Trusted relations of support** can help to facilitate access to a range of services for women in ways that avoid breaks in support and delays when referral processes are less effective.

- Service users (and staff) identified examples of where **inflexible and counter-productive responses from services** could act as barriers to effective support and recovery.

Good practice

- Many organisations (e.g. Barnardo's, Housing First, Dundee Women's Aid) operate under the premise of offering **support from first point of contact**.
- **Women identified supportive and trusting relationships** across a wide range of organisations and service provision.

Areas for action:

- **Women need to be viewed holistically**, rather than looking at a single issue.
- Women should be allowed **a choice over how services are provided** to them, e.g. the gender of their worker and the location of access, and the decisions they make after having received advice without judgement.
- Women should be offered **support from first contact**, avoiding the delay of support through a referral process.
- Adopting a **person-centred approach** goes hand-in-hand with adopting gendered approaches and trauma-informed approaches, as all highlight the importance of taking individual background and experiences into consideration when carrying out service provision. A **code of conduct** should be implemented to ensure ethical and compassionate treatment of all individuals and the **lead professional approach** should be developed to support women and facilitate effective multi-agency working.

7.2 Addressing the fragmented landscape of service provision and barriers to services

A fragmented 'service-landscape' can be a deterrent for some service users. Whilst many women were willing to overlook this when continuous and supportive care was available (often facilitated by a key worker/ lead professional), the difficulties of navigating fragmented services can lead some women to disengage with services.

Key issues:

- Women are often not aware of services available to them
- Women are sometimes afraid of establishing initial contact to an unknown service independently.
- Intimidating locations and non-flexible opening hours which limited access affect service use, as can issues with childcare.

Good practice

- Women with a lead professional worker/ dedicated support work are more likely to engage with a wider range of services if they are accompanied by the worker to initial meetings at other organisations.
- Multiple agencies operate out of buildings such as the Crescent in Whitfield, or the Cairn Centre, offering a potentially neutral location for individuals to attend if they have concerns about a specific location. This also allows individuals to access support from different services. However, it is important to balance this with the value of women-only safe spaces, particularly for GBV-related services (Bowstead, 2019; Lewis et al., 2015).

Areas for action:
- Encouraging peer word-of-mouth to create a wider outreach. - Having services with more flexible opening hours would help clients who may not be able to attend service which are open only weekdays from 9-5. It would be beneficial if more flexible hours could be introduced to support those people who work or have other responsibilities. - Co-locating services in non-stigmatised buildings could offer one way to encourage engagement, but this also needs to be balanced against the need for safe spaces e.g. in relation to specialist GBV services. - Fostering multiagency responses through an increase of partnership working. This includes taking joint ownership of risk and mitigating any inter-organisational differences.

7.3 Supporting staff and building their capacity

Staff across the sector require training and support in working with service users in order to ensure the wellbeing of staff and service users. It is vital for organisations to support staff in making decisions in the interest of service users without leaving themselves open to disciplinary action or censure (while balancing professional requirements and issues of risk management). Organisations should seek to build the capacity of their staff to deal with complex cases by adopting national guidelines and policies into practice, recognising the need for support for staff wellbeing and developing opportunities for reflective practice.

Key issues:

- **Risk-averse organisations** might struggle to implement person-centred policies if staff are required to adhere to strict guidelines.
- Staff in non-specialist organisations/roles may **lack training** in identifying GBV and how to operate in a gender- and trauma-informed way.
- **Some staff are not receiving or aware** of any occupational therapy options available to them and report struggling mentally because of dealing with traumatic cases without supportive or reflective practice in their organisation. Organisations may currently have insufficient capacity to provide increased specialist support at present.

Good practice:

- A consultant psychologist at Dundee Women's Aid can provide counselling for employees. Other organisations offer support through occupational health.
- Organisations have begun to request training and support to expand awareness of and engagement with these issues.

Areas for action:

- Implementing options for **staff training and support** across the sectors, particularly in relation to GBV and trauma-informed practice.
- Opening discussion around the workforce, incorporating **reflective practice**, and adopting existing policy and guidelines into practice.
- **Listening to the experiences of service users and staff** and incorporating these in to practice.

7.4 Key recommendations and creating a positive cycle of change

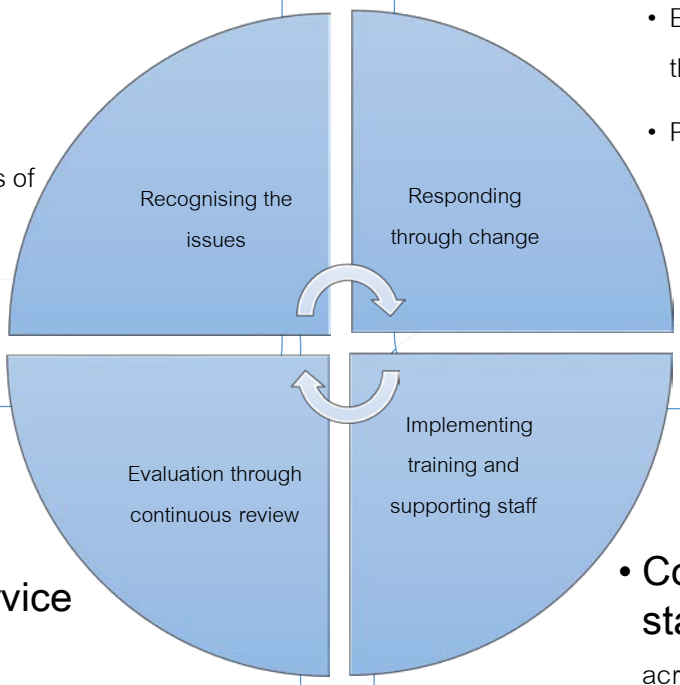
Table 2 - Key Recommendations

These are the issues	Suggestions for best practice	Things to consider
Women who experience Gender-Based Violence (GBV) were referred onto specialist services, which delayed immediate support. Staff in some organisations report feeling reluctant to engage with women experiencing GBV. Staff highlight issues surrounding stigma from other workers towards women with substance use issues or experiencing GBV.	Staff across all sectors should receive training on how to deal with Gender-Based Violence. A specialist in gendered services could act as a consultant mainly to statutory services, with the option of consulting Third Sector organisations.	It is vital that services do not re-enact scenarios of control and allow women the freedom to make their own choices. Staff need to feel supported (e.g. reflective practice).
Women in employment may struggle to access services during opening hours or be subjected to high costs if they do not fit criteria .	Consider how services can be accessed by a range of women (alternative venues). Provide out-of-hours support options.	Continuity of care to build trust is key.
Women with children struggle to access services.	Improve childcare facilities and options to take children to appointments. Women report positive experiences of peer-support	Women with a history of experiencing GBV are often not comfortable leaving children with strangers.
Women are excluded from mainstream psychiatric services (e.g. because of substance use or an ongoing GBV court case)	Offer alternative services, such as workshops in existing support groups or courses on specific issues (e.g. managing anxiety). These approaches were valued by women.	Women may well need formal mental health treatment, which suggests a need to reconsider current barriers to formal (NHS) mental health provision.

	Extend trauma-informed practices across the sector and ensure correct advice is provided.	
Women often experience increased vulnerability and exploitation when faced with mixed-sex temporary acoommodation.	Reduce vulnerability for homeless women by adopting different approaches to temporary housing need.	Increased vulnerability included experience of violence, sexual or drug-related exploitation.
Women with multiple complex needs require support from a range of specialists.	Promote partnerships and multi-agency collaborations to identify the best possible support for the women. Adopt person-centred/ "lead professional" approaches to take the specific needs of women and their wishes into consideration. Provide support from first contact.	Staff report tensions between organisations who were competing for funding. Service providers need to take joint ownership of risk. Staff also voice concerns about the guidelines on the mitigation of risk, which may hinder services being carried out on a person-centred basis. Services need to find a balance that does not prevent person-centred approaches.

Figure 9: Creating a positive cycle of change

- Women are being **stigmatised** and do not always receive appropriate care
- Women are being **subjected to dangerous situations** when they are vulnerable
- Recognise barriers of **conditionality**
- There are also examples of **good practice**



- Implement guidelines on **gender-responsive, trauma-informed and person-centred practice** and allow women to make their own **choices**
- Offer **alternative venues and opening hours** to overcome existing barriers
- Ensure **continuity of care** through a lead professional approach
- Provide **support from first contact**

- **Engage with service users** to hear their experiences and incorporate these into practice
- **Review evidence** and policy to ensure service delivery reflects ongoing issues
- Incorporate **reflective practice** to ensure best practice

- **Consult with specialist staff** to improve service provision across all sectors and taking joint ownership of risk rather than shifting responsibility (esp. on GBV) to specialist organisations
- Organisations **adopt guidelines into practice**
- Staff are supported through **counselling and training**

Key resources for training and practice

- The **Safe and Together model** offers advice on keeping children with the non-offending parent in GBV case and avoiding any further harm or traumatisation (e.g. re-location, loss of income). Details available from https://safeandtogetherinstitute.com/
- **Domestic abuse: a good practice guide for social landlords** offers guidelines for protecting the non-offending parent and their children in cases of GBV and how to involve services. Available from https://womensaid.scot/wp-content/uploads/2019/08/Domestic-abuse-guidance-for-social-landlords-FINAL.pdf
- **Equally Safe at Work**[4], an employer accreditation programme in local councils in Scotland, recognises that gender-based violence is the result of wider gender inequality, so tackling equality of women within the workplace and within management positions is imperative to tackling the wider issue.
- The framework **Transforming psychological trauma: a knowledge and skills framework for the Scottish workforce** released by NHS Education for Scotland (2017) provides guidelines for multiple levels of trauma-informed practice. Available from www.nes.scot.nhs.uk
- Engaging with complexity (Centre for Mental Health, 2019) offers advice on trauma-informed practice with a particular focus on women. Available from https://www.centreformentalhealth.org.uk/engaging-complexity
- The report *How to promote wellbeing and tackle the causes of work-related mental health problems*, published by Mind UK (2017), offers advice on how workplaces can provide working environments that promote positive mental health in employees. Available at https://www.mind.org.uk/media/428496/Resource3_HowToPromoteWellBeingFINAL.pdf
- The HR department of NHS Tayside (2014) released guidelines for staff to recognise GBV, including advice on how to engage with women who have experienced GBV and ensuring staff mental health and wellbeing throughout the process. Available via https://www.nhstaysidecdn.scot.nhs.uk or click the active link above.

[4]Equally Safe at Work is an employer accreditation programme that is being piloted in local councils in Scotland. The programme enables employers to better support employees who have experienced gender-based violence and work towards creating an inclusive workplace culture that prevents violence against women. More info at: https://www.equallysafeatwork.scot/

References used in the report

Allcock, A., and Smith, L., 2018. Impact of gender-specific interventions. The Institute for Research and Innovation in Social Services (Iriss). Available at: https://www.iriss.org.uk/resources/esss-outlines/women-specific-intervention.

Bowstead, J. C., 2019. Spaces of safety and more-than-safety in women's refuges in England. *Gender, Place & Culture, 26*(1): 75-90. DOI: 10.1080/0966369X.2018.1541871

Burman, E., Smailes, S. L., and Chantler, K., 2004. 'Culture' as a barrier to service provision and delivery: domestic violence services for minoritized women. *Critical Social Policy*, 24 (3): 332-357.

Cameron, A., Abrahams, H., Morgan, K., Williamson, E., and Henry, L., 2016. From pillar to post: homeless women's experiences of social care. *Health and Social Care in the Community, 24*(3): 345–352. doi: 10.1111/hsc.12211

Ceannt, R., Macdonald, S. H.-F., Fenton, J., & Larkan, F., 2016. Circles Within Circles: Dublin's Frontline Homeless Sector Workers Discuss the Intersectional Issues of Homelessness, Mental Illness and Addiction, *European Journal of Homelessness*, 10(2), 61–86.

Centre for Mental Health, 2019. *Engaging with Complexity: Providing effective trauma-informed care for women.* Centre for Mental Health. Available online at https://www.centreformentalhealth.org.uk/engaging-complexity

Cloke., P., May, J., and Johnsen, S., 2008. Performativity and affect in the homeless city. *Environment and Planning D; Society and Space,* 26(2), pp.261-278.

Corbin, J. and Strauss, A., 2009. *Basics of qualitative research: techniques and procedures for developing grounded theory.* (3rd ed). London: Sage.

Dundee City Alcohol and Drugs Partnership (2018). *Dundee City Alcohol and Drugs Partnership Report to the Dundee Independent Drugs Comission*. Dundee.

Dundee Health and Social Care Partnership. *Implementation Plan* 2019-2022. Dundee.

Engender, 2017. Engender submission of evidence on homelessness to Scottish Parliament Local Government and Communities Committee. Available at: https://www.engender.org.uk/content/publications/Engender-submission-of-evidence-on-homelessness-to-Scottish-Parliament-Local-Government-and-Communities-Committee.pdf

Fang, M. L., Gerbrandt, J., Liwander, A., and Pederson, A., 2014. Exploring Promising Gender-Sensitive Tobacco and Alcohol Use Interventions: Results of a Scoping Review. *Substance Use & Misuse, 49*(11): 1400–1416. DOI: 10.3109/10826084.2014.912225

Jupp Kina, D., Jones, L., Hemsteede, R., Searle, B. and Smith, F.M., 2019. *Dundee Community Hubs Evaluation Report*. University of Dundee. Available from f.m.smith@dundee.ac.uk

Kulesza, M., Matsuda, M., Ramirez, J. J., Werntz, A. J., Teachman, B. A., & Lindgren, K. P., 2016. Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender. *Drug and Alcohol Dependence*, 169, 85-91

Lewis, R., Sharp, E., Remnant, J., & Redpath, R., 2015. 'Safe spaces': experiences of feminist women-only space. *Sociological Research Online, 20*(4): 1–14. https://doi.org/10.5153/sro.3781

Mayock, P. and J. Bretherton, J. (eds) 2016. *Women's Homelessness in Europe.* London: Palgrave.

Mayock, P., Bretherton, J. and Baptista, I., 2016. Women's Homelessess and Domestic Violence: (In)visible Interactions. In Mayock, P. and J. Bretherton, J. (eds) W*omen's Homelessness in Europe.* London: Palgrave, pp. 127-154.

McNeish, D. & Scott, S., 2014. *Women and Girls at Risk: Evidence Across the Life Course, Lankelly Chase*. [online] Available at: http://lankellychase.org.uk/wpcontent/uploads/2015/12/Women-Girls-at-Risk-Evidence-Review-040814.pdf

Moss, K. and Singh, P., 2015. *Women Rough Sleepers in Europe: Homelessness and victims of domestic abuse.* Policy Press, London.

NHS Education for Scotland (2017) *Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce.* NHS Education for Scotland.

Prison Reform Trust, 2013. *International good practice: alternatives to imprisonment for women offenders.* [online] Available at: <http://www.prisonreformtrust.org.uk/Portals/0/Documents/Women/InternationalGoodPractice.pdf>

Richards, L., 1999. *Using NVivo in Qualitative Research.* London: Sage.

Rose, D., Trevillion, K., Woodall, A., Morgan, C. and Howard, L., 2010. Barriers and facilitators of disclosures of domestic violence by mental health service users: qualitative study. *The British Journal of Psychiatry*, 197, 1-6, doi: 10.1192/bjp.109.072389.

Saldaña, J., 2009. *The Coding Manual for Qualitative Researchers.* London: Sage.

Salter, M., and Breckenridge, J., 2014. Women, trauma and substance abuse: Understanding the experiences of female survivors of childhood abuse in alcohol and drug treatment. *International Journal of Social Welfare, 23*(2): 165–173.

Scottish Government, 2018. *Ending homelessness together: high level action plan.* [online] Available at: https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/ending-homelessness-together-high-level-action-plan/documents/00543359-pdf/00543359-pdf/govscot%3Adocument/00543359.pdf

Scottish Government, 2018.*Equally Safe. Scotland's strategy for preventing and eradicating violence against women and girls.* Available at: www.gov.scot.

Scottish Government,.2018. *Rights , Respect and Recovery Scotland's strategy to improve health*

by preventing and reducing alcohol and drug use, harm and related deaths. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/strategy-plan/2018/11/rights-respect-recovery/documents/00543437-pdf/00543437-pdf/govscot%3Adocument/00543437.pdf

Scottish Women's Aid, 2015. *Change, justice, fairness: "why should I have to move everywhere and everything because of him?"* Edinburgh: Scottish Women's Aid.

Tweed, E. with Miller, R., Matheson, C. and Page, M., 2018. Why are drug-related deaths among women increasing in Scotland? *Scottish Government: Social Research: Health and Social Care Research Findings* 141/2018.

Warrener, C., and Koivunen, J. M., 2014. The Complex Nature of Serving Divorced and Separated Women: A Qualitative Analysis of Needs and Service Provision. *Families in Society, 95*(4): 245–252. DOI: 10.1606/1044-3894.2014.95.34

Women's Aid, 2019. *Nowhere to Turn: Findings from the third year of the No Woman Turned Away Project.* Women's Aid: Bristol. Available online at www.womensaid.org.uk.

Appendices

Appendix 1 - Service user information leaflet

Will I get something for taking part?

- We hope you will enjoy taking part in the research. By telling us about your views and ideas, we hope to help improve services for women across Dundee.
- We will NOT pay you money for taking part in the project.
- We will cover local bus fares. Please speak to the group organiser named below to arrange for your costs to be refunded (you'll need to bring in your bus ticket for this).
- We don't want to exclude anyone who needs childcare. Please let your group organiser know if you need help with childcare during the group discussion and we will do our best to organise suitable cover.

Any more questions?

If you have questions, please speak to the person in your organisation who is helping organise this:

…….. (name of group organiser)

Or you can contact the researchers at University of Dundee:

Dr Fiona M. Smith (f.m.smith@dundee.ac.uk) (research leader)

or Marisol Lopez (m.j.lopez@dundee.ac.uk) (researcher), School of Social Sciences, University of Dundee, DD1 4HN

Or you can contact Dundee Women's Aid, which is the organisation that is coordinating the project overall: info@dundeewomensaid.co.uk

Time and place for the discussion group

Date: ……

Time: ……

Place: ……..

Listening to women's views about services in Dundee

A group of service-providing organisations has been awarded funding by the Scottish Government to undertake research to improve services for women in Dundee. Researchers from the University of Dundee are conducting the research for this project on their behalf.

It is important that services are provided in ways that are suitable for the women who use them. To do this it is important that organisations that fund them and run them have a clear idea of the views of the people using those services. **So we would like to invite you to take part in a discussion group about what you think about the service or services you use.**

This leaflet gives you some more information about the project so that you can decide if you want to take part or not.

What am I being asked to take part in?

You are being asked to take part in a discussion with a small group of other women who use the same service as you (around 5 women in total) which will be led by one of our researchers (who are both women).

This should take about 1 to one and a half hours and will be at a time that will be arranged by the organisation giving you this information. Usually it will take place at the venue you normally attend but we may arrange a quieter location that is more suitable for a discussion if needed.

We will ask you about what is positive and what could be improved for you or for other women in the services that you use (or would like to use).

We will not ask anyone to talk about the details of what has happened to them. There are several reasons for this. You might not be comfortable about this. Also other women in the group might become upset. The person leading the discussion will try to keep the focus on the main theme – what women want from the services they use in Dundee.

Why have I been asked to take part?

It is important for organisations that provide services to listen to those who use them. This project specifically wants to look at the views of women to help improve how services are delivered for them across Dundee.

The organisation that you attend has agreed to help the project and is asking some of the women who use the service to take part in the discussion group.

What might be the good things about taking part?

We hope this will be something interesting for you. You will hear from the other women in the discussion what they think and you can give your views. We are also talking to women who use services across Dundee in other groups so your views will be part of the wider picture that we are building up.

We are also talking with people who provide services in a range of organisations and will write a report and develop staff training to help organisations understand the views of the women we are talking to.

Confidentiality is important

- Everyone who takes part in the group discussion will be asked to respect that what people say should not be discussed away from the group.
- We will not identify anyone by their name or by any other details that could identify you when we use the information from the groups. We will use short quotations from what is discussed to make sure women's voices are being heard. These will always be **anonymised**.
- We will not link your name in any way to comments about specific services or organisations. Your organisation will not know what you say.
- Your personal details will not be passed on to the researchers. We will only see you at the group discussion. **The researchers will not keep any personal information.**
- You will not be contacted again by the researchers directly. But we will provide some feedback to the organisation you use about what ideas come up in the overall project. This is planned for November 2019. So you might want to keep an eye out to see what information comes up.

Important things to know

Taking part is entirely up to you. It is **voluntary**.

- Whether you take part or not, or what you say, will have no effect on whether you are able to use this service or any other service in future. This is totally voluntary and if you decide not to take part, that is fine. You don't have to take part in the project if you don't want to. And you can decide to stop taking part at any time, even if you've signed to say you will do it.
- During the discussion group, if you wish to stop at any time, that is fine. Also if you don't feel comfortable answering any particular question, that's fine too.

If there are any risks in you taking this information home with you, please ask someone at your organisation to keep the information safe for you, for example, a support worker.

Before we start the discussion group, we'll ask you to give your consent for the discussion to be audio-recorded (voices only). These recordings will then be typed up and anonymised. Only the anonymised information will be used for the analysis. The original recordings will be deleted.

The consent forms which you will be asked to sign to say you agree to take part will be kept safely by the organisation and will be destroyed once we have completed the data collection.

Remember, even if you sign up to take part, you can stop at any time.

Someone will be on hand from your organisation if you have any issues or need any further support or advice after the discussion in the group.

Appendix 2- Staff information leaflet

Remember, **even if you sign up to take part and you are sent by work, you can stop at any time and are not required to answer anything you are uncomfortable with.**

Will I get something for taking part?

- We hope you will enjoy taking part in the research. By telling us about your views and ideas, we hope to help improve services for women across Dundee.
- We will NOT pay you money for taking part in the project.

How to take part

Please contact either the person in your organisation who is the contact for the project, who will pass your email contact to our researcher, or email our research directly.

Her email is Marisol Lopez (m.j.lopez@dundee.ac.uk) (project researcher)

She will then get in touch to make arrangements about the scheduling of the focus group.

Further questions?

You can contact the research leader at University of Dundee:

Dr Fiona M. Smith (f.m.smith@dundee.ac.uk) (research leader)

School of Social Sciences, University of Dundee, DD1 4HN

Or you can contact Dundee Women's Aid, which is the organisation that is coordinating the project overall: info@dundeewomensaid.co.uk

Listening to service staff about gender-specific service provision in Dundee

A group of service-providing organisations in Dundee has been awarded funding by the Scottish Government to undertake research to improve services for women, particularly in the areas of gender-based violence, substance use and/or homelessness. Researchers from the University of Dundee are conducting the research for this project on their behalf.

It is important that services are provided in ways that are suitable for the women who use them. To do this it is important that organisations that fund them and run them have a clear idea of the current picture of service provision in Dundee. **So we would like to invite you to take part in a discussion group about your experience of how services are currently being delivered and what could be improved and how.**

This leaflet gives you some more information about the project so that you can decide if you want to take part or not.

What am I being asked to take part in?

You are being asked to take part in a discussion with a group of other service staff from around Dundee (around 15-20 participants in total) which will be led by one of our researchers. There will be separate groups for frontline staff and for managers, meaning that frontline staff won't have to discuss things in front of their managers.

This one-off event should take up to two hours and will be at a time that will be arranged by the researchers to suit as many of you as possible. The discussions will take place within a meeting room at Dundee Women's Aid.

.Even though you may have been sent through work, you won't have to answer any questions you're uncomfortable with answering. We'll ask you to state what organisations you come from so we have an overview of who's taking part, but all the answers will be anonymised, and we won't report on what specific people said about specific organisations. If you have any concerns you can decide not to answer any of the particular questions discussed or withdraw from the discussion at any time.

Why have I been asked to take part?

It is important for organisations that provide services to listen to what's happening on the frontline and for initiatives that seek to coordinate actions across the sector to hear from those who manage the services that people use. This project specifically wants to look at the views of women and those who provide services to women to provide a holistic overview of the current state of the service sector. This will then help improve how services are delivered for them across Dundee.

The organisation that you work for has agreed to help out on the project and is asking some of the frontline staff (whether paid or voluntary) and some of those in management positions to give their views on how services in Dundee can be improved to be more effective for women.

What might be the good things about taking part?

We hope this will be something interesting for you. You will take part in a discussion with other staff from the sector and hear their thoughts on what is being done well or where barriers to effective service provision exist. We are talking to service staff from a wide range of services across Dundee, so your views will be part of the wider picture that we are building up.

We are also talking with female service users from a range of organisations and will write a report and develop recommendations towards service provision in cooperation with staff once we have collated the findings. These will be made public in a dissemination events in November 2019.

Confidentiality is important!

- Everyone taking part in the group discussion will be asked to respect that what people say should not be discussed outside the group.
- We will not identify anyone by their name or by any other details that could identify you when we use the information from the groups. Quotes will always be **anonymised**.
- We will not link your name in any way to comments about your employing organisation. Your organisation will not be able to identify you. However, the report may seek to identify examples of good practice from the sector to share with others.
- Frontline staff and managers will hold their discussions separately.
- Your personal details will not be passed on to anyone other than the researchers. You will be contacted by the researchers to arrange the timing of the focus group you wish to attend. You will also be sent a detailed information and consent form which you will asked to read and complete before the focus group begins. The consent forms will be kept safely by the researchers and will be destroyed once we have completed the data collection.
- We will provide some feedback to all participating organisations based on our findings. This is planned for November 2019. So you might want to keep an eye out to see what information comes up.

Important things to know

Taking part is entirely up to you. It is **voluntary**.

- What you say in the discussions will be anonymised. You are only being asked to contribute from your own knowledge or experience – this is not about you having to represent your organisation. Sharing your opinion is voluntary and if you decide not to answer certain questions, that is fine.
- The main thing we are interested in is to get a sense of what the current picture is of service provision for women affected by issues in relation to any of the themes of substance use, homelessness or gender-based violence in the city and to get a sense of what, if any, are the areas for future development and training that staff identify.

Before we start the discussion group, we'll ask you to give your consent for the discussion to be audio-recorded (voices only). These recordings will then be typed up and anonymised. Only the anonymised information will be used for the analysis. The original recordings will be deleted.

Appendix 3 - Information sheet for service users

Participant Information Sheet for Service Users

A Gendered Approaches to Service Delivery and Design – Listening to Women's Views about Services in Dundee

You are invited to take part in a research project. Before you decide whether or not you would like to participate it is important that you read the information provided below. This will help you to understand why and how the research is being carried out and what participation will involve. Please let the researcher who gave you this information know if anything is unclear or you have any questions.

If you do not wish to take this information away with you, but would like it to be kept safely at the organisation you attend, please let the researcher know and we will arrange for this to happen.

Who is conducting the research?

Researchers in the School of Social Sciences at the University of Dundee are conducting the research. Marisol Lopez (m.j.lopez@dundee.ac.uk) is the researcher for this part of the project, and the lead researcher is Fiona Smith (f.m.smith@dundee.ac.uk).

Who is funding the research?

This research is funded by a grant which Dundee Women's Aid received to undertake this research from the Scottish Government Challenge Fund. University of Dundee has been commissioned by Dundee Women's Aid to undertake this research for them.

What is the purpose of the research?

This study aims to look at what women's views are on the services they use in Dundee and what could be done to improve them. We will also be speaking to staff who provide services in different organisations to see what their ideas are too.

Why have I been invited to take part?

You have been contacted because you use, or have used services which are related to some aspects of homelessness, substance use, or violence against women. The researchers have not been given any information about you or your particular story and we will not ask you about this.

Do I have to take part?

No. You can choose to take part or choose not to take part. If you choose to take part you can stop the study at any time. You do not have to give a reason for not taking part or for stopping. Whether you

take part or not will not change the support you receive at this organisation or from any other organisation.

What will happen if I take part?

The study will involve a conversation with a researcher in a small group of other women who use or have used your organisation's service. The conversation will normally take place at your organisation, but if a different location is arranged, we will make sure you know where and that the location is suitable for everyone. You will be asked about your experience of the organisation's services, what you like, and what you think could work better. We will also ask you what you think about other services in Dundee if you have used other ones. This conversation will be audio recorded.

Are there any risks in taking part?

We will deliberately not ask you or the other people taking part about your own personal story. We will focus the discussion on what you think about the services, what works well for you and what your ideas are about what would make them better. We will also ask everyone in the group not to talk about things that might be difficult for other people in the group to deal with.

However, although you will not be asked about them directly, there is always some risk of difficult or sensitive topics coming up in the conversation. You can refuse to answer any questions which you feel uncomfortable with and you can stop at any time without explanation. You can also ask the group to take a break and then re-start the conversation.

What are the possible benefits of taking part?

The findings will be used to inform future decisions about policy and service provision for women who use services across Dundee.

Will my taking part in this project be kept confidential?

Yes. The staff at your organisation may know that you have taken part, but they won't know what you have said. In a group conversation, the other members of the group will know what you said. Everyone in the group is asked to agree to respect each other's views, and not share anything outside of the group. However, you are asked to carefully consider what you share, and only talk about what you are comfortable with the group knowing. You are asked not to tell other people who else was in your interview, or anything you have heard.

This project specifically aims to understand your experiences of using the services of your organisation and we ask you not to disclose any illegal activity. If you tell us about any harm or risk of harm to a child or vulnerable person we will need to tell the organisation staff and they will follow their normal reporting procedure. We will tell you if this happens.

What will happen to the information I provide?

Following the interview, we will transcribe it and remove any names or places you have mentioned. You will be given a pseudonym so nobody will know the identity of who said what. The transcript will be encrypted, password protected and stored on Box, a secure online system, at the University of Dundee. Only the immediate research team will be able to read the transcripts. Any paper documents containing

your personal details (i.e. signed consent forms) will be kept in a locked drawer and securely destroyed after the completion of the project.

The findings will be used for a report, workshop and other research outputs. You will not be identifiable in any of these outputs. Some direct quotes may be used but nobody will know it was you that said it.

Data Protection

The personal data that will be collected and processed in this study are the signed consent form, transcribed interview and audio recording.

The University asserts that it is lawful for it to process your personal data in this project as the processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. The University of Dundee is the data controller for the personal data processed in this project

The University respects your rights and preferences in relation to your data and if you wish to update, access, erase, or limit the use of your information, please let us know by emailing Fiona Smith (f.m.smith@dundee.ac.uk). Please note that some of your rights may be limited where personal data is processed for research, but we are happy to discuss that with you. If you wish to complain about the use of your information please contact the University's Data Protection Officer in the first instance (email: dataprotection@dundee.ac.uk). You may also wish to contact the Information Commissioner's Office (https://ico.org.uk/).

You can find more information about the ways that personal data is used at the University at: https://www.dundee.ac.uk/information-governance/dataprotection/.

Is there someone else I can complain to?

If you wish to complain about the way the research has been conducted please contact the Convener of the University Research Ethics Committee (https://www.dundee.ac.uk/research/ethics/contacts/).

Appendix 4 - Informed consent form for service users

University of Dundee

Informed Consent for

A Gendered Approaches to Service Delivery and Design – Listening to Women's Views about Services in Dundee[5]

	Yes	No
1. Taking part in the study		
I have read the Participant Information Sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	☐	☐
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time during data collection, without having to give a reason.	☐	☐
I understand the interview will be audio recorded and consent to this.	☐	☐
I understand that taking part in the study involves discussion of sensitive topics as potential risk.	☐	☐
2. Use of the information in the study		
I understand that information I provide will be used for a summary report, workshop and other research outputs.	☐	☐
I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the study team.	☐	☐
I agree that anonymised direct quotes can be used in research outputs.	☐	☐

3. Signatures

_____ _____ _____

Participant's Name Participant's Signature Date

By signing above, you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

_____ _____ _____

Name of Researcher Signature of Researcher Date

4. Study contact details for further information

For further information contact researcher, Marisol Lopez (m.j.lopez@dundee.ac.uk) or lead researcher, Fiona Smith (f.m.smith@dundee.ac.uk)

[5] This document is adapted from the UK Data Service Template Form April 2018 retrieved from https://www.ukdataservice.ac.uk/manage-data/tools-and-templates.aspx

Appendix 5 - Information sheet for staff

University of Dundee

Participant Information Sheet for Service Provider Staff

A Gendered Approaches to Service Delivery and Design – Listening to Service Staff about Gender-Specific Service Provision in Dundee

You are invited to take part in a research project. Before you decide whether or not you would like to participate it is important that you read the information provided below. This will help you to understand why and how the research is being carried out and what participation will involve. Please let the researcher who gave you this information know if anything is unclear or you have any questions.

Who is conducting the research?

Researchers in the School of Social Sciences at the University of Dundee are conducting the research. Marisol Lopez (m.j.lopez@dundee.ac.uk) is the researcher for this part of the project, and the lead researcher is Fiona Smith (f.m.smith@dundee.ac.uk).

Who is funding the research?

This research is funded by a grant which Dundee Women's Aid received to undertake this research from the Scottish Government Challenge Fund. University of Dundee has been commissioned by Dundee Women's Aid to undertake this research for them.

What is the purpose of the research?

This study aims to look at services Dundee for women across the sectors of gender-based violence, homesslessness and substance use to look at examples of good practice, consider what could be improved and to find out what training or staff development would help with this. We are speaking to frontline and management staff in a range of organisations. We are also seeking to hear the experiences and views of women using services in these sectors across the city.

Why have I been invited to take part?

You have been contacted because you are a staff member (whether employed or voluntary) in an organisation that provides services related to some aspects of homelessness, substance use, or gender-based violence, and that provides those services either specifically to women, or to women as part of a wider client group.

Do I have to take part?

No. Even if you have been asked to participate in the research through your work, you can choose to take part or choose not to take part. If you choose to take part you can stop the study at any time. You do not have to give a reason for not taking part or for stopping. Whether you take part or not will not be reported to the organisation you work for.

What will happen if I take part?

The study will involve a conversation with a researcher in a group of staff from other organisations around the city (there will be separate ones for staff in managerial positions and for more 'frontline' staff). The conversation will normally take place at the meeting space in Dundee Women's Aid, or another public meeting space that has been arranged with you and the other participants before the event. You will be asked about your experience of providing services in your organisation, what you think works well, and what you think could work better. You will only be asked to give your own opinions and reflect on your own experiences. You will not be asked to represent your organisation. This conversation will be audio recorded.

Are there any risks in taking part?

The discussion will focus on aspects of service delivery and the ideas and experience of the participants about how to improve such service delivery in the future. We will not ask you or the other people taking part about any personal information, and we will not ask you to discuss any of the information of your clients/ service-users. We will focus the discussion on what you think about the services, what works well for you and what your ideas are about what would make them better.

However, there is potentially a small risk of difficult or sensitive topics coming up in the conversation. You can refuse to answer any questions which you feel uncomfortable with and you can stop at any time without explanation.

What are the possible benefits of taking part?

The findings will be used to inform future decisions about policy and service provision for women who use services across Dundee.

Will my taking part in this project be kept confidential?

Yes. Some staff at your organisation may know that you have taken part if they have helped to facilitate recruitment for the discussion but they won't know what you have said. In a group conversation, the other members of the group will know what you said. Everyone in the group is asked to agree to respect each other's views, and not share anything outside of the group. However, you are asked to carefully consider what you share, and only talk about what you are comfortable with the group knowing. You are asked not to tell other people who else was in your interview, or anything you have heard.

If you tell us about any harm or risk of harm to a child or vulnerable person we will need to tell the relevant organisations and they will follow their normal reporting procedure. We will tell you if this happens.

What will happen to the information I provide?

Following the interview, we will transcribe it and remove any names or places or organisations you have mentioned. You will be given a pseudonym so nobody will know the identity of who said what. The transcript will be encrypted, password protected and stored on Box, a secure online system, at the University of Dundee. Only the immediate research team will be able to read the transcripts. Any paper documents containing your personal details (i.e. signed consent forms) will be kept in a locked drawer and securely destroyed after the completion of the project.

The findings will be used for a report, workshop and other research outputs. You will not be identifiable in any of these outputs. Some direct quotes may be used but nobody will know it was you that said it.

Data Protection

The personal data that will be collected and processed in this study are the signed consent form, transcribed interview and audio recording.

The University asserts that it is lawful for it to process your personal data in this project as the processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller. The University of Dundee is the data controller for the personal data processed in this project

The University respects your rights and preferences in relation to your data and if you wish to update, access, erase, or limit the use of your information, please let us know by emailing Fiona Smith (f.m.smith@dundee.ac.uk). Please note that some of your rights may be limited where personal data is processed for research, but we are happy to discuss that with you. If you wish to complain about the use of your information please contact the University's Data Protection Officer in the first instance (email: dataprotection@dundee.ac.uk). You may also wish to contact the Information Commissioner's Office (https://ico.org.uk/).

You can find more information about the ways that personal data is used at the University at: https://www.dundee.ac.uk/information-governance/dataprotection/.

Is there someone else I can complain to?

If you wish to complain about the way the research has been conducted please contact the Convener of the University Research Ethics Committee (https://www.dundee.ac.uk/research/ethics/contacts/).

Appendix 6 - Informed consent form for staff

Informed Consent for Service Provider staff

A Gendered Approaches to Service Delivery and Design – Listening to Service Staff about Gender-Specific Service Provision in Dundee [6]

	Yes	No
1. Taking part in the study		
I have read the Participant Information Sheet, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.	☐	☐
I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time during data collection, without having to give a reason.	☐	☐
I understand the interview will be audio recorded and consent to this.	☐	☐
I understand that taking part in the study involves discussion of sensitive topics as a small potential risk.	☐	☐
2. Use of the information in the study		
I understand that information I provide will be used for a summary report, workshop and other research outputs.	☐	☐
I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the study team.	☐	☐
I agree that anonymised direct quotes can be used in research outputs.	☐	☐

3. Signatures

_____	_____	_____
Participant's Name	Participant's Signature	Date

By signing above, you are indicating that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

_____	_____	_____
Name of Researcher	Signature of Researcher	Date

4. Study contact details for further information

For further information contact researcher, Marisol Lopez (m.j.lopez@dundee.ac.uk) or lead researcher, Fiona Smith (f.m.smith@dundee.ac.uk)

[6] This document is adapted from the UK Data Service Template Form April 2018 retrieved from https://www.ukdataservice.ac.uk/manage-data/tools-and-templates.aspx

Appendix 7 - Focus group questions for service users

Initial practicalities

- Ensure that everyone has seen and understood the participant information form. Talk through the information there again to ensure everyone understands.
- AND that they have understood and signed off the Participant Consent form.
- Explain that if anyone wishes to stop at any point, that is fine. We can take a break. Remind everyone that the discussion will NOT affect people's access to services in any way and that everything that is recorded will only be used anonymously.
- You can decide to not answer a particular topic, if you wish.
- Remind everyone, that we will not be asking about people's own specific circumstances. Rather the main thing we are interested in is women's opinions about the service here – and more widely in the city. About what is good and what would make it better for them or for other women.
- Remind everyone that there is also someone on hand from the organisation if they have any issues or questions that come up in the discussion.

Topics for discussion

- Start by people introducing themselves – first names only required.
- Thinking about the particular service where the meeting is taking place:
o Can you start by telling us about what you think people get out of coming here?
o What are the ways it helps people?
o Are there any things that would be good to add to the service? Or to expand it?
o Do you think some people might feel awkward about coming here in the first place? If so, what do you think might be some of the things that make people feel like that?
o How do people find out about the service in the first place? Do you think it could be better known? What would be helpful to make more people aware of it?
o Are there things that could make the service easier to use? (Location, costs, knowledge, times of service being open, other issues…)
- If the service is one which is focused specifically on women – explore these topics (otherwise go to points below):
o What difference does it make that this service is aimed particularly at women?
o What things do you think women get from this service?
o Do some women need different things compared to other women?
- If the service is on focused on a wider group of service users – ask these topics:
o Thinking about the needs of women specifically, when they use this service –
o Do you think women need particular things from this service?
o Do you think that women's needs are taken in to account?

o Are there specific things that you think might make (some) women less likely to want to use this service?
o Or are men be less likely to use it?
Thinking about services you have used overall in Dundee – either this one, or other ones:
o What is it that makes the experiences of using services positive - e.g. supportive, understanding, women-only, expert help, timely help, low threshold/costs, accessible, friendly ….?
o And what are the things that shape negative experiences of services? – costs, fragmented services, feeling uncomfortable, wrong time of day, location etc.
- Moving on finally to think about the main things that you think would improve services for women in Dundee …
o What kinds of services would you like to see for women?
o Would you prefer different services in one place? Or is it better to have them in various places around the city?
o Are there gaps in the services that are available?
o Are there gaps in the ways services are relevant for women's needs?
o Are the needs of specific groups of women taken in to account? If so, how. If not, what are the gaps?
- Final thanks. Remind about pointers to service user support.
- Check with host organisation that participants' travel costs and "thank you" vouchers are in process (most organisations will invoice DWA for costs)

Appendix 8 - Focus group questions for staff

Initial practicalities

- Ensure the formal consent form process is completed.
- Explain the focus group process. Everyone's voice is important. We also agree to confidentiality among the participants – please do not discuss the topics here outside the group.
- Explain that even if you were sent by work, you don't have to answer any specific questions if you are not comfortable about this. Also, although we'll ask you to say what organisations you come from so we have an overview, all the answers will be anonymised and we won't be reporting on what specific people said about specific organisations. If you have any worries, you can also decide not to answer any of the particular questions discussed.
- The main thing we are interested in is to get a sense of what the current picture is of service provision for women affected by issues in relation to any of the themes of substance use, homelessness or gender-based violence in the city and to get a sense of what, if any, are the areas for future service development and training.
- You are only being asked to contribute from your own knowledge or experience – this is not about you having to represent your organisation.

Topics for discussion

· Start by people introducing themselves and say what organisation they come from.
- Let's start then by thinking about what your particular organisation provides in terms of services for women.
o To what extent would you say that your organisation specifically focuses its services on women? Or are they part of a wider service-user group?
o In the areas of substance use, gender-based violence and/or homelessness – what are some of the ways these different issues intersect among your service users?
o Do these affect women in particular ways?
o How does this affect how your organisation provides services? (If at all)
- Thinking about the provision of services to women in the groups of service users we have been discussing, from your perspective:
o What are some of the examples of where this might be working in positive ways?
§ What are some of the examples of good practice? Or working effectively?
§ What are the key features that you think are important here in making the services work well for women in these groups of service users?
o What are the barriers which come up in trying to make the service provision more effective or appropriate for the client group involved?
§ To what extent are these issues which are about the ways services are being provided? About the nature of the client group? About other issues (e.g. impacts of benefits system changes)?

§ How, if at all, has your organisation tried to address this (or worked with other organisations to do so)?
o Are there specific gaps in service provision which could usefully be addressed which would help?
- Moving to consider how Dundee as a whole might move forward to improve the service provision and the outcomes for the women who are service users in these groups:
o What are some of the key changes you think would help?
o In terms of how services are delivered - what are the models of service provision which you think could be more effective in future?
o What are the areas of cooperation/partnership which might be working well and what might need improved?
o What support do you think staff in your organisation would need to help with this? What kinds of training would be useful on this?