

Guest editorial

Joana Sharpen

Motherhood and multiple disadvantage

When considering issues related to dual diagnosis and motherhood, it is crucial to view them through a gendered lens. Substance use and mental health are often described as wider forms of “multiple disadvantage”, along with domestic and sexual abuse, homelessness, criminal justice involvement and poverty. Research shows us that these issues often intersect:

- One in every 20 women have experienced extensive physical or sexual violence and abuse across their life course (compared to one in every 100 men).
- Of these women, more than half have a common mental health condition, one in five have been homeless and one in three have an alcohol problem ([Scott et al., 2016](#)).
- Up to 50 per cent of women with a dual diagnosis have experienced sexual abuse ([Royal College of Psychiatrists, 2002](#)).

They don't see addiction as a coping strategy to cope with mental health and other issues. When mental health treatment starts, it's easier to cope with addiction as you don't need to self-medicate (Woman with lived experience).

As well as gender, other issues such as a woman's race/ethnicity, immigration status, sexuality, socio-economic position and experiences living with disability, all impact experiences of multiple disadvantage ([AVA and Agenda, 2018a, 2018b](#)). In addition, many women experiencing multiple disadvantage will be mothers, and will have had varying experiences of children's social care involvement.

AVA (Against Violence and Abuse) has produced several pieces of research on women facing multiple disadvantage and their experiences of accessing services. In 2017, AVA and Agenda published *Mapping the Maze*, which provided a broad picture of the support that homelessness, substance use, mental health and criminal justice services are providing to women.

The research found that in only 19 areas of England and Wales (out of 173) were there services for women that address all of the following issues: substance use, mental health, homelessness, offending and complex needs. Most services operated in silos (i.e. substance use and mental health services) which resulted in women being passed around between services, often not meeting the threshold for many of them, due to their other intersecting issues. There was a postcode lottery for support available but more than a quarter of all support for women facing multiple disadvantages was for pregnant women or those with a young baby. In terms of gender specific support; Less than half (49.0 per cent) of all local authorities in England and only five unitary authorities in Wales (22.7 per cent) had substance use support specifically for women and 104 English local authorities and five Welsh unitary authorities provide support for women experiencing mental health problems. Similarly, for both dual diagnosis issues, the most common forms of women specific services were for pregnant women or new mothers.

Jumping Through Hoops ([Sharpen, 2018](#)), explored the experiences of local areas across the country that are seeking to bring services together to develop a more coordinated

Joana Sharpen is the Director of Policy and Practice, AVA (Against Violence and Abuse), London, UK.

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response for individuals facing multiple disadvantage. Many practitioners interviewed mentioned that gender is not taken into account by services when planning provision for women and that there needs to be more recognition that women still experience gender discrimination that prevents them from accessing some services. During the research, it became apparent that women with lived experience and service providers often had divergent views on women's experiences, how these differ from men, and how this affects their support needs.

Two main themes emerged relating to women's experiences and how services responded.

Trauma

For the women in this study, the main trauma they referred to was abuse, namely child sexual abuse or domestic and/or sexual violence. Many women had experienced early developmental trauma which provided an added layer of complexity when added to their experiences in adulthood. Women frequently described a pattern of experiencing abuse, becoming homeless and using substances to cope, potentially becoming involved in criminal behaviour or prostitution and developing mental health issues. They reported that the impacts of trauma can make it feel impossible to cope with the additional barriers and obstacles posed by other complex needs, and indeed those posed by services themselves.

A common narrative across all the focus groups was the feeling that services can often re-traumatise women by the lack of joined up approaches, causing them to constantly re-tell their stories to multiple practitioners. One woman described services as feeling like "another abuser", taking control of her again. The women felt that a failure to understand trauma and its impact on current behaviour and presenting needs, led to ineffective support.

Children

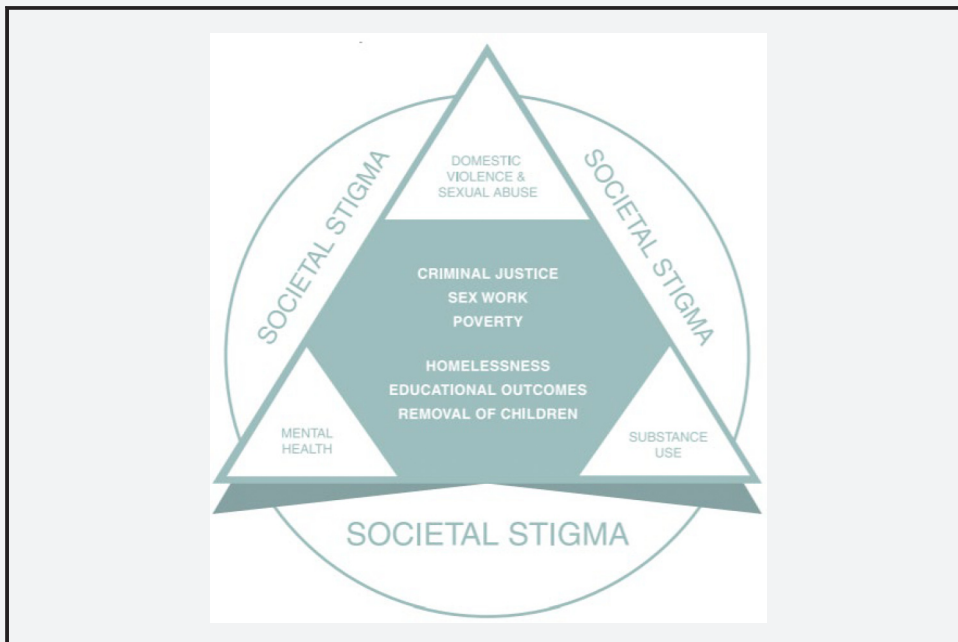
The majority of women interviewed had had children removed. Many of these women had been teenage mothers and had previously been in care themselves. Where children had been removed, this additional layer of trauma and grief often led to internalised shame, guilt and a sense of not fulfilling societal expectations of what it means to be a woman (i.e. a mother, a caretaker and a home-maker). This became yet another form of trauma and could lead to more issues relating to mental ill health and substance use.

The Commission on women facing domestic and sexual violence and multiple disadvantage (2018) was established by AVA (Against Violence and Abuse) and Agenda, the alliance for women and girls at risk. It was funded by the Lloyds Bank Foundation of England and Wales. The Commission was established to evidence the connections between women's experiences of domestic and sexual violence and multiple disadvantages, and to fill a vital gap in the current response to their needs. The Commission involved a national call for written evidence, seven oral evidence sessions, a community of practice of 35 professionals and 13 volunteer peer researchers, all women with lived experience of abuse and multiple disadvantages.

As part of the peer researcher training, the women developed a model to define multiple disadvantages. This clearly shows the three most common experiences being domestic and/or sexual abuse, mental ill-health and substance use. Other outcomes that intersected with these experiences were in the centre, surrounded by a layer of social stigma which left them feeling further trapped and labelled as problematic, complex, chaotic, damaged or harmed (Figure 1).

The peer researchers interviewed 29 other women with lived experience of abuse and multiple disadvantage and co-produced the report *Hand in Hand* (AVA and Agenda, 2018a, 2018b). 38 per cent of women specifically mentioned being diagnosed with some form of mental health issue (however, all women clearly described the traumatic impacts of abuse);

Figure 1



30 per cent disclosed using substances, with cocaine and heroin being the most common. Fewer women mentioned using alcohol with 13 per cent raising this. However, some women mentioned parents' or partners' problematic drinking negatively affecting them. 25 per cent of women had experienced some form of social services involvement in relation to their children:

Later on, my mental health suffered, I suffered for years with depression, I had counselling at school. I started experiencing flashbacks, when I would feel like I was being raped again, things like that. My physiologist said it was PTSD. When I was 29, after a breakup of a relationship, after lots of drug taking, recreational drugs, I was diagnosed with bi-polar disorder. I ended up having a total psychotic breakdown and being hospitalised, I got released after three years (Woman with lived experience).

The issue of dual diagnosis was common for the women in this study, which acted as a further barrier to helping them access the support they needed. Mental health and substance use practitioners were not routinely enquiring about experiences of domestic and/or sexual abuse, despite the significant overlap between these issues. An understanding of how trauma manifests in behaviour, in addition to how to respond appropriately, is crucial for any service attempting to support women who experience these issues:

At 15 I got diagnosed with anxiety and depression. I started smoking weed at 13 which didn't help but I just carried on, trying to cope. I was with CAMHS when I got diagnosed, I was expecting them to wave a magic wand. It took me six months to realise I was the wand and would have to help myself. I'd just grasped that when they transferred me to the Adult MH team at 18, they wanted me to stop smoking weed for six months before they would see me. I did that, but I would see somebody different each week, it didn't work for me, only monthly appointments, I went to three appointments, each time, somebody different (Woman with lived experience).

Despite nearly half of the interviewees having experience of using substances, there were very few mentions of actual substance use support services. There was a view that professionals were not noticing the link between trauma and addiction and how substances are often used as a coping strategy for dealing with abuse and violence. Women who use

substances often face significant social stigma (as referenced in the diagram above), this can result in women being disinclined to access services, and as a result, less is known about the prevalence and patterns of women's substance use or their treatment needs:

I got introduced to drugs because I started drinking because my daughter was taken into care. The drugs started after that. One of my friends was a heroin addict. I would go to his house because my family had abandoned me, and I had nowhere to go (Woman with lived experience).

As with previous research, motherhood was a common theme with pregnancy (already associated with an increase in domestic abuse) often a determining factor in realising abuse and deciding whether to leave. However, this was balanced with the fear of the response of services, with so many women having had poor experiences of previously being in care themselves. Where women were able to leave with their children, our peer researchers found that the lack of specialist support for children, as well as a lack of access to childcare, created further barriers for mothers who need to attend appointments and meetings in order to access support. The assumption that children do not require post crisis support ignores the on-going repercussions of abuse and trauma which can last for years.

Recommendations for services

This paper has briefly summarised some of the key themes relating to dual diagnosis and motherhood from AVA's recent research. Each of these reports concluded with recommendations for improved practice, some of which are shared below:

Importance of experts by experience. The most dominant theme across the research reference above was the value in having people with lived experience involved in the design and delivery of services. This helps with engagement with services, women feeling understood and staff developing an enhanced understanding. Services should be encouraged to offer paid employment opportunities to women with lived experience.

Women only spaces. All women should be able to access appropriate women specific, trauma-informed services as a priority, particularly in spaces that are currently failing to meet women's needs such as substance use services. Childcare should be provided to enable women to attend appointments.

Multi-agency support. Services should work collaboratively to break down service silos and offer person-centred, holistic support for women from diverse backgrounds, including through one-stop-shops, drop-in services and co-location of professionals.

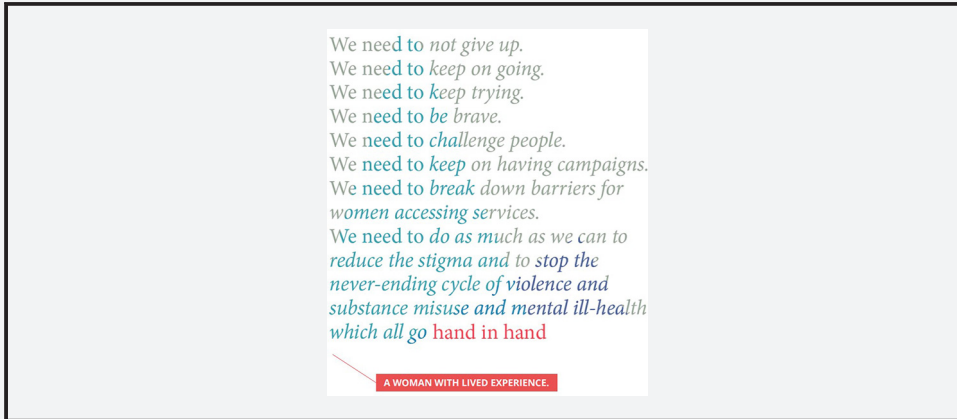
Staff training. Staff working with women experiencing multiple disadvantage need skills, knowledge and awareness of the issues in order to provide effective support. As well as training on relevant topics, staff must build relationship skills as the overall element of support that women valued more than anything was empathy:

It's about professionals having the ability to treat you in a human way [...] to show empathy, despite whatever their personal feelings may be, that shouldn't ever be evident in your relationship or engagement with the person you are working with (Woman with lived experience).

AVA offer training on routine enquiry, trauma informed approaches and working with women and children affected by domestic and sexual abuse - <https://avaproject.org.uk/training/#Training>

Trauma-informed support. Trauma-informed practice is the most effective model of support for survivors facing multiple disadvantages. Essentially this involves a change in ethos from 'what is wrong with this person?' to a strengths based approach of 'what has happened to this

Figure 2



person?’ and is achieved via training, culture and environment that both prioritises understanding the impact of trauma on those that they are working with, but also on staff themselves who may be affected by secondary trauma (Figure 2).

References

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Corresponding author

Joana Sharpen can be contacted at: joana.sharpen@avaproject.org.uk