Case by Case:

Refuge provision in London for survivors of domestic violence who use alcohol and other drugs or have mental health problems

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solace women's aid

AVA Stella Project

Acknowledgements

The idea for this research flowed from conversations among a small number of professionals who actively work towards improving service responses to women who experience multiple disadvantages in their life, namely domestic and sexual violence, problematic substance use and mental ill-health. Understanding that getting a better picture of refuge provision for this particularly marginalised group of women was vital, the group undertook this research on top of an already busy work schedule.

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“The tragic irony is that women who sustain the most damage are those for whom the least support and services exist. They, and their lives, are complicated, difficult and do not ‘fit’ into the way services have developed.” (Kelly & Lovett, 2005)

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Executive summary

Not long after the inception of the Stella Project in 2002, a survey of Women's Aid refuges found that just 13% would always accept women with mental health or drug or alcohol needs, while another 48% said that they would sometimes take these women, depending on other factors (Barron, 2004). Over the intervening decade, we have witnessed greater recognition of the intersections between the issues and seen many examples of increased partnership working across the domestic violence, substance use and mental health sectors.

Despite the many positive changes, however, one of the most persistent concerns raised by practitioners is the lack of refuge space for women who are affected by substance use and/or mental ill-health. This study aimed to provide an updated picture of access to refuge services for this group of survivors. This was achieved through:

- Telephone or face-to-face interviews with London-based refuge service providers (n=30) about their policies on accommodating women with drug and alcohol and/or mental health problems.
- Freedom of information requests to all London boroughs (excluding the City of Westminster) in April 2012 and August 2013 about the number of women with drug and alcohol and/or mental health problems accommodated in refuges in the borough in the previous twelve months.

The key findings were:

- Most boroughs (n=18) include some level of requirement to support women with drug and alcohol and/or mental health problems within service specifications for refuge provision. This sometimes a specific requirement or a more generic 'expectation' that all survivors would be supported and that problematic substance use or mental ill-health would not constitute an absolute exclusion criteria.
- Only two boroughs actively exclude women with drug and alcohol and/or mental health problems from the refuges they fund.
- Most refuges fulfil the requirements in their service specification by operating a 'case by case' basis for assessing the needs and risks of potential service users.
- Many refuges do, however, operate a partial blanket policy relating to certain types of substance use and/or mental health problems, most commonly women using opiates (including methadone) and those who have been diagnosed with schizophrenia, autism spectrum disorder or dementia.
- Only seventeen (53.1%) of 32 local authorities were able to provide full or partial information on the number of domestic violence survivors accommodated by their refuge providers in the past year who had identified problems with drugs and/or alcohol and mental health needs.
- In 2012 and 2013 these 17 boroughs accommodated, at most, 239 women with identified problems in relation to alcohol or drug use or mental health.
- Only 14 boroughs could provide information about the number of women with drug and alcohol and/or mental health problems were refused access to refuge accommodation in their borough.

Key recommendations include:

- Service specifications for domestic violence refuge provision should include specific provisions in relation to supporting women who have substance use problems and mental health problems.
- Contract monitoring of refuges for survivors of domestic violence should include:
    - The number of survivors accommodated who have intersecting needs in relation to problematic substance use and mental health.
    - The number of survivors with these needs that have been refused from refuge accommodation and the reason for the refusal.
- Funding for all refuge services should include the costs of capacity development in order to improve existing provision, including staff training, development of policies, procedures and partnerships and equipment such as sharps bins and locked boxes.
- Funding for specialist workers and/or more refuge spaces for women with substance use and/or mental health problems should be made available. This could include pan-London commissioning of specialist substance use or mental health support workers that can float between all refuges in London.
- Investigate options for move-on accommodation for single women, as limited access to alternative temporary or longer-term accommodation is a barrier to accessing refuge services.
- Develop service level agreements (SLAs) between refuges and substance misuse and mental health services to promote stronger partnership working and clearer pathways between agencies.
- All service providers should have a clear policy on working with women who have these particular support needs, even if there are two separate policies covering drugs/alcohol and another for mental health.
- Service providers should introduce a more comprehensive approach to assessing the risks associated with problematic substance use and mental ill-health, rather than using substance type or diagnosis as a means of deciding whether a women is accepted into the refuge. This will ensure that a ‘case by case’ approach is not used to discriminate against this group of survivors.
- Training for all refuge staff and managers who are involved in the assessment of referrals and supporting service users who have substance use and/or mental health problems.

Introduction

It is now ten years since AVA, then the Greater London Domestic Violence Project, and the Greater London Drug & Alcohol Alliance (GLADA) established the Stella Project to address gaps in service provision for survivors and perpetrators of domestic violence who use substances problematically. The Stella Project was formed to find positive and creative ways to work towards more inclusive service provision, including in the area of temporary accommodation for women fleeing violence. This report is authored in partnership with Solace Women's Aid, who recognised that many domestic violence refuges did not have sufficient resources to offer a service to women with additional needs and developed a specialist drugs and alcohol service to increase access into refuges across London.

Since the Stella Project's inception in 2002, we have seen many examples of increased partnership working across both sectors and greater recognition of the intersections between domestic violence and problematic substance use. We have also seen an increase in specialist posts created to jointly address both areas of need together, although many of these posts have been lost in budget cuts over the past few years. However, despite many positive changes in responses to domestic violence survivors who use substances and have mental health problems, the research presented here demonstrates that there remains some longstanding issues that are yet to be addressed.

In a 2002/03 survey of Women's Aid refuges, Barron found that just 13% would always accept women with mental health or drug or alcohol needs, while another 48% said that they would sometimes take these women, depending on other factors (2004:15). Back then, at the Stella Project launch event, Marai Larasi, then Director of Hackney Women's Aid and now Director of Imkaan, urged attendees:

> *Stop discriminating! Stop being judgemental! Stop making excuses! Feel the fear and do it anyway. Take women with substance misuse issues into refuges – work with them,,, If a substance misuse agency ignores a woman's safety, she may never get sober. If we ignore her using as domestic violence providers, she may never be safe. Can we really afford to keep taking that risk?* (cited in GLDVP, 2003).

In some respects, there have been improvements. Since 2008, Solace Women's Aid has delivered a Substance Misuse Service. The service is home to a Senior Drug and Alcohol Worker whose primary objective has been to increase access to refuges for women who use substances problematically. With funding from London Councils, the worker is active across 30 London boroughs, providing support to service users with multiple needs. Much of the impetus for this research stems from her experience of trying to access support for women who experience substance use and/or mental health problems, as outlined below:

My experience – Sim Mandair, Complex Needs Worker, Solace Women's Aid

"In the four years that I have been trying to refer women with multiple needs into refuges, access has become even more limited. Often refuges will refuse women without any sort of assessment of her needs having been completed, even women with very low risk drug/alcohol use and mental health support needs are rejected. Does this mean that refuge providers believe that women

fleeing violence have only one support need?!

Statistics demonstrate the high levels of women who have substance use or mental health needs as a direct impact from the violence and abuse, so why is this knowledge not reflected in everyday refuge practice. When referring even low risk women I have come across very bad practice in refuges, I recently referred a young woman who smoked cannabis in the evening to cope with the violence she had to endure from her family, she was also prescribed medicine for her anxiety and panic attacks resulting from the abuse. Upon disclosure of the cannabis use and before I have given any significant details the response from the refuge worker was: *"We don't accept women who are using drugs as firstly there are children in the refuge and secondly we are unable to support her around this issue."*

If a full referral and risk assessment had been completed they would have identified her need as low, she only smoked cannabis in the evening and therefore her support plan could have highlighted the requirement to do this away from the refuge, she only smoked one joint a night to help her sleep and had done so for 5 years which meant her level of intoxication would be very minimal and she would be prohibited from storing any cannabis at the refuge meaning there would be no risk to the refuge or children there. In regards to providing support, this could have been facilitated through myself as the refuge was in a borough I am funded to work in, further decreasing her risk to others.

Women are often too fearful to disclose mental health and drug/alcohol use whilst in refuges resulting in them leaving without ever having accessed the relevant support. This means that once they leave refuge they are still at risk of forming unhealthy relationships due to their substance use/mental health which could have been avoided if refuges were offering more inclusive services and the support needs were identified and addressed in a more holistic manner."

More recently Solace Women's Aid secured funding for a specific complex/multiple needs service. The organisation now manages an 8-bed specialist refuge for women affected by domestic and sexual violence experiencing complex health needs. Funded by London Councils, the refuge takes referrals from across London, supporting risk-assessed women with priority mental health and substance use needs. The refuge provides a 24-hour service, including individual and group support covering safety, harm reduction and recovery from problematic substance use and mental health needs as well as addressing needs relating to domestic violence. Staff work closely with other services to deliver holistic and collaborative support prioritising the women's needs. There is also community-based outreach and advocacy for women with these additional needs, alongside specialist parenting support.

Ten years on from Women's Aid's survey, this report presents the findings of a review of the current state of refuge provision in London for women with drug and alcohol and mental health problems and highlights key areas of on-going need in developing effective responses that meet the needs of this marginalised group of women. Whilst very few boroughs reported refusing many women with substance use or mental health problems access to refuge accommodation, anecdotal evidence from domestic violence workers specialising in substance use and mental health as well as drug and alcohol and mental health services suggest that accommodation-based support for this group of survivors remains very limited. Further research is, therefore, needed to track individual women's attempts to access refuge accommodation.

Nonetheless, as a result of these findings, we hope to encourage services to move towards a more inclusive approach to supporting women in refuges who have these particular needs.

Definitions

The UK Government defines **domestic violence** as: *"any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*

- *Psychological*
- *Physical*
- *Sexual*
- *Financial*
- *Emotional*

***Controlling behaviour** is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

***Coercive behaviour** is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group."

The Stella Project defines **problematic substance use** as: *"the use of substances (such as illegal drugs, medicines or alcohol) in such a way that results in harm to the individual user or to the wider community. The range of harms includes problems for physical health, psychological health, violence, financial problems, family problems and social problems."*

This report is about the needs of a specific group of women seeking emergency accommodation, who are also experiencing problematic substance use and/or mental health problems. These women are often referred to as having **"complex needs"** and many respondents themselves used this term. However, we have deliberately chosen not to use the term "complex needs" in this report, other than when quoting respondents. This decision reflects our position that all women fleeing domestic violence have a range of different needs and require different levels of support, regardless of whether they use substances or have a mental health problem. The PATH Project (NHS Scotland, 2008), for example, defines complex needs as "multiple interlocking needs that span health and social issues that lead to limited participation with society." We argue that using the term "complex needs" specifically in relation to substance use and mental health designates some - already marginalised - women as particularly difficult to support and often results in further stigmatisation and exclusion from services.

Furthermore, "complex needs" designates the "problem" of not accessing services with the survivor herself, rather than with the institutions and structures that should be designed to support her. Through our work, both AVA and Solace Women's Aid aim to promote an ethos of services that are flexible and adaptable to the needs of survivors, rather than requiring survivors to adapt to the needs of our services.

Aims and methodology

Aims of the research

The aims of this research were to:

1. Identify the extent of domestic violence refuge provision currently available in London to women who use substances problematically or have mental health problems.
2. Identify examples of promising practice in relation to the provision of domestic violence refuge accommodation for these women.
3. Develop recommendations for commissioners and service managers to improve access to domestic violence refuges for these women.

Methodology

Refuge service providers

There are currently 58 refuges in London. Between January and April 2012, we made contact with 30 refuges, asking them to complete a questionnaire, providing more detail about how women's access to their refuge is assessed. The questionnaire was conducted either over the phone or in person by a researcher, or was completed electronically by the service manager. Where possible, we attempted to have the questionnaire completed by the refuge manager, but in some cases the questionnaire was completed by regional managers within organisations.

The questionnaire consisted of 10 questions on current practice around accepting women into refuges who used alcohol and other drugs and 10 mirrored questions in relation to women with mental health problems. The questionnaire also included one question on dual diagnosis. A full copy of the questionnaire is provided in Appendix 2; in summary the questions covered the following areas:

- Service capacity: bed spaces; how many women with multiple needs (if any) could be housed at any one time;
- A table of the most commonly used drugs / mental health problems, with a simple tick box of "yes" or "no" stating whether the refuge would be able to accommodate a woman using that substance or with that mental health diagnosis;
- Current cross-sector partnerships and how they communicate with the mental health and substance misuse sectors;
- Whether women have to be actively engaging and progressing within their local substance misuse or mental health agency, including success and time frames, prior to acceptance;
- Eviction criteria based on mental health problems and the use of any alcohol or other drugs if survivors disengage with support services;
- Acceptance of women with a dual diagnosis of substance dependency and mental ill health.

Local authorities

In April 2012, Freedom of Information (FOI) requests were submitted to 32 London local authorities. A request was not submitted to the City of London as it does not fund its own refuge

provision. The FOI requested answers to the following four questions, submitted through www.whatdotheyknow.com:

1. What refuge provision do you fund for women fleeing domestic violence?

2. Do your service specifications for any of the refuge provision that you fund require service providers to provide access for women who have (a) problems with alcohol or other drugs; and (b) mental health problems (either diagnosed or undiagnosed[1])?

3. In the past 12 months, how many women who have: (a) problems with alcohol or other drugs; and (b) mental health problems (either diagnosed or undiagnosed); have accessed the refuge provision that you fund?

4. In the past 12 months, how many women who have: (a) problems with alcohol or other drugs; and (b) mental health problems (either diagnosed or undiagnosed); have been refused access to the refuge provision that you fund (for any reason, including that the refuge is full)?

Some local authorities were then asked to clarify their responses via email, if the information they had given was unclear. Responses were received from all 32 London boroughs to whom FOI requests were submitted, although not all were able to provide all the information requested.

The same FOI request was submitted to each London Borough (excluding the City of London) in August 2013 to identify any changes in refuge provision since the first request.

[1] Our request for information on undiagnosed, as well as diagnosed, mental health problems is based on our observation that often survivors of domestic violence display symptoms of mental health problems but have not engaged with mental health services and/or received a diagnosis.

Findings

Service specifications

As a starting point for this research, local authorities were asked whether their service specifications for any of the refuge provision that they fund require service providers to provide access for women who have problems with alcohol or other drugs or mental health problems. Over the two year period of collecting information, the majority of boroughs (n=18) provided some level of requirement – either a specific requirement or a more generic 'expectation' that all survivors would be supported and that problematic substance use or mental ill-health would not constitute an absolute exclusion criteria (see table 1).

Table 1: Service specification references to problematic substance use and mental ill-health

Borough	**Service specification includes requirement to support women with substance use and/or mental health problems?**		**Comments**
	2012	*2013*	
Barking & Dagenham	*Yes*	*Yes*	*No details provided*
Barnet	Specific	Generic	In 2012, substance use and mental health were described as 'key priority groups', whilst in 2013 they stated that all refuges accept women who have substance use or mental health problems depending on their need and risk level.
Brent	*Yes*	*No response to FOI request received*	*No details provided*
Bromley	Specific	Generic	In 2012, the intended outcomes for the refuge provider included service users with substance misuse problems or complex needs are supported to access relevant services; in 2013 the expectation is that the provider will support all service users but does not refer to any specific groups.
Camden	Specific	Specific	The 2012 service specification included reference to supporting service users to better manage their mental health and substance use. In 2013, providers are required to 'ensure that those identified with relevant need receive specialist and high-level interventions for mental health, drug and/or alcohol use.'
Croydon	Generic	*Yes*	In 2012, the only requirement was that no blanket exclusion policies were used. In 2013, no details were provided.

Ealing	No	Specific	In 2012 there were no requirements, but by 2013 one provider only accepts women with substance use or mental health problems, and the second provider accepts women with mental health problems, women on methadone and substance dependent but have not used/drank for six months.
Greenwich	Generic	Specific	In 2012, refuge provision in the borough included support for women with mental health and substance use problems. In 2013, there was specific provision for single women who use substances if they are willing to engage with support services.
Hammersmith & Fulham	Generic	Generic	In 2012, there was no specific requirement other than to accept women "[w]hose needs can be met by a low-medium supported refuge accommodation service and do not present an unmanageable risk to other women and children living in the refuge accommodation. The 2013 FOI request states that the "service specification has provision" for women with these needs (but does not provide detail) and each case should be assessed individually.
Haringey	Specific	Generic	In 2012, one refuge specifically supports women with drug and alcohol problems although it was not in the service specification. In 2013, the service specification includes 'provision for access for women who have problems with alcohol or other drugs or mental health.'
Hounslow	*Yes*	*Yes*	*No details provided*
Islington	No	Generic	In 2013, the borough stated that whilst there is no requirement in the service specification, there is an expectation that women with substance use and mental health problems will be accommodated.
Kensington & Chelsea	Generic	Specific	In 2012, the service specification includes reference to assessing needs on a case by case basis, but by 2013 this had been amended to include 'working with complex needs, i.e. alcohol/drug or mental health issues.'
Kingston upon Thames	Generic	Generic	In both years the borough reported that the service specification does not include any particular reference to substance use or mental health, but explicitly states providers should not

			operate any blanket exclusion policies.
Lambeth	*No details provided*	Generic	In 2012 no details were provided; in 2013 service providers are not allowed to operate a blanket policy excluding women with substance use or mental health problems, but at the same time there is no specific requirement to support women with these needs.
Southwark	*No details provided*	Generic	In 2012 no details were provided; in 2013 service providers are required to identify substance use or mental health problems and support access to appropriate services. This does not specifically mean women with these needs must be accepted into the refuge.
Sutton	Generic	Generic	In both years, the borough stated that the refuges are not substance use or mental health specific and referrals would be considered based on need and risk.
Waltham Forest	No	Generic	In 2013, refuges were not required to support women with these issues, but also should not operate a blanket exclusion policy.

Overwhelmingly, the information about service specifications reflects the information presented on Refuges Online and collected through the refuge survey used in this research. Namely, that in most cases, refuges consider referrals on a case by case basis and are supported to do so by the local authorities that fund them. In fact, only two boroughs (Ealing and Greenwich) reported providing refuge accommodation specifically for women with substance use or mental health problems.

As is also noticeable in table 1, a large number of boroughs provided differing information in response to this question in each round of FOI requests. This is possibly due to changes in the service specifications, but also possibly a result of varying staff completing the FOI requests and accessing differing documentation in each year.

A further eleven boroughs stated that they do not include any requirements in their refuge service specification/s in relation to supporting survivors who have problems with either substance use or mental health:

Table 2: Boroughs that have no requirements about substance use or mental health in their service specifications

Borough	**Comments**
Bexley	This FOI response stated "there is no contract in place between LB Bexley and Bexley Women's Aid for the refuge service. Funding is now via Individual Budget allocation. The Initial support period is funded for 10 weeks from entry to refuge

	then continuation of IB funding after 10 weeks is subject to a review. The refuge customer has a support contract directly with BWA."
Enfield	In 2012, the information provided indicated that assessment and support covers substance use and mental health but did not necessarily require providers to accommodate women with these needs. The 2013 request stated that substance use and mental health are 'not in the service specification to date.'
Hackney	See p.16 for further details
Havering	'No mention' of these issues in the service specification
Hillingdon	In 2013 specifically, 'the service specification is silent on access for women with substance use or mental health problems.'
Lewisham	No requirement in service specification
Redbridge	No requirement in service specification
Richmond upon Thames	No requirement in service specification
Tower Hamlets	In 2012, no specific requirement was report but cases should be assessed individually on the basis of need and risk; in 2013 the question was not answered.
Wandsworth	No requirement in service specification
Westminster	No requirement in service specification

Only Harrow[2] and Merton have service specifications that specifically exclude women with alcohol and drug problems or mental health problems:

> *Women with alcohol and drug problems are excluded from the service. Women with severe mental health problems would be referred to a specialist service that can meet their needs, however, not all women with mental health problems are excluded as there are many aspects to mental health which can range from depression through to suicidal tendencies.* (Harrow, 2012)

> *The Service Specification for Shanti whilst having exclusion criteria do not specify drugs and/or alcohol/Mental Health, so cases can be judged upon appropriateness/need/level of abuse or ill health. The Service Specification for Merton Refuge does exclude clients upon the basis of substance abuse and/or Mental Health.* (Merton, 2012 and 2013)

In 2012 - but not in 2013 - Newham also identified that their Asian women's refuge operates an exclusion policy in relation to substance use.

> *The Asian refuge specifically excludes people with drug or alcohol problems (but have no exclusion related to mental health needs).* (Newham, 2012)

[2] Harrow stated in 2012 that the service specifications for refuge services excluded women with substance use and mental health problems. They did not respond to the 2013 request so we cannot confirm if this has changed.

The FOI requests in 2012 also revealed that at least one borough changed their service specification during the tender process, removing requirements to support women who use drugs and alcohol in order to reduce the costs of provision. It is unclear whether this is an isolated incident or is indicative of a more common practice. Hackney's draft service specification, released in February 2010 for the purposes of inviting organisations to tender, included several references to the refuge accommodation being commissioned to support women with drug and alcohol support needs:

> *"[One of the main objectives of the service is to] help women to rebuild their lives including helping them to access community facilities such as drug treatment services, counselling, legal and financial advice services etc" (p. 6)*
>
> *"The Service Provider will develop a domestic violence housing related support service for vulnerable women" (p. 6)*
>
> *"No service user should be unreasonably excluded from accessing a service.... Reasonable exclusions are where... referrals are refused on the grounds of risk as a result of the outcome of a needs assessment process" (p. 8)*
>
> *"The Service provider is expected to meet the diverse needs and requirements of the client group."*
>
> *"The service must also show how it is enabling service users to achieve the National Outcomes for Supporting People... [including] The number of service users who are better able to manage their drug/alcohol use" (p. 16 & 20)*

However, Hackney's FOI response for this research indicated that there were no requirements in the service specification to support women with drug and alcohol or mental health problems. We queried this with Hackney's Procurement Officer with responsibility for commissioning refuges, who confirmed that the service specification had been changed during the tender process:

> *The spec changed during the tender process due to the cost of delivering this service... We currently fund two hostels in Hackney, one for women only but across the two we deliver 44 bedspaces for single women - we often use the hostels for women who are fleeing dv and have dependency issues as the hostels are staffed 24 hours a day and the front door is controlled by support staff thus providing increased security for the women living within the hostel setting. The cost of supporting 5 or 6 women in one house could not be met in the current tender.*

This response was broadly reiterated in 2013.

Referral criteria

The data above highlights that at least half of all London boroughs require providers of refuge accommodation that they fund to provide accommodation and support to women with substance use and/or mental health problems. In terms of the referral criteria that individual refuges themselves set, however, a different picture emerges – most commonly that women using opiates, including methadone, and those who have been diagnosed with schizophrenia, autism spectrum disorder or dementia, are excluded from refuge provision. For the most part, it therefore appears, a significant number of refuges across London do operate partial blanket policies relating to certain types of substance use and/or mental health problems. It is unclear how such blanket exclusion

criteria can be justified under the Equality Act 2010, which states that disability constitutes a "physical or mental impairment….[that] has a substantial and long-term adverse effect on [an individual's] ability to carry out normal day-to-day activities". As such, the Equality Act 2010 does cover impairment arising from mental ill-health and the use of and/or dependence on prescribed medication (but not alcohol or illicit substances).

In June 2012, of the 58 refuges in London, 36[3] stated in their referral criteria on Refuges Online that they do not accept women who use alcohol or other drugs, and 12 do not accept women experiencing mental ill-health. With the exception of the Emma Project (a specialist substance misuse refuge in Haringey), all other London refuges stated that women who use alcohol or other drugs or have mental health problems are assessed on a "case by case" basis.

By October 2013, there were 56 refuges in London, 36 of which purport to support women who drink or use drugs. Upon closer examination, however, there are inconsistencies in the service descriptions. For one refuge, for example, the service user referral criteria states, "May offer services drug/alcohol dependency support needs if actively engaged with services." Yet the exclusion criteria include women on methadone programme, which would commonly constitute engagement with a service. In addition, it is apparent that refuges in individual boroughs that are part of the same overarching service provider, i.e. Refuge and Hestia, have diverse practices in their acceptance of women with drug and alcohol support needs. Whilst this may reflect varying funding arrangements between refuges in different boroughs, it may also point to inconsistent implementation of organisational policies or a lack thereof.

The information provided on Refuges Online largely reflects the findings of this research, in that refuges are more likely to accept women with mental health problems than drug and alcohol problems. Of the 23 refuges we received responses from, only three reported that they rarely or never accept women with drug and alcohol problems (Figure 1) and all stated that they would accept women with mental health problems (Figure 2).

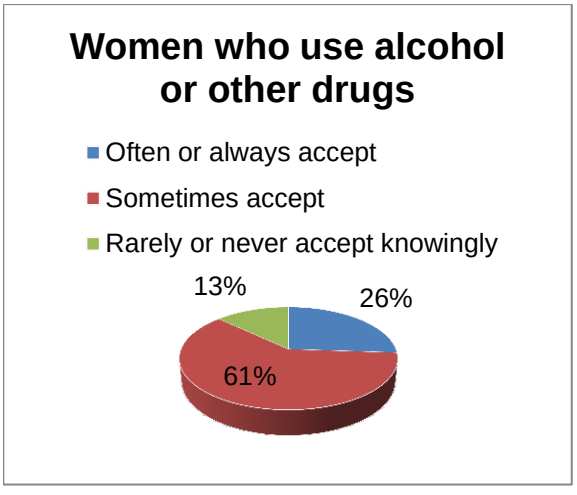

Figure 1

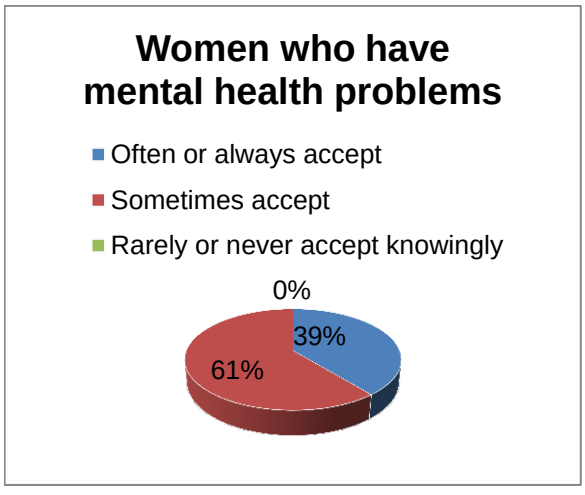

Figure 2

Whilst this paints a relatively positive picture, particularly in relation to mental health, in many cases conditions are attached. As demonstrated in Table 3 below, refuges who said that they "sometimes" accept women with substance use or mental health problems generally did not define

[3] Data captured on June 22nd 2012

specific exclusionary criteria, but rather stated that each survivor would be risk assessed on a case-by-case basis. Most commonly, refuges reported that they would exclude survivors who were currently using heroin, with several refuges stating that they would also include survivors using any opiates, including prescribed methadone. It was also common for refuges to report that survivors must be engaged with a substance misuse service prior to taking up a place in the refuge.

Refuges were much less likely to report definite exclusions in relation to survivors with mental health problems, but for those who did, they reported that they would not accept women with diagnosed Schizophrenia or Autism Spectrum Disorders. Often, refuge providers also displayed a poor understanding of specific diagnoses: for example, one refuge stated that they would only accept someone with a diagnosed personality disorder if they were “on regular medication”. There are, however, no medications currently available specifically to treat personality disorders.

Table 3: Access criteria to London refuges for women with drug and alcohol problems, mental health problems and dual diagosis, by borough

= often accept after assessment = sometimes accept after assessment **or** conditions attached = seldom **or** don't accept	**AOD** = Women who use **alcohol and/or other drugs** **MH** = Women with **mental health** problems **DD** = Women with a **dual diagnosis** of substance use and mental health problems

Borough	Type	Beds	AOD	MH	DD	Case study example (given by service provider)	Definite exclusions
Barnet	Generic		✓	✓		Woman binge drinking alcohol on a regular basis, also suffered with an eating disorder. Engaged with SWA specialist worker and sustained tenancy. Has various other support needs in addition to the ones above.	**AOD:** Women who are regular[4] users of heroin or crack. **MH:** No definite exclusions.
	Specialist (BAMER)		✓	✓			Dependant on current residents and their support needs.
Brent	Generic[5]	13	✓	✓			**AOD:** Exclude if not engaged with substance misuse service prior to entry into refuge **MH:** No definite exclusions
Bromley	Generic		✗	✓			**AOD:** Using any substances other than alcohol or prescribed methadone; exclude if not engaged with substance misuse service prior to entry into refuge. **MH:** No definite exclusions.
Camden	Generic	25	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia

[4] The term 'regular' was used by the staff member completing the survey but not clarified.

[5] Two survey responses were received from this service provider, one from the refuge manager and one from the area manager. The two responses were different and the refuge manager's responses have been used here.

= often accept after assessment = sometimes accept after assessment **or** conditions attached = seldom **or** don't accept	**AOD** = Women who use **alcohol and/or other drugs** **MH** = Women with **mental health** problems **DD** = Women with a **dual diagnosis** of substance use and mental health problems

Borough	Type	Beds	AOD	MH	DD	Case study example (given by service provider)	Definite exclusions
Ealing	Generic	12	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Enfield	Generic		✓	✓		Woman with 1 child on Subutex script[6] - linked in with local drug treatment agency for script. Drug treatment agency worked well in being flexible with the refuge. Woman diagnosed with bulimia and depression. Also used cannabis on a regular basis. Had hospital care for bulimia and under GP's care for depression. Also offered counselling for past abuse but did not engage with support. Mental health improved while in the refuge.	**AOD:** Regular users of heroin or crack. **MH:** No definite exclusions.
	Specialist (BAMER)	10	✗	✓	✗	No case studies provided: "we do not cater for complex needs"[7]	**AOD:** Using any drug except alcohol; if using alcohol, must have a treatment plan in place before entering refuge **MH:** Personality disorders, post-natal depression, PTSD, Schizophrenia, Autism Spectrum Disorders
Greenwich	Generic		✓	✓		Woman on methadone script accepted. Most women accepted suffer with depression or PTSD.	**AOD:** Exclude if not engaged with substance misuse service prior to entry into refuge **MH:** No definite exclusions

[6] A form of Buprenorphine used to treat opioid addiction.

[7] In this context, it is assumed that 'complex needs' refers to mental health and substance use and not, for example, insecure immigration status or language barriers.

✓ = often accept after assessment ✓ = sometimes accept after assessment **or** conditions attached ✗ = seldom **or** don't accept	**AOD** = Women who use **alcohol and/or other drugs** **MH** = Women with **mental health** problems **DD** = Women with a **dual diagnosis** of substance use and mental health problems

Borough	Type	Beds	AOD	MH	DD	Case study example (given by service provider)	Definite exclusions
Hackney	Specialist (BAMER)		✗	✓		Woman regularly using alcohol, use not disclosed at referral. Caused disruption in the house so referred to alternative provider as needs too high. Woman with learning disability; had a support worker. After moving in alcohol use disclosed and became aggressive and erratic. Unable to support her so moved on.	**AOD:** Women on a methadone programme; all other substances exclude if not engaged with substance misuse service prior to entry into refuge **MH:** Exclude if more than 2-3 women with mental health problems are already being accommodated in the refuge
	Generic	33	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Hammer-smith & Fulham	Generic	14	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Haringey	Generic		✓	✓			**AOD:** Regular users of heroin or crack; not willing to engage with substance misuse services **MH:** No definite exclusions.
	Specialist (sub. misuse)		✓	✓		Woman referred with 8 year history of alcohol use and methadone prescription from history of heroin use. Also used crack but did not identify this as a pressing issue. Conflicting mental health diagnoses including schizo-affective disorder, bi-polar, borderline personality disorder and schizophrenia. Also previously had 5 children removed and placed for adoption as a result of her substance use and experiences of domestic violence.	None

✓ = often accept after assessment ✓ = sometimes accept after assessment **or** conditions attached ⊗ = seldom **or** don't accept	**AOD** = Women who use **alcohol and/or other drugs** **MH** = Women with **mental health** problems **DD** = Women with a **dual diagnosis** of substance use and mental health problems

Borough	Type	Beds	AOD	MH	DD	Case study example (given by service provider)	Definite exclusions
Harrow	Generic	12	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Hillingdon	Generic	13	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Islington	Generic		✓	✓		Woman with long term alcohol dependency - had to drink every day, referred to SWA substance use worker where care plan with local substance misuse agency in place, maintained refuge space while awaiting a place in rehab and then moved on. Woman's mental health deteriorated whilst living at the refuge, resulting in legal proceedings regarding her children. Support plan put in place and risk assessment carried out weekly. Local GP provided additional support to staff. MH crisis team involved and woman had respite care with local team in addition to counselling through DV service.	**AOD:** Regular users of heroin or crack. **MH:** No definite exclusions.
Kensington & Chelsea	Generic	19	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Kingston upon Thames	Generic	15	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia

= often accept after assessment = sometimes accept after assessment **or** conditions attached = seldom **or** don't accept	**AOD** = Women who use **alcohol and/or other drugs** **MH** = Women with **mental health** problems **DD** = Women with a **dual diagnosis** of substance use and mental health problems

Borough	Type	Beds	AOD	MH	DD	Case study example (given by service provider)	Definite exclusions
Lambeth	Generic		✓	✓		Woman on a methadone programme, had a long history of use. Prior to entering refuge she had no care plan in place as had been stable on methadone for some time. She was offered SU services through SWA worker and other external services but declined. She did lapse a few times on crack. Woman diagnosed with schizophrenia 12 weeks before coming into refuge. Woman had social worker (due to children) and Community Mental Health Team with care plan in place. Woman still in refuge and doing well.	**AOD:** Regular users of heroin or crack. **MH:** No definite exclusions.
Richmond & Hounslow	Generic		✓	✓		Heavy alcohol user, not disclosed at referral, also self-harmed and mental health team was involved. Unable to support her at the refuge as risk was too high. Moved to specialist substance use refuge.	**AOD:** Must be engaged with a substance misuse service prior to entry to refuge. **MH:** No definite exclusions
Wandsworth	Generic	13	✓	✓	✓	See case study below table	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Westminster	Generic		✓	✓		Woman with 2 children; engaged well at first but became aggressive. Woman abandoned space at refuge. Social services took children into care and social worker informed refuge of woman's regular crack use. Woman suffering from PTSD, anxiety and depression, had a mental health worker, was on medication and receiving counselling. Managed risk through regular key work.	**AOD:** Must be engaged with a substance misuse service prior to entry to refuge. **MH:** No definite exclusions

One refuge provider submitted the following case study of a woman accepted into one of their refuges who was alcohol dependent and used cannabis.

Case study: supporting an alcohol-dependent domestic violence survivor in refuge

A woman made a self-referral for refuge space as was fleeing domestic violence and ended up sleeping rough for few nights. She disclosed upon referral that she was using alcohol regularly to cope with her situation but did not feel there was an issue with her intake at this point. Within the first week it became apparent that the woman was using alcohol a lot which was affecting her ability to engage with the service. This was brought up in keywork session and as agreed this was incorporated in support plan to assist her further. At this point she was adamant that she was not using any other substances and said that she had recently become dependent on alcohol. She stated that she had had some haphazard help in the past but was never confident to attend services on her own. She had been worried but was not aware of how to tackle the problem.

A referral was made to an alcohol service … staff accompanied her to the initial assessment. The woman had some difficulty with attendance but eventually started to engage in sessions without assistance. Although her consumption did not reduce she started to become aware of how much she was actually drinking through the help of drink diaries. She also developed a trust in a keyworker at the refuge as she said she had never been supported before. She also disclosed her other drug use, which was cannabis. She was informed of policies and how this may affect her tenancy if she was to use on the premises. She adhered to these rules but displayed drunken behaviour around the house which endangered her and others, such as falling down the stairs drunk and leaving cooker on.

Through regular keywork sessions and working with the alcohol agency it came to light how vulnerable this client was... She was assisted further with establishing contact with her daughter and attending parenting classes as well as enrolling on courses to occupy her days. She was keen to gain new life skills which she never had and also started to develop relationships with other people who were not alcohol dependent. She has since requested to be moved to supported accommodation as she became more aware of her own vulnerability and how much she had gained through regular support.

Refuges also often gave conflicting information, perhaps reflecting a lack of understanding about substance use and mental health. One refuge, for example, stated that they would accept survivors experiencing depression, but not survivors experiencing post-natal depression. Several refuges stated that they accept women who are using prescribed medications, but exclude women who are using methadone, which is a prescribed medication. Furthermore, information provided by refuges was not always consistent with the information provided on Refuges Online, nor indeed in line with the provision with their own service specifications.

A summary of the referral criteria provided refuges and that stated in the local authority FOI requests can be found in appendix 1 on p.48.

Assessing risk

As illustrated in Table 3, the majority of refuges in London that accept women with substance use or mental problems do so on a case-by-case basis. For this reason, we asked refuges whether they have a standard risk assessment form in relation to substance use or mental health needs.

Surprisingly, of the 23 refuges surveyed that say they accept women on a case-by-case basis, only eleven state they do not have a standard risk assessment tool in place. It is quite possible, however, that the 'standard risk assessment' refers simply to the inclusion of generic questions about substance use or mental health, e.g. *Do you have any drug or alcohol problems?*, into the standard risk assessment tool the refuge uses rather than an in-depth risk assessment that would enable frontline practitioners or managers to systematically establish the individual's level of substance use and/or mental ill-health and the risks associated with this.

Referral acceptance rates

In order to ascertain how both the local authorities' service specifications and the refuge providers own referral policies relating to substance use and mental health were implemented in practice, including the case-by-case approach to assessing referrals, the FOI request submitted to local authorities included questions about the numbers of women with these additional needs that were accepted into refuges in the local authority areas in the most recent reporting period. Seventeen (53.1%) of 32 local authorities were able to provide full or partial information on the number of domestic violence survivors accommodated by their refuge providers in the past year who had identified problems with drugs and/or alcohol and mental health needs, as shown in Table 2. It is not possible to provide an exact breakdown of the number of women with substance misuse and/or mental health problems accommodated in these 17 boroughs, as not all these boroughs provided information as to whether there was overlap between these groups e.g. one woman may have had both substance use problems and mental health problems and was therefore counted twice. These 17 boroughs thus accommodated, at most, 239 women with identified problems in relation to alcohol or drug use or mental health.

Table 4: Women with drug, alcohol or mental health problems accommodated in domestic violence refuges by borough in 2012 and 2013 (local authority data)

Borough	**Number of women with drug and/or alcohol problems accommodated**		**Number of women with mental health problems accommodated**		**Total number of units of refuge accommodation (bed spaces) funded by the local authority**	
Year	*2012*	*2013*	*2012*	*2013*	*2012*	*2013*
Barking & Dagenham	Alc: 1 Other drugs: 3	4	0	5[8]	12	13
Brent	*18 for substance use and mental health*	*No response to FOI request received*	*18 for substance use and mental health*	*No response to FOI request received*	25	*No response to FOI request received*

[8] As well as accepting five women mental health problems, they also accepted three women with co-existing substance use and mental health problems.

Borough	Number of women with drug and/or alcohol problems accommodated		Number of women with mental health problems accommodated		Total number of units of refuge accommodation (bed spaces) funded by the local authority	
Bromley	*2 for substance use and mental health*	3	*2 for substance use and mental health*	13	37	37
Camden	Not stated	0	Not stated	4	25	25
Croydon	Not stated	Not stated	Not stated	Not stated	3 refuges	20
Ealing	14	8	26	21	30	29
Enfield	Not stated	Not stated	Not stated	Not stated	29	33
Greenwich[9]	7	Not stated	29	Not stated	28	30
Hackney	Not stated	15	Not stated	26	48	48
Hammersmith & Fulham	5 or below[10]	2	7	3	14	14
Harrow	0	*No response to FOI request received*	2	*No response to FOI request received*	6	*No response to FOI request received*
Hillingdon	Not stated	1	3	1	7	7
Hounslow	Not stated	12	Not stated	4	33	34
Islington	2	5	3	57	Not stated	27
Kensington & Chelsea	6	6	7	2	19	19
Kingston upon Thames	Not stated	0	Not stated	0	15	15
Lambeth	Alc: 8 Other drugs: 9	Not stated	15	No stated	52	52

[9] The Royal Borough of Greenwich was able to obtain information from two of their three refuge providers, so it is possible that the actual numbers of women with substance use and/or mental health problems supported are higher than those shown here.

[10] The London Borough of Hammersmith & Fulham noted: "we are unable to provide this data as it is deemed as personal data by virtue of s.40 Freedom of Information act 2000, when numbers are so small the individuals become identifiable."

Borough	Number of women with drug and/or alcohol problems accommodated		Number of women with mental health problems accommodated		Total number of units of refuge accommodation (bed spaces) funded by the local authority	
Lewisham	2	14	7 (diagnosed)	25	40	40
Merton	5[11]	Not stated	Not stated	Not stated	Not stated	2 refuges
Newham	Not stated	0	Not stated	3	25	25
Redbridge	0	0	1	'some'	10	10
Richmond upon Thames[12]	Not stated	Not stated	Not stated	Not stated	15	15
Southwark	Alc: 3 Other drugs: 4	*13 for both substance use and mental ill-health*	3	*13 for both substance use and mental ill-health*	24	24
Sutton	2	2	12	12	12	12
Tower Hamlets	Not stated	Not stated	Not stated	Not stated	34	34
Waltham Forest	0	Not stated	35	Not stated	Not stated	29
Wandsworth	Not stated	Alc: 3 Methadone : 1	Not stated	20	Not stated	26
Westminster	Not stated	0	Not stated	20	35	35
TOTAL	**<64**	**92**	**150**	**>223**	**575**	**671[13]**

The most striking feature of the data collected about referrals into refuges is the actual lack of information and what changes have occurred in the past 1-2 years. In 2012, 15 boroughs were unable to provide information on the number of women with drug and/or alcohol problems or mental health problems had been accommodated by their funded refuge providers in the previous year. In 2013, eight of these boroughs were unable to provide the requested information, which is a significant improvement. Conversely, four local authorities that provided the data in 2012 were not able to access it in 2013. In both 2012 and 2013, the boroughs most commonly reported that they do not require service providers to report this information or simply stated that the information is

[11] The London Borough of Merton was able to obtain information from one of their two refuge providers, so it is possible that the actual numbers of women with substance misuse and/or mental health problems supported are higher than those shown here.

[12] The London Borough of Richmond upon Thames submitted the same response in 2012 and 2013 as their 'responses remain the same'.

[13] The increase in refuge spaces does not reflect an actual increase in the number of bed spaces in refuges in London but rather more accurate information being provided in 2013 than in 2012. Overall, the number of refuges spaces appears to have remained relatively stable over the past year.

not available. That local authorities do not include this information in their reporting requirements is discussed further on p.35.

Another distinct trend highlighted in Table 4 is the differing numbers of women who have substance use problems and those who are experiencing mental ill-health who are accepted in refuges. It was more common for refuges in these boroughs to have provided accommodation to women with identified mental health problems (150 in 2012; over 223 in 2013), than to women with identified problems with alcohol or other drugs (up to 64 in 2012; 92 in 2013). This is most likely due to mental health problems being more common than substance use among the general population as well as among domestic violence survivors. The overall numbers of women experiencing problematic substance use and/or mental ill-health have also increased in the past two years.

It is possible that in some cases, such as Lewisham and Islington who, respectively, saw a 257% and 1800% increase in the number of women with mental health problems being accepted into refuges in their area, the dramatic rise is a consequence of changes in monitoring systems. The primary cause of the overall increased number of women with mental health difficulties being accommodated in refuges, therefore, is simply more detailed information being supplied by the local authorities rather than an actual increase in the number of women with these additional needs being supported in refuges.

Whilst collating the numbers of women with substance use and/or mental health problems that accessed refuge accommodation in London over a two-year period, local authorities were not asked to provide the total number of domestic violence survivors accommodated over the same period of time. It is, therefore, not possible to determine what proportion of women accommodated were identified as having substance use or mental health problems. However, nine boroughs (Table 5) did provide the number of units of accommodation they fund, as well as figures for both substance use and mental health problems in both 2012 and 2013. As a snapshot, for these boroughs taken together, accommodation provision in 2012/2013 for women with alcohol or other drug problems represented 25.9/28.3% of refuge units available and accommodation provision for women with mental health problems represented less than half (38.5/45.6%) of refuge units available in the boroughs. Given that most survivors do not stay in refuge for a full year, it is likely that these percentages would be lower if compared with the total number of survivors accommodated throughout the year.

Table 5: Women with drug/alcohol or mental health problems accommodated as proportion of units available, by borough (local authority data)

Borough	**Number of women with drug and/or alcohol problems accommodated, as % of total units of accommodation available**		**Number of women with mental health problems accommodated, as % of total units of accommodation available**	
Year	*2012*	*2013*	*2012*	*2013*
Barking & Dagenham	33.3%	30.7%	0	38.4%
Ealing	46.7%	27.5%	86.7%	72.4%

Hammersmith & Fulham	0	14.2%	33.3%	92.8%
Kensington & Chelsea	31.6%	31.7%	36.8%	10.5%
Lewisham	5%	35%	17.5%	62.5%
Sutton	16.7%	16.7%	100%	100%

Referral refusal rates

In an attempt to establish a fuller picture of access to refuge provision by women who use drugs or alcohol problematically, or who have mental health problems, each local authority was also asked for information on the number of women with these needs who had been refused access to refuge provision in their boroughs in the past year. Fourteen of 32 local authorities were able to provide full or partial information on this question.

Table 6: Women with drug/alcohol or mental health problems refused access to domestic violence refuge accommodation, by borough (local authority data)

Borough	**Number of women with drug and/or alcohol problems refused accommodation**		**Number of women with mental health problems refused accommodation**	
Year	*2012*	*2013*	*2012*	*2013*
Barking & Dagenham	0	2	1	2
Barnet	Not stated	Not stated	Not stated	Not stated
Bexley	Not stated	Not stated	Not stated	Not stated
Brent	*7 for substance use and mental health combined*	*No response to FOI request received*	*7 for substance use and mental health combined*	*No response to FOI request received*
Bromley	1	0	2	0
Camden	Not stated	3	Not stated	0
Croydon	Not stated	Not stated	Not stated	Not stated
Ealing	35	3	2	15
Enfield	Not stated	Not stated	Not stated	Not stated
Greenwich	Not stated	Not stated	6 (2 refused; 4 initially accommodated but then had “support withdrawn”)	Not stated
Hackney	Not stated	0	Not stated	8 (4 refuge full; 1

Borough	Number of women with drug and/or alcohol problems refused accommodation		Number of women with mental health problems refused accommodation	
				support needs too high; 3 violent or offending behaviour
Hammersmith & Fulham	8	3	12	4
Haringey	Not stated	0	Not stated	28 (24 refuge full; 2 declined space; 2 did not come)
Harrow	2	*No response to FOI request received*	0	*No response to FOI request received*
Hillingdon	1	1	6	5
Hounslow	Not stated	6	Not stated	2
Islington	0	12	0	68
Kensington & Chelsea	2	0	2	0
Lambeth	0	Not stated	0	Not stated
Lewisham	Not stated	*23 refusals in total, not just substance use or mental health*	Not stated	*23 refusals in total, not just substance use or mental health*
Merton	Not stated	Not stated	Not stated	Not stated
Newham	0	0	0	0
Redbridge	*10 for both substance use and mental ill-health*	Not stated	*10 for both substance use and mental ill-health*	Not stated
Richmond upon Thames	Not stated	Not stated	Not stated	Not stated
Southwark	0	*Data withheld*[14]	1	*Data withheld*
Sutton	Not stated	Not stated	Not stated	Not stated

[14] The number of refusals was withheld under section 40(2) of the Freedom of Information Act, as this information was considered to the personal, third party data, which is exempt from Freedom of Information requests, and disclosure would breach one of the data protection principles.

Borough	Number of women with drug and/or alcohol problems refused accommodation		Number of women with mental health problems refused accommodation	
Tower Hamlets	Not stated	Not stated	Not stated	Not stated
Waltham Forest	0	Not stated	0	Not stated
Wandsworth	Not stated	0	Not stated	0
Westminster	Not stated	3	Not stated	12

Similarly to the responses about accepting referrals, the data about refusal rates is significantly limited, with 19 local authorities providing no information to at least one of the FOI requests and 8 boroughs not being able to provide the data for either year. The implications of this are discussed further on p.34.

Some responses in this section suggested alternative referral options if women are rejected from refuges, although none of these respondents provided information about whether they track these onward referrals and know whether these women are, in fact, ultimately offered a refuge space.

> *Any rejections go back to Refuges Online to ensure that women do not fall through the support net.* (Hillingdon, 2012)

> *There is a wide recognition that supporting women who have complex needs is necessary, however, there are certain restrictions placed upon most refuges. Each case is assessed on a case-by-case basis... This is due to many considerations, such as the safety of the other residents and children primarily as it is a shared environment... There is one specialist project and this provides specific support for these clients. All refuges have their eligibility criteria within the GOLD book, so when clients are referred this criteria is referred to.* (Barnet, 2012)

> *This information is not held ... clearly it is primarily a service to work with women who are at risk or are victims of domestic violence. The service is funded to provide low to medium support and so by its very nature would not be able to work with high need clients.* (Lewisham, 2012)

Similar to service providers, local authorities also highlighted an inability to provide 24-hour support as a barrier to accepting survivors with drug and alcohol or mental health needs, however no local authority provided an example of how they would assess that someone requires 24-hour support.

> *We do not operate a strict policy on substance misuse or mental health but our criteria specifies that we will not consider referrals with high support needs that require 24 supervision. This is purely because we are not staffed 24/7.* (Waltham Forest, 2012)

> *There is no specific reference to provide access for women suffering from alcohol, drug or mental health conditions as it does not provide a 24 hour high support service.* (Redbridge, 2012)

> *All the refuges will accept women with substance misuse or mental health issues, but every client has a risk assessment undertaken first and this is used as the criteria. The refuges have to be mindful that there are children in the house and the staff are not there*

24/7 so safeguarding has to be considered before any client is accepted into the refuge. (Barnet, 2013)

Staff training

Understanding the need to have a skilled and competent workforce, refuge providers were asked whether their staff had received substance misuse or mental health training in the past two years. Of the 23 refuges that responded, 19 stated that staff had received training about substance use and about mental health in the past two years. In relation to each training subject, four refuges either answered no, don't know or gave no answer.

When asked about the impact of the training, the majority of refuges said that the impact was on-going and that, particularly in relation to substance use, staff understanding of the issues and confidence in being able to support survivors who use substances has increased.

Overall, this is a positive finding, and we are encouraged by the fact that so many refuge staff have access to substance use and mental health training. Further investigation is, however, needed to identify exactly how many staff have received the training and how in-depth the training was - despite reports of staff having attended training, the surveys did suggest limited knowledge of problem alcohol and drug use or mental ill health[15]. A lack of knowledge particularly from service managers seemed to be reflected in the way they were assessing risk in relation to a (potential) service user's substance use or mental health. On the other hand, managers that appeared to have a good knowledge of these issues also seemed more likely to accept service users who had these issues.

Partnership working

Finally, in recognition of the vital importance of close partnership working in supporting women who experience domestic violence, problematic substance use and mental ill-health, refuge providers were asked a number of questions relating to their working relationships with other relevant organisations. To ascertain potential levels of partnership working, we asked refuges i) if they work with drug and alcohol or mental health services in their borough, ii) if they have a formalised working relationship, iii) if they were currently jointly supporting a service user with a partner agency, and iv) how often they saw their partners in these agencies.

In response to these questions, refuge providers indicated they were equally likely to work in partnership with both drug and alcohol and mental health services (n=11). Only one refuge does not, and one refuge provider did not answer the question. A small number of respondents provided information about the agencies they partner with; these included a drug and alcohol floating support worker, an "excellent partnership with the chemist", Community Mental Health Teams, Child and Adolescent Mental Health Services, Mind, a local counselling service and a GP.

Despite the high levels of reported partnership working, and in particular the fact that five refuges were currently jointly supporting service users with mental health problems and six were working in partnership with drug and alcohol services to support service users, only one provider (Hestia) noted having a Service Level Agreement with these specific partner agencies and Refuge stated they have formalised partnerships but gave no details. Interestingly, the same two providers highlighted the difficulties in accessing drug/alcohol and mental health services: Hestia noted that

[15] It should be noted that the staff that completed the survey may not have attended training on these issues.

they work in partnership with drug and alcohol services “where available, but these are quite scarce”, whilst Refuge stated “there is nowhere to refer service users with mental health problems as the thresholds [for mental health services] are too high.” The outlook is likely to be similar in many boroughs, although some respondents highlighted that it is possible to form partnerships with the relevant agencies, including statutory mental health services, who have a poor reputation for working jointly with domestic violence services.

The frequency that refuge providers reported meeting with colleagues in drug and alcohol services differed to that reported for mental health services. Of the eleven refuge providers that stated they had a partnership with drug and alcohol services, one stated they rarely met with colleagues from those services and one said they never did. By comparison, six refuge providers stated they have little to no face-to-face contact with mental health services (5=rarely, 1=never), despite two providers currently supporting service users jointly with mental health services. Having face-to-face meetings is not necessarily an essential facet of successful partnership working, although joint keywork or support sessions are typically recommended in models of enhanced partnership work as it promotes a more joined up approach and can make the service user feel more supported rather than feeling as though they are being passed from pillar to post (AVA, 2013).

Table 7: Frequency of meetings with partner drug and alcohol or mental health services (service provider data)

Frequency	Contact with substance use services	Contact with mental health services
Regularly	2	2
Sometimes	4	3
Rarely	1	5
Never	1	1
Don’t know/not applicable	3	-
No answer	2	2

Discussion

Data collection

The FOI requests revealed that commissioners in half of all London boroughs cannot easily access information on the number of women with drug and alcohol problems or mental health problems accessing, or being refused access to, domestic violence refuge provision. For at least one borough, collecting this information was identified as requiring more than 18 hours of work.

Given the now strong body of evidence demonstrating the high prevalence of related support needs related to problematic substance use and mental ill health amongst domestic violence survivors, it is concerning that many local authorities are still failing to collect data on these issues.

For services to be commissioned in a way that addresses the needs of all survivors of domestic violence, commissioners must have access to reliable information on the level of need in their borough. As such, we would expect it to be standard practice that joint strategic needs assessments (JSNAs) for domestic violence service provision include consideration of the level of related needs related to problematic substance use and mental health problems. Clearly, this has been recognised by the majority of London local authorities who do collect this information and our recommendations below suggest that this is an appropriate model for the remaining local authorities to follow.

Service specifications

Fifty per cent (n=15) of the boroughs include either a generic or specific reference to substance use and/or mental ill-health, and most often both issues, in the service specifications for the provision of refuge accommodation-based support. Most frequently (n=10), the reference is generic, such as:

- “The refuge should accept all service users” (Bromley, 2013)
- The refuge should “not operate any blanket exclusion policies” (Kingston upon Thames, 2013) or exclude women solely on this basis (Lambeth, 2013)
- The refuge should identify any substance use or mental health problems and support service users to access the appropriate support (Southwark, 2013). Identifying problems, however, does not necessarily mean that the refuge has to accept women with these needs in the first place.

Further to this, two boroughs introduced more specific provisions within the service specifications between 2012 and 2013. Ealing, for example, in 2012 reported no requirements, but by 2013 one provider only accepts women with substance use or mental health problems, and the second provider accepts women with mental health problems, women on methadone and substance dependent but have not used/drank for six months.

Whilst it is encouraging to note that in only one borough (Merton) refuges definitely continues to actively exclude women who use substances or experience mental health problems, refuges in a further eleven boroughs are not explicitly required within their funding contracts to support women with these needs.

Specific reference to survivors with particular support needs, including substance use and mental ill-health within service specifications may prompt refuge services to become more inclusive, and is therefore recommended.

Provision of support to women with these needs does, however, need to be monitored, and this does not appear to be happening across all boroughs. As an example, four boroughs (Croydon, Lambeth, Tower Hamlets and Waltham Forest) all state to varying degrees that women with substance use and/or mental health problems should have access to refuge accommodation. However, the FOI requests revealed that none of these boroughs were able to provide the numbers of women accepted into, or refused entry, to the refuges they fund. Croydon, in particular, stated that "[t]he specification for the support service requires that women with the characteristics mentioned are not excluded and our contract monitoring confirms that this is complied with by the service provider." Yet the FOI requests in both 2012 and 2013 revealed that data on the numbers of women with these needs accessing the refuges in the borough was not available. This may reflect the limitations of FOI requests, or may be indicative of a wider problem whereby refuge referrals and refusals are not as closely monitored as one might hope.

Policies

This study found that some refuge service providers do not have a written drug and alcohol or mental health policy but still accepted women with these support needs. Responses from larger service providers that have organisation-wide policies, demonstrated that the policies are sometimes interpreted differently across services in different boroughs, or indeed by individual staff members. Furthermore, some staff were unaware that such policies existed or not.

Without adequate support through the development of policies, which are ideally accompanied with practice guidance, staff may continue to believe that supporting survivors with substance use and/or mental health problems is neither their responsibility nor in the remit of their work. In addition, in the absence of a formalised policy, staff may not feel sufficiently well supported to work with this group of survivors. Policy and practice guidance can go some way to remedying this and also provide a clear framework for assessing referrals and pathways for supporting service users jointly with partner agencies.

Conditions to staying in the refuge

Where policies – formal or informal – exist, they tend to include a wide range of conditions attached to accepting a referral for women using substances or experiencing mental ill-health. Most commonly, there is an expectation that the woman will already be engaged with a service and have had several months of support before entering the refuge. Alongside this, however, it is remarkable that most exclusion criteria relating to substance use includes use of opiates, ***including methadone***. Methadone is a prescribed medication and people on a methadone script are often required to engage in support (through the chemist, GP, shared care worker) in order to receive their prescription.

For women with mental health problems, the requirement to be supported by a Community Psychiatric Nurse (CPN), social worker, GP and/or receiving medication for their diagnosis works to exclude women who have no formal diagnosis, who do not meet the threshold for statutory mental health services, or who have a mental health problem that cannot be treated with medication or that they do not *want* to treat with medication because of the multiple side effects of many psychiatric drugs.

Furthermore, such stipulations fail to acknowledge that some women will have been prevented by their perpetrator from accessing support for their substance use or mental ill-health. Some women will have been forced to use drugs by their partner, and it is not uncommon for perpetrators to control access to psychiatric medication too. Conversely, this approach further presupposes that *all* survivors who use substances and/or experience mental distress are incapable of managing their own drinking, drug use or mental health once they have left an abusive partner and moved into the refuge. Moreover, the imposition of these criteria also reinforced rather than dismantles the abuser's control.

An alternative, and far more inclusive approach, has been adopted by Manchester Women's Aid (MWA). Rather than requiring women to have already accessed support as a condition of entry into the refuge, MWA stipulates that women must be willing to engage with support once in the refuge. MWA also provides simple measures such a lockable boxes for medication and provision for storing methadone. Lack of provision of lockable boxes or cupboards is one of the key stated reasons that refuges are not able to accept women with drug problems, as it means that children in the refuge are at risk of accidentally consuming the drug or medication. As MWA proves, providing lockable boxes is a relatively inexpensive and simple solution to expanding service provision to include women with substance use and/or mental health problems. It is also worth noting that many users of substitute prescriptions are on supervised consumption at the pharmacy and, therefore, methadone will not need to be stored at the refuge.

Gate keeping

In completing the survey, particularly when done over the telephone, refuge workers admitted to "cherry picking" service users, i.e. gate-keeping the service. One worker, for example, stated:

> *"If you take three referrals and two of them have substance use or mental health issues then obviously you're going to pick the other one because it's going to involve the least work."*

This is a surprisingly candid statement. It highlights how refuge staff are managing increasingly heavy and complex workloads under ever reducing resources. Research has found that local authroity funding for domestic violence and sexual abuse services fell by 31% between 2010/11 and 2011/12 (Towers and Walby, 2012). This, in part, has resulted in redundancies leaving increased caseloads for the remaining staff. Practice-based evidence from refuge workers also indicates that they are also supporting women with increasingly high needs, including those relating to substance use and mental ill-health.

Another reason given for "cherry picking" women was that workers felt they did not have the knowledge or capacity to safely and adequately support women who had mental health or drug/alcohol issues. They fear that, in the event that the service user, or another child or adult living in the refuge came to harm, the staff member would be blamed and reprimanded for this and therefore did not wish to be responsible for supporting them. This points to a clear need for more training as well as closer partnership working to ensure that staff feel knowledgeable and confident to support this client group. As this research found that refuges in all boroughs have had substance use and mental health training in the last two years, a question arises about the extent to which the training met the learners' needs and whether more in-depth training is needed. Furthermore, almost all boroughs reported working relationships with local drug and alcohol or mental health

services. Clearly, again, there is evidence to suggest that these relationships could be closer to engender more confidence in refuge workers and, through regular contact with services, also offer on-going learning about problematic substance use and mental ill-health.

"Cherry picking" referrals is easier when refuge workers are allowed to assess and decide whether to accept a referral without discussing with a manager. Requiring all referrals – particularly those that the worker wishes to refuse – to be approved a manager may go some way to alleviating this problem. Finally, women or agencies referring to a refuge will often disclose substance use and/or mental health problems straight away, often in the knowledge that this is a common exclusion criteria and they want to avoid wasting time. This can result in the refuge worker immediately refusing the person before even a formal referral and risk assessment is undertaken. With no evidence of the referral being made and refused, demonstrating exclusions and/or discrimination against women with support support needs around problematic substance use or mental ill-health is difficult.

Capacity and staffing

Both service providers and local authorities identified the lack of 24-hour on-site staffing in refuges as a reason that they are unable to accommodate women with either drug and alcohol or mental health problems. Without 24-hour staffing, workers reported they could not adequately manage the risks nor meet the survivor's support needs. There are, however, some refuges in London who only have staff on site during normal office hours and operate an emergency out hours on call service, yet are successfully able to accommodate women with high support needs relating to substance use and mental ill-health.

This perhaps suggests that staff in many refuges are insufficiently trained or supported to be able to assess levels of risk that women pose or the support they realistically require in relation to their drug and alcohol or mental health needs. Certainly in terms of mental health, if a survivor needs 24-hour on-site care, it may be that the most suitable place for her is in a crisis house for people experiencing acute mental distress, or possibly even hospital.

Furthermore, concerns about a lack of 24-hour staffing become somewhat superfluous when it is revealed that refuge providers reported that women are seldom evicted because of the mental health or substance use, if it is disclosed once they are at the refuge. This emphasizes the fact that refuges do have the capacity to support these women and raises the question as to why they are so often ecluded referral stage. Again, this points to the need for clearer policies, more in-depth training and improved partnership working in order that staff can feel more confident in supporting survivors who have these particular needs.

Partnership working

As no-one can be an expert in every subject, partnership working is vital for supporting survivors of domestic and sexual violence who also experience difficulties with substance use and/or their mental ill-health. This study found that the majority of refuges do work in partnership with local drug and alcohol treatment services and with community-based mental health support. Unfortunately, the partnership working is, however, based primarily on informal arrangements and accessed in an ad hoc fashion. Only one service provider stated specifically that they have formalised Service Level Agreements in place with their local drug and alcohol service, but at the same time this provider does not accept women on a methadone programme. On the other hand, the Emma

Project, a specialist refuge for substance using women reports having an excellent relationship with their local chemist, even in the absence of a formalised arrangement.

More concerning than the lack of formal agreements to work in partnership, was the suggested lack of contact between agencies. It was surprising to find that even agencies that are jointly supporting a service user never appeared to meet their counterpart in the partner organisation. Ideally, partnership working requires professionals to come together, meeting in the same room at the same time with a service user to develop a truly joint support plan. There is, otherwise, a possibility that areas of support may not be addressed as one worker presumes the other is addressing it, or separate support plans being devised by each agency that contradict one another. Undoubtedly, more effort needs to be made not only to develop formalised partnerships arrangements, but also to encourage and enable practitioners to physically meet and support survivors with drug and alcohol and mental health problems together.

Children in refuges

Refuges often exclude women who drink, use substances or experience mental ill-health due to the presence of children in the refuge who might be put at risk by the woman's behaviour. While in some cases this may be a legitimate concern, it again needs to be thoroughly assessed on an individual basis, rather than deciding in advance that women who drink problematically are automatically a risk to children. Whilst there is plentiful research on the negative impact of parental substance use on children living in the household, not all parents who use or drink, nor those who experience mental health problems, pose a significant risk to the safety and wellbeing of their own children, or of any other children.

Black and minority ethnic and refugee (BAMER) women

The need for specialist refuge provision for Black and Minority Ethnic and Refugee (BAMER) women has been well evidenced, with 87% of BAMER women surveyed by Imkaan saying that they preferred to be accommodated within a BAMER refuge service. Furthermore, a quarter of those women who had also accessed non-BAMER services stated they had found them unhelpful and reported that *"they were not able to engage with the services [and] felt that their voices were not heard"* (Thiara & Roy, 2010). In 2004/05, Southall Black Sisters conducted research on the support needs of BAMER survivors of domestic violence in relation to mental health (Siddiqui & Patel, 2010), finding that "[w]hile there were specific and unique experiences for particular ethnic minority groups, the survey confirmed the view that there are many experiences shared in common by BME [Black and Minority Ethnic] women with mental health issues in Britain" (p. 119). The research highlighted needs around depression, self-harm and suicide as being particularly important, but substance misuse and drug-related harm through gang association were also highlighted.

Further research by EACH (2009) and Southall Black Sisters has highlighted some of the particular difficulties facing Asian survivors of domestic violence. In research for the Stella Project in 2004, Southall Black Sisters noted that:

> *Asian women are not supposed to drink, they are not supposed to be taking drugs, they're not supposed to be stepping out from certain traditional forms of behaviour and taking drugs or alcohol is particularly seen as an act which is just simply not acceptable… So really I think they keep their problems far more hidden, much more harder to detect, and therefore they don't access the help and services that they should be getting… And I think that is a problem*

far greater for women in minority communities than in majority communities (Hannana Sidiqqui cited in Humphreys et al, 2004)

This study found that two out of the three specialist BAMER refuges excluded women who use substances (with the exception of methadone in one refuge) and listed multiple mental health diagnoses in their list of exclusion criteria. We are not aware of any further research that has specifically investigated the experiences of BAMER women with drug and alcohol and/or mental health problems seeking access to domestic violence refuges. It is, however, likely that Thiara and Roy's (2010) assessment that "a generic approach to addressing need is fundamentally flawed" remains true for BAMER women experiencing problematic substance use and/or mental ill-health and that these women's right to specialist BAMER provision should be addressed. Indeed, it could be argued that the failure to do this places local authorities in breach of the Equality Act 2010.

Paper trail

There is little compulsion for refuge service providers to keep records of referrals, and particularly to securely store information about unsuccessful referrals. It is not necessarily included in contract monitoring, and there are legitimate concerns about keeping data about vulnerable people who do not go on to use the service. Not retaining records of the numbers of, and reasons for, refusing referrals into a service, however, limits service providers' ability to analyse trends in refusals. Knowing that reasons for refusals are reviewed regularly by senior service managers may help address unmet need and also hold staff to account for their assessment decisions.

A lack of monitoring of refusals also means there is a lack of evidence about where women turn to in the absence of refuge accommodation. In this study, both refuge providers and local authorities suggested that if they had to refuse accommodation to a survivor with drug and alcohol or mental health needs, she would be referred back to the National Domestic Violence Helpline (run in partnership by Women's Aid and Refuge) or to another organisation that has access to Refuges Online or the Gold Book to identify a different refuge that is able to support her. Although respondents did not specify whether they then track these referrals to ensure the woman is offered a space, it is our understanding that invariably this does not happen.

This, in itself, suggests limited understanding about the extent of refuge provision available for this group of survivors – workers assessing referrals may be overly confident that another refuge will accept the survivor, when in reality many will not. Moreover, it means we do not know what happens to these women. Do they ever get a refuge space? Do they end up in a hostel? In bed and breakfast accommodation? Or do they give up and just go home? Further research is urgently needed to track individual women's attempts to access refuge accommodation and find out where, eventually, they end up staying.

Promising practice

Islington Complex Needs working group

The Domestic Violence Coordinator in Islington currently leads a complex/multiple needs working group. Meetings are held on a quarterly basis. The purpose of this Group is to improve joint working between different sectors to improve services and responses to those with multiple and complex needs. This is primarily done through networking and encouragement of partnership working between the agencies. The Working Group also facilitates the involvement of substance misuse agencies in the free training offered by the Safer Islington Partnership (SIP) on MARAC and risk assessment. This has led to an increase in participation in the MARAC process by substance misuse agencies leading to a greater identification of high risk individuals. The group allows for consultation with different stakeholders and service users about how to take the work forward, and it is from this that a pilot has been developed with The Pilion Trust on working with women with complex needs**.**

Nia Project

The Nia's Emma Project is a six-bed specialist refuge for women fleeing gender-based violence with the additional vulnerability of substance use. The women in the house have a variety of additional needs including mental health, emotional health, physical health, learning difficulties and other needs associated with poverty, poor housing conditions homelessness and experiences of abuse. 24 hour support is provided, with a sleeping shift from 10pm to 8am for emergency cover.

The Emma Project engages with women in holistic wrap around support planning which includes extensive needs assessment and risk assessment with the service user. Risk management in the shape of a support plan is devised from the assessment with the support worker offering information and advice on how to address and minimise the identified risk through safety planning, harm minimisation advice, issuing panic alarms and multiagency involvement. Risk assessments are regularly reviewed so that any changes are captured and addressed. This can be as practical and functional as referring into local prescribing services, transferring methadone prescriptions to the local area, registering with a GP, referrals to counselling services, supporting residents to initial meetings with services and registering for personal benefits. Women are empowered to be able to identify and express their own needs.

Manchester Women's Aid

Manchester Women's Aid (MWA) currently have a Mental Health Worker and Substance Misuse Practitioner who work across five refuges and various community settings. Refuges are only staffed on a 9-5 basis, but they still successfully manage risk and support women who have multiple needs.

MWA actively challenges the widely held belief that survivors who have mental health and/or drugs and alcohol problems are 'too risky', 'too high need' or 'too chaotic', particularly for refuge services. The specialist practitioners support generic domestic violence workers to assess clients more effectively and identify possible risks: this reduces concerns about unknown or unmanageable risks amongst generic workers.

Specialist practitioners work with their colleagues to develop risk management and care plans that take into account the effects of different substances and mental health problems. MWA refuges in general adopt a realistic care plan for the client based on the cycle of change and what could be

achievable at different stages for the clients. The only expectation from clients is to engage with the team fully, this does not mean to stop using drugs as for some people this may not be an achievable goal.

Through this joint working approach, staff have been supported to utilise greater holistic knowledge in developing safety plans in creative and meaningful ways, both in community and refuge settings. Clients also benefit from improved relationships with external agencies. For example, clients accessing shared care services at the GP can meet with a domestic violence worker to discuss concerns about keeping their methadone script or withdrawing from substances in the refuge.

As refuge providers increasingly take on the management of multiple refuges, rather than just one, this is a model that could be replicated elsewhere.

Solace Women's Aid

Solace Women's Aid (SWA) has adopted a culture of good practice and risk management for working with women with multiple needs. The new complex needs refuge further highlights the commitment they have in working with the most vulnerable women in an inclusive way.

All SWA refuge workers are trained in mental health and substance use and are familiar with local services. A comprehensive risk assessment is used in the refuge from which the service user and worker can formulate an individual support plan that is reviewed on a regular basis. Good partnership working is encouraged by inviting workers from mental health and substance use agencies to house meetings so women are familiar with local services and what they offer. In addition strong partnership links mean staff are able to gain advice from specialists when they need extra support in successfully engaging women who have multiple support needs.

SWA has a comprehensive drug and alcohol policy that was developed taking the Stella Project recommendations into consideration. The policy is reviewed every two years to ensure recent trends or changes in working practice are included. A multiple needs policy has also been devised.

Referrals for the refuge are taken one at a time, and are always discussed with the manager. This limits 'cherry picking' by individual workers and also promotes best practice. If a woman presents as having multiple support needs, they are risk assessed accordingly. As a result of this practice Solace Women's Aid are rare providers of refuge spaces in London for women who have multiple needs.

In the near future, SWA will be delivering training and education sessions to professionals in 17 London boroughs to i) raise awareness around domestic and sexual violence; ii) to support work with women affected by domestic and sexual violence, substance use and mental health problems; iii) to promote partnership working between statutory and voluntary sector services; and iv) to ultimately increase engagement with survivors who experience problems with substance use and/or mental ill-health and improve their access to relevant services.

St Mungo's

St Mungo's is a homelessness charity with over 100 accommodation and support projects across London and the South of England. This includes mixed and women only accommodation. St Mungo's has a Women's Strategy which aims to ensure all services are meeting the personal, emotional and social needs of women, as well as housing, health and employment or education. The Esmée Fairbairn Foundation is funding a Women's Strategy Coordinator to implement

changes such as staff and service development, improved partnership working, and increased opportunities for client involvement. Support for women who have experienced domestic violence is a priority within the strategy. A recent research report found that 35% of St Mungo's female clients who had slept rough became homeless because of domestic violence.

St Mungo's North London Women's Project is a 29-bed hostel for single homeless women with complex needs such as physical or mental health problems, drug or alcohol issues and involvement in prostitution. Many of the women at the project became homeless because of domestic violence, but were unable to access refuge provision because of their high support needs. The location is kept confidential to ensure security. The project supports residents through assessment and planning to meet their individual needs, and to access other services such as GPs, substance use, education and domestic violence services.

With support from AVA, St Mungo's has recently reviewed and re-launched their internal domestic abuse policy, which now has more focus on non-physical as well as physical abuse and a more pro-active approach, asking the questions and following up on any indicators of abuse, working with local domestic violence services and MARACs.

Conclusion

> *"Today is not about barriers, it's about bridges….Today is not about feeling entrenched in our disciplines or resistant to change; it is about daring to hear the other view, however uncomfortable this might be. It is about focusing on the women and children who we work with and asking if there is something we are missing or something we could do better."*
>
> Sarah Galvani, Stella Project Launch Seminar, 2003

Just over ten years ago, the Stella Project was founded to develop more joined-up responses to survivors of domestic violence who are also affected by substance use. Whilst the intervening years have borne witness to improvements in services, sadly the same survivors today are still often labelled as having 'complex needs' and are regularly considered to be too high risk to be accepted into a refuge.

Having more than one need does not, however, necessarily mean a person poses an unmanageable risk to staff and other service users. Consider for a moment a woman fleeing domestic who, for example, suffers from depression and anxiety. She drinks in the evening and smokes cannabis to help her sleep. At the point of referral, she ticks the boxes for 'mental health' and 'substance use'. She may have multiple needs as a result of this, not to mention the other needs she has relating to her housing situation, lack of money, her children, and so on. Is this, however, a case of 'complex needs', of too high support needs that refuge staff cannot meet?

Without a full risk assessment at the point of referral, we will never know. Without recording the number of women who are refused access to refuge on the basis of their substance use and/or mental health and the reason why, we will also never know the extent of the problem that needs to be addressed. What we do know, sadly, is that currently some women are being turned away from refuges because of the way they cope with the trauma they have experienced, namely by self-harming, by attempting suicide, by drinking heavily or by using both illicit and prescribed medication. It is often not possible to address any of these behaviours until the person is and feels safe, yet it is exactly these behaviours that create a barrier to safety.

This cannot continue.

Every woman who arrives at the refuge front door has complex needs. There is no such thing as 'straight forward domestic violence', nor is there a 'straight forward survivor'. We all, therefore, have a responsibility to make our service more inclusive, and to open our doors wider to the women who need us most.

Recommendations

1. Commissioners

1.1 Local data on intersecting needs in relation to problematic substance use and mental ill health should be included in domestic violence joint strategic needs assessments.

1.2 Service specifications for domestic violence refuge provision should include specific provisions in relation to supporting women who have substance use problems and mental health problems, including realistic funding to support refuge providers to provide this service. Realistic funding must include the costs of capacity development in order to improve existing provision, including staff training, development of policies, procedures and partnerships and equipment such as sharps bins and locked boxes.

1.3 All refuges commissioned should have current mental health and substance misuse policies, including details of the risk assessment process for mental health and substance misuse if the refuge operates a “case-by-case” inclusion policy.

1.4 Contract monitoring of refuges for survivors of domestic violence should include:

- The number of survivors accommodated who have intersecting needs in relation to problematic substance use and mental health.
- The number of survivors with these needs that have been refused from refuge accommodation and the reason for the refusal.

1.5 Funding for specialist workers and/or more refuge spaces for women with substance use and/or mental health problems should be made available. This could include pan-London commissioning of specialist substance use or mental health support workers that can float between all refuges in London.

1.6 Options should be investigated for move-on accommodation for single women, as limited access to alternative temporary or longer-term accommodation is a barrier to accessing refuge services.

2. Community safety teams and domestic violence partnerships

2.1 Community Safety Teams should be responsible for ensuring that their services are available to all women fleeing violence, including those who experience difficulties with their mental health and/or substance use. Domestic violence or violence against women and girls coordinators should consider facilitating networking between the three sectors, such as the Islington Complex Needs Forum

2.2 Collaboration with housing colleagues should be undertaken to ensure that there is relevant, safe, move on accommodation for women with mental health and/or substance use problems.

2.3 London boroughs could consider a pan-London advocacy and coordination role, in order to support services to implement the recommendations above. Although some of this work currently

happens within the remit of the Stella Project, to be truly effective this would need to be a dedicated, full time role.

3. Service providers

3.1 Improved partnership working

Service level agreements (SLAs) do not exist between refuges and substance misuse services or mental health services in any London borough. Referrals currently happen on *ad hoc* basis, however formalisation of this process through SLAs would allow for:

- More in-depth understanding of services in the other sector and what each service can provide to service users.
- Shared learning between staff in each sector, building knowledge and understanding and confidence about intersecting multiple needs across the three sectors
- A clear referral protocol
- Developing good links with local specialist agencies, crucial to delivering effective responses to service users.
- Ensuring partnership working survives as staff leave and are replaced.
- Increased potential for training exchanges.

SLAs should include joint agreement to provide training to staff in the other agency and an agreement about how to approach dual diagnosis e.g. can a service user access mental health services without being abstinent? In addition, SLA's should include clear agreement on confidentiality so that service providers are able to refer service users to the required agency without delay.

Improved partnership working to address multiple needs offers the potential for increased acceptance of women with additional needs into generic refuges, as refuge staff feel supported and more confident in addressing service users' needs. Refuge staff should take responsibility for contacting specialist services for further advice on supporting a woman with these needs or invite them for case conferences regularly so support plans reflect the partnership working.

3.2 Training

All refuge staff and managers who are involved in the assessment of referrals and supporting service users need training in:

- The links between problematic substance use, mental health and domestic violence including how drug/alcohol use and mental ill-health can be used as a form of control by the perpetrator.
- Encouraging disclosures – both asking the right questions and having the appropriate responses.
- Basic knowledge of harm minimisation advice for people who use drugs or alcohol problematically or who self-harm.
- Risk assessment in relation to drugs and alcohol and mental health (see below for more detail).

Staff induction manuals should include basic training packs on problematic substance use and mental health, and internal training should be provided on organisational policies and procedures in addressing complex needs[16].

Staffing budgets need to include the cost of training and staff need to be given sufficient time to access the required training. If budgets are limited explore the potential of training exchanges with local drug/alcohol and mental health agencies. In the current funding environment, training budgets are very limited therefore so this is a financially viable opportunity to meet training needs and also further improve partnership working. Staff also need to take responsibility for highlighting their own knowledge gaps and ensure they discuss these at every supervision. Managers then need to look for sufficient training to bridge these gaps.

3.3 Policies and procedures

All service providers should have a clear policy on working with women who have these particular support needs, even if there are two separate policies covering drugs/alcohol and another for mental health. Without this, workers can feel unsupported and unsure of the organisational approach to these issues. Policies should include:

- A clear view on the agency's response to working with women with multiple needs.
- Ensure that the Refuges Online information is accurate and updated on a regular basis, and it reflects the service provider's view on accepting women with multiple needs into refuge accommodation.
- A formalised risk assessment to be used with all women who fall into this category.
- A process whereby only one referral is taken at a time, and which goes through a manager. This can reduce the likelihood of 'gate-keeping'.
- The requirement to keep accurate records kept of all past referrals and refusals, particularly monitoring of refusals in relation to multiple needs. These refusals should then be used to review barriers and services to work towards a more inclusive approach.
- Advice on how to respond in certain situations and behaviours associated with drug/alcohol use and mental health.
- A clear referral process into specialist agencies, tied into service level agreements that all staff are aware of.

Refuge managers should regularly review and providing training on organisational policies. Changes and update to policies should be addressed at team meetings.

3.4 Risk Assessment

Service providers need to introduce a more comprehensive approach to assessing the risks associated with problematic substance use and mental ill-health, rather than using substance type or diagnosis as a means of deciding whether a women is accepted into the refuge.

Risk assessment tools should include, at a minimum:

Substance use	Mental health

[16] AVA's *Complicated Matters* toolkit and e-learning programme on working with domestic and sexual violence, substance use and mental ill-health can be accessed for free from www.avaproject.org.uk.

Alcohol consumption – frequency, amount consumed, individual's perception of whether use is problematic, receiving treatment, willingness to engage with support, triggers for use	Any diagnosed or undiagnosed mental health problems – when did it start, does anything trigger decline, treatment received in the past and currently receiving, contact with services/support
Prescribed medication – name/dose/frequency/purpose, risks around over/under-medicating, accidental or intentional overdose, triggers for misuse	Admissions into hospital because of mental health
Unprescribed drugs (illicit and over the counter - name/dose/frequency/purpose, risks around over/under-medicating, accidental or intentional overdose, receiving treatment, willingness to engage with support, triggers for use	Self-harming and suicidal thoughts – triggers for self-harming, last time self-harmed or felt suicidal, coping mechanisms, treatment received in the past and currently receiving, contact with services/support
Has any substance use been forced by perpetrator	History of eating disorders, isolating self or neglecting self – triggers, last time felt this way, treatment received in the past and currently receiving, contact with services/support

Furthermore, risk assessments should only be completed by professionals that have sufficient understanding of substance use and mental ill-health and are actually able to assess the potential risk based on the information provided. Referrals to refuges, including information about potential risks associated with substance use and/or mental ill-health, should be stored securely to ensure evidence is available in the case that a decision not to accept a women with these needs is challenged. This approach also reduces the risks of professionals 'gate keeping' women with additional support needs.

3.5 Service provision

To adequately support women with multiple needs, substance use and mental health needs need to be identified via the risk assessment and then reviewed through a support plan on a regular basis. It is important to include historical substance use or mental health as often women's health can deteriorate whilst in refuges potentially leading to a relapse of drug/alcohol use and a decline in mental health.

To work holistically with women who have multiple needs in refuges, frontline staff and service managers should:

- Encourage disclosures by confirming their policy around supporting rather than excluding women with mental health or substance use needs.
- Ensure staff are trained to use the risk assessment tool and phrase questions appropriately. For example, rather than saying, "*You're not using any drugs or alcohol, are you?"*, which can instantly create an impression that the refuge does not accept women who may be using, staff should be encouraged to use a more open approach such as, *"We recognise that women will sometimes use drugs or alcohol as a way of coping with any trauma or violence/abuse, has his ever been the case for you?."*
- Carry out more regular room checks in order to identify risks at an earlier stage. If, for example, a woman covers the mirrors in her room, this may be an indication to ask further questions

about her mental health. Alternatively, if there are drugs paraphernalia or empty alcohol bottles visible then discuss this with her in an open, empathetic manner.

- Manage risk in a more individual, service user focused way instead of trying to risk assess the whole refuge at once. A woman who is on a supervised methadone script which she receives and takes at a pharmacy means she will never bring the methadone onto the refuge premises. In such cases, staff do not need to worry about the risks to the children or the need to purchase lockable cupboards, which have been given as reasons for not allowing women on a methadone script into refuges.
- Safety plan adequately to include any triggers for, or signs that, substance use is increasing or mental health is deteriorating, and how the person may behave when under the influence or unwell. This is best completed in partnership with a specialist agency where possible.

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Appendix 1: Comparison of local authority and refuge responses

Below is a summary of the information collated about different boroughs, from both the local authority (through an FOI request) and the refuge provider (through the survey or interview).

Borough	Local authority response	Refuge response	
Barking & Dagenham	*No details provided*	*No contact made*	
Barnet	In 2012, substance use and mental health were described as 'key priority groups', whilst in 2013 they stated that all refuges accept women who have substance use or mental health problems depending on their need and risk level.	***Generic***	**Alcohol or drugs (AOD):** Women who are regular users of heroin or crack. **Mental health (MH):** No definite exclusions.
		Special-ist (BAMER)	Dependant on current residents and their support needs.
Bexley	This FOI response stated "there is no contract in place between LB Bexley and Bexley Women's Aid for the refuge service. Funding is now via Individual Budget allocation. The Initial support period is funded for 10 weeks from entry to refuge then continuation of IB funding after 10 weeks is subject to a review. The refuge customer has a support contract directly with BWA."	*No contact made*	
Brent	*No details provided*	**AOD:** Exclude if not engaged with substance misuse service prior to entry into refuge **MH:** No definite exclusions	
Bromley	In 2012, the intended outcomes for the refuge provider included service users with substance misuse problems or complex needs are supported to access relevant services; in 2013 the expectation is that the provider will support all service users but does not refer to any specific groups.	**AOD:** Using any substances other than alcohol or prescribed methadone; exclude if not engaged with substance misuse service prior to entry into refuge. **MH:** No definite exclusions.	

Borough	Local authority response	Refuge response	
Camden	The 2012 service specification included reference to supporting service users to better manage their mental health and substance use. In 2013, providers are required to 'ensure that those identified with relevant need receive specialist and high-level interventions for mental health, drug and/or alcohol use.'	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia	
Croydon	In 2012, the only requirement was that no blanket exclusion policies were used. In 2013, no details were provided.	*No contact made*	
Ealing	In 2012 there were no requirements, but by 2013 one provider only accepts women with substance use or mental health problems, and the second provider accepts women with mental health problems, women on methadone and substance dependent but have not used/drank for six months.	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia	
Enfield	In 2012, the information provided indicated that assessment and support covers substance use and mental health but did not necessarily require providers to accommodate women with these needs. The 2013 request stated that substance use and mental health are 'not in the service specification to date.'	***Generic***	**AOD:** Regular users of heroin or crack. **MH:** No definite exclusions.
		Specialist (BAMER)	**AOD:** Using any drug except alcohol; if using alcohol, must have a treatment plan in place before entering refuge **MH:** Personality disorders, post-natal depression, PTSD, Schizophrenia, Autism Spectrum Disorders
Greenwich	In 2012, refuge provision in the borough included support for women with mental health and substance use problems. In 2013, there was specific provision for single women who use substances if they are wiling to engage with support services.	**AOD:** Exclude if not engaged with substance misuse service prior to entry into refuge **MH:** No definite exclusions	
Hackney	In both 2012 and 2013 there was no specific requirement to accept women with these needs but we were informed that the service specification was about to change.	***Generic***	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia

Borough	Local authority response	Refuge response	
		Specialist (BAMER)	**AOD:** Women on a methadone programme; all other substances exclude if not engaged with substance misuse service prior to entry into refuge **MH:** Exclude if more than 2-3 women with mental health problems are already being accommodated in the refuge
Hammersmith & Fulham	In 2012, there was no specific requirement other than to accept women "[w]hose needs can be met by a low-medium supported refuge accommodation service and do not present an unmanageable risk to other women and children living in the refuge accommodation. The 2013 FOI request states that the "service specification has provision" for women with these needs (but does not provide detail) and each case should be assessed individually.	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia	
Haringey	In 2012, one refuge specifically supports women with drug and alcohol problems although it was not in the service specification. In 2013, the service specification includes 'provision for access for women who have problems with alcohol or other drugs or mental health.'	***Generic***	**AOD:** Regular users of heroin or crack; not willing to engage with substance misuse services **MH:** No definite exclusions
		Specialist (Substance use)	None
Harrow	In 2012 the service specifications for refuge services excluded women with substance use and mental health problems. They did not respond to the 2013 request.	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia	
Havering	'No mention' of these issues in the service specification.	*No contact made*	
Hillingdon	In 2013 specifically, 'the service specification is silent on access for women with substance use or mental health problems.'	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia	

Borough	Local authority response	Refuge response
Hounslow	*No details provided*	**AOD:** Must be engaged with a substance misuse service prior to entry to refuge. **MH:** No definite exclusions
Islington	In 2013, the borough stated that whilst there is no requirement in the service specification, there is an expectation that women with substance use and mental health problems will be accommodated.	**AOD:** Regular users of heroin or crack. **MH:** No definite exclusions.
Kensington & Chelsea	In 2012, the service specification includes reference to assessing needs on a case by case basis, but by 2013 this had been amended to include 'working with complex needs, i.e. alcohol/drug or mental health issues.'	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Kingston upon Thames	In both years the borough reported that the service specification does not include any particular reference to substance use or mental health, but explicitly states providers should not operate any blanket exclusion policies.	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Lambeth	In 2012 no details were provided; in 2013 service providers are not allowed to operate a blanket policy excluding women with substance use or mental health problems, but at the same time there is no specific requirement to support women with these needs.	**AOD:** Regular users of heroin or crack. **MH:** No definite exclusions.
Lewisham	No requirement in service specification	*No contact made*
Merton	"The Service Specification for Shanti whilst having exclusion criteria do not specify drugs and/or alcohol/Mental Health, so cases can be judged upon appropriateness/need/level of abuse or ill health. The Service Specification for Merton Refuge does exclude clients upon the basis of substance abuse and/or Mental Health."	*No contact made*
Newham	"The Asian refuge specifically excludes people with drug or alcohol problems (but have no exclusion related to mental health needs)."	*No contact made*
Redbridge	No requirement in service specification	*No contact made*

Borough	Local authority response	Refuge response
Richmond upon Thames	No requirement in service specification	**AOD:** Must be engaged with a substance misuse service prior to entry to refuge. **MH:** No definite exclusions
Southwark	In 2012 no details were provided; in 2013 service providers are required to identify substance use or mental health problems and support access to appropriate services. This does not specifically mean women with these needs must be accepted into the refuge.	*No contact made*
Sutton	In both years, the borough stated that the refuges are not substance use or mental health specific and referrals would be considered based on need and risk.	*No contact made*
Tower Hamlets	In 2012, no specific requirement was report but cases should be assessed individually on the basis of need and risk; in 2013 the question was not answered	*No contact made*
Wandsworth	No requirement in service specification	**AOD:** Currently using opiates, including methadone **MH:** Diagnosis of schizophrenia, autism spectrum disorder or dementia
Westminster	No requirement in service specification	**AOD:** Must be engaged with a substance misuse service prior to entry to refuge. **MH:** No definite exclusions

Appendix 2: Refuge survey questionnaire

Drugs and Alcohol:

1.

Do you accept survivors of domestic violence who are currently using drugs or alcohol into your refuge?	Yes always	
	Yes sometimes	
	Never	
	Don't know / Unsure	

1a.

Would you accept women who are on methadone or other substitute medication prescription for their addiction?	Yes	
	No	

2.

What is the capacity of your Refuge?	
How many survivors with substance use can you house at once?	
Would you accept a survivor who had a dual diagnosis of both mental illness and drug / alcohol problems?	

3.

Do you have a drug or alcohol policy?	No	Yes
If yes, would you be willing to send us a copy?	No	Yes

4.

Using the table below please identify which would you allow women to be using or receiving treatment in relation to whilst accessing your refuge? (Please specify any in the area provided)

Types of substance	**Yes**	**No**
Alcohol		
Amphetamines		
Anabolic Steroids		
Cannabis		
Cocaine powder		
Crack		
Club Drugs (eg: Ecstasy/MDMA, GHB, Ketamine)		
Hallucinogens (eg: LSD, psilocybin/magic mushrooms)		
Opiates (e.g. heroin, methadone, codeine)		
Other Drugs, (eg: solvents, methadone)		
Prescription Medications (e.g. SSRIs, benzodiazepines)		
Would a client, using multiple drugs or with dual diagnosis of both a drug problem and mental health be accepted into the refuge?		
Are there any conditions on accepting the above? Eg; Methadone programme in place, use of Subutex or attending AA		

5.

Do you require survivors to have a drug/ alcohol care plan in place before offering them a refuge place?	Yes	
	No	
	Dependent on individual & their circumstances	
Any further comments		

6.

Do you have a standard risk assessment that you use to assess all potential clients who use substances?	Yes	
	No	
If yes, would you send us a copy?	Yes	No
If no, how do you assess risk in relation to substance use?		

7.

Please provide an example of a time when you accepted a woman into your refuge that was currently using substances? Please think about the following questions when answering: • What substance was the client using? • How long had the client been using? • Was she accessing drug treatment or have a care plan in place? • Where other professionals working with you at the time? • What was the overall outcome? • Where there any difficulties you encountered or barriers you came up against whilst working with this client?

8.

Should the client disengage from drug / alcohol treatment, what action would be taken and how would their stay at the refuge be affected?	

9.

If use of substances is only disclosed once the client is in the Refuge, what action is taken?		
How often does this happen, eg; drugs / alcohol use is not disclosed at referral stage?		Regularly
		Sometimes
		Always
		Never

10.

Do liaise with your local chemist and are you able to get survivors there regularly?	Yes	No	If other, what partnerships have you established?	

Do you work in partnership with any drug / alcohol services in your borough, or the local drug and alcohol team?		Yes	If other, what partnerships have you established?			
		No				
		Other				
Are partnerships formalised in a specific way?		SLA	Other			
		Satellite Services				
		No				
How often do you meet with colleagues in the drug / alcohol sector to share information?		Regularly		Sometimes		
		Rarely		Never		
		Further comments				
Do you have any current clients who you are supporting in partnership		No	Who are these agencies?	***Please list***		
		Yes				

with other agencies		On-Going		

Has bullying ever occurred or is it apparent when taking in women with mental health needs and drug problems?		Regularly
		Sometimes
		Always
		Never
Is the person who uses substances usually the survivor or the perpetrator?		Survivor
		Perpetrator

11.

Has your staff received any drug and alcohol training in the last two years?		Yes	***If yes from whom***
		No	
Have you seen a change in services and understanding since training was implemented?		Yes	***Further comments***
		No	
		On-going	
		Unsure	

Mapping Questions – Mental Health

1.

Do you accept survivors of domestic violence who have a mental health problem into your refuge?	Yes always	
	Yes sometimes	
	Never	
	Don't know / Unsure	

1a.

Would you accept a survivor with a history of abuse to others?	Yes	
	No	

2.

What is the capacity of your refuge?	
How many survivors with mental illnesses can you house at once?	

Do you have a mental health policy?	No	Yes
If yes, would you be willing to send us a copy?	No	Yes

3.

Using the table below do you accept women into your refuge with any of the following diagnosed mental illnesses? (Please specify any in the area provided)

4.

Mental health diagnosis	**Y**	**N**
Alzheimer's Disease		
Autistic Spectrum Disorder		
Anxiety		
Bi-polar Disorder		
Dementia		
Depression		
Eating Disorders		
Obsessive Compulsive Disorder		

Personality Disorders (for example paranoid, schizoid, borderline, antisocial) Which ones? (any restrictions)		
Postnatal Depression		
Post-Traumatic Stress Disorder		
Seasonal Affective Disorder		
Sleep Disorders		
Schizoaffective Disorder		
Schizophrenia		

5.

What would be the protocol for dealing with someone who was self harming?	

6.

Do you have a standard risk assessment that you use to assess all potential clients with mental illnesses?	Yes			
	No			
If yes, would you send us a copy?	Yes		No	
If no, how do you assess risk in relation to mental illness?				

7.

Please provide an example of a time when you accepted a women into your refuge who had a diagnosis of a mental illness. Please think about the following questions when answering: • What was the mental illness? • How long had the client been suffering from this? • Was a care plan set in place? • Where other professionals working with you at the time? • What was the overall outcome? • Where there any difficulties you encountered or barriers you came up against whilst working with this client?

8.

Should the client disengage from their mental health treatment programme or stop taking required medication what action would be taken and how would their stay at the refuge be affected?	

9.

If a mental illness is only disclosed when once the client is in the refuge, what action is taken?		
How often does this happen, ie mental illness not disclosed at referral stage?		Regularly
		Sometimes
		Always
		Never

10.

Do you work in partnership with any mental health services in your borough, or the other local teams?		Yes	If other, what partnerships have you established?	
		No		
		Other		
Are partnerships		SLA	Other	

formalised in a specific way?			Satellite Services			
			No			
How often do you meet with colleagues in the mental health sector to share information?			Regularly		Sometimes	
			Rarely		Never	
			Further comments			
Do you have any current clients who you are supporting in partnership with other agencies		No	Who are these agencies?	***Please list***		
		Yes				
		On-Going				

11.

Has your staff received any mental health training in the last two years?		Yes	***If yes from whom***
		No	
		No	
Have you seen a change in services and understanding since training was implemented?		Yes	***Further comments***
		No	
		On-going	
		Unsure	