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Fixing a gendered system II:

Rethinking women in drug treatment

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Anna and her daughter Rain-India Millington would like to dedicate their involvement to all the Mothers who use/have used drugs both with and without their children and to Vicky Anne Major, Nurse Consultant at Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

Contributors include:

- Two Mothers from the M2M network, unable to access support or drug treatment services, who spoke to us anonymously *(referred to as Amy and Laura in the report)*
- A Mother from the M2M network who refused to access drug treatment services after her baby was taken from her care at the hospital where she had just given birth, who spoke to us anonymously *(referred to as Sophie in the report)*
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"I don't usually get involved with reports, they usually never want to hear anything but a sanitised version of reality. From the start this was different and for the first time mums from the network got to interact directly with researchers, their voice, their views.

We can't give some magic answer, this report can't change everything. But, unlike other reports it's based on our truth, their world, how they feel – this is the now, not the past. It gives you brutal honesty and that is the only thing that can help us make change.

We are all counting on you. My ask from you is please give them a voice, a real choice and a realistic chance to make change. I believe that is effective drug treatment."

Anna Millington, *M2M Network*

As a pharmaceutical company working to improve outcomes for people with opioid dependence, Camurus is committed to identifying and supporting solutions to challenges in access and delivery of drug treatment services.

This report has been developed in collaboration with, and informed by interviews with, service provider representatives, Mothers with living experience, academics and healthcare professionals.

Their views and experiences have shaped this report and its recommendations.

Camurus would like to thank them for their invaluable contributions, and in particular those who shared their own personal stories.

All case studies and quotes from or about Mothers with living experience have been anonymised, with names changed, unless specific permission has been provided.

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Jess Phillips MP

"I am pleased to introduce this vital report, following on from 2023's *Fixing a Gendered System: Addressing women's needs to tackle drug-related harm*. Women can face innumerable barriers in getting access to the help and support that they need for drug dependence – experiencing menopause, being victims of domestic violence and abuse. For Mothers, the system is almost entirely inaccessible."

There is a glaring shortage of services designed with women's needs, or Mothers' needs, in mind. This not only prevents women from asking for the help they critically and urgently need, but also amplifies the difficulties they face.

Recognising that a one-size-fits-all approach does not work is absolutely vital if we are to address the diverse needs of women navigating various life stages and circumstances. Without a clear focus on meeting women's needs, they will continue to contend with the absence of targeted services for Mothers, the fear of having children taken away, the distinct challenges linked to menopause, or the intensified struggles faced by women with experience of domestic abuse.

Even when women manage to access drug treatment services, the absence of wraparound care for issues like housing, child support, trauma, and physical health, hampers their progress. Addressing this requires a concerted effort to break down siloes between support services, ensuring that women receive the thorough support they deserve.

The lack of long-term funding is also a significant problem. Despite commitments from the 10-Year Drugs Plan, current funding for drug treatment services lacks the longevity needed to commission care with patients' long-term needs in mind. To see genuine change, sustained commitments are essential, enabling drug treatment services to plan for the future and reduce drug-related harm among women.

But good care is possible, and it's happening now. Throughout this report are examples of drug treatment programmes and projects that have built services around the needs of the women they support, making a meaningful difference in their lives. They serve as examples of what can be achieved through listening and responding to women's needs, and making simple, practical changes to how support is delivered.

To make sure that, no matter where women live, they can access the best possible care, is the critical next challenge.

In essence, this report issues a sobering call to action. It implores policymakers, stakeholders, and communities to unite in their commitment to addressing the distinctive needs of women seeking drug treatment services. It underscores the need for increased support, targeted interventions, and funding commitments that extend well beyond 2025.

The urgency to act is evident, and collective efforts will shape a more equitable and compassionate future for women navigating the challenging landscape of drug treatment.

Jess Phillps MP is Labour MP for Birmingham Yardley, a former Shadow Minister for Domestic Violence and Safeguarding and member of the APPG for Domestic Violence and Abuse.

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Anna Millington
M2M Network

"I am a Mother. I am a user and a criminal. It can make people feel very angry and uncomfortable when I say that. It shows the depth of bias surrounding those words because using labels that other people have placed on me is somehow seen as a negative when I own them - I refuse to 'other' myself. There is no bad and good and no before and after, there is only me."

Identified in her early teens as a 'prolific offender', Anna has a long history of lived experience within the criminal justice system, and both negative and positive experiences of harm reduction and drug treatment services.

After her last prison sentence in 2001, Anna gained a degree in criminology at Northumbria University. She was asked by the National Treatment Agency for Substance Misuse (NTA) to represent women's issues on the National Service User Advisory Group and was an expert by experience for the NTA on the Hidden Harm Agenda and the prisons Integrated Drug Treatment System (IDTS) programme where she delivered core IDTS training to prison healthcare – often in prisons she had previously been housed within. She has also worked at the regional and national level for key treatment providers.

"It was not a miracle that helped me, it was treatment. It was an easy access approach that services had back then. It was not punitive, it was positive to come forward to access treatment, the focus was on stability not sobriety. The system as it is now set-up feels like it does not like users, it positions them as bad, it is all about the shame and blame. Who would want to put themselves through that? For many, it has become a last choice and it should be a first one."

Anna Millington, *M2M Network*

Whilst others mainly identified her by what she currently did, or what she had done in the past, she has always identified herself first and foremost as a Mother. This was a facet of her life that was continually ignored throughout her criminal justice, drug treatment, and harm reduction interactions unless it was related to punitive action.

"All she has ever been to me is my Mum and I love her, I know people have always wanted to call her a bad Mother but I don't know what they mean by that. She has always been a great Mother and I know her the best."

Rain-India Millington, *M2M Network*

Anna has spent the last 20 years with a focus on women, particularly Mothers who use drugs, both as a professional and in her own time. She set up the HR M2M network having identified the gaps in provision for Mothers who use drugs. These Mothers know coming forward for help will likely mean referral to social services.

"We can keep spinning this line that it is not like the old days - the data backs this up, its worse."

Anna Millington, *M2M Network*

"Sometimes when I have seen they were a good Mum and then they've taken the kids anyway - it makes me scared, would I have went back to my Mum if it was now. It all happens so fast, what time is there for change like my Mum had?"

Rain-India Millington, *M2M Network*

The harm reduction network provides injecting and smoking equipment to Mothers who are not engaged in services. 'Gift bags' often contain things to increase positive engagement, ranging from children's crafts to cooking ingredients for 'meal' nights. It is based around a no shame principle.

Whilst those in the using community are subjected to stigma in general, there is additional moral outrage and punishment that is directed at Mothers who use drugs.

"How deviant must you consider us if you have taken our children away permanently"

Anna Millington, *M2M Network*

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My focus has always been aimed at Mothers who use drugs and their children. I first presented at a conference on this in 2005. I was the expert by experience for the NTA in the original development of the Hidden Harm agenda. My message has remained consistent since then, that the key issues for this group were engagement and comprehensive treatment that included medical, social and psychological interventions. I believe that Mothers who use drugs should have easy access to interventions to provide stability; what choices they make about a chosen pathway after that are their own and will vary.

For almost all the Mothers over the course of the last 20 years I have been involved with, they do not identify themselves by saying they are a woman and then have Mother tagged on as some lesser part of their identity. Mother comes first.

Their Mother identity is devalued when added to a list of things by others as something that increases the stigma they face as a woman. This is not true, the stigma they face as a Mother is unlike anything else. No other user faces that level of societal negative moral outrage or punishment.

Mothers and their children are ignored completely in the drug strategy. I haven't seen the word Mother mentioned in any drug strategy since 2010.[1]

The strongest familial bond is often Mother to child and yet a reference to wider input is all that is noted.

Can people understand why it might feel to these Mothers they are simply being ignored? That they and therefore their children do not matter, and they are not wanted or welcomed. That there is almost an expectation that Mothers and their children do not need to be talked about because they will not be together.

Mothers are not included or mentioned by commissioners in contracts for services and there is no provision made in relation to child safety whilst accessing a provider or pharmacy with their Mother. We are left out of everything unless it relates to something punitive. When does safeguarding become not just something that we are measured on, but commissioned services are required to ensure they are also being measured on?

This is clearly gendered. For many Mothers, their experience is that safeguarding interventions are far more likely to occur as a result of their own challenges being scrutinised. It can feel like the drug use of the men that live with them does not trigger the same response.

Over the past 10 years many smaller and community rooted specialist services such as women's services have closed as a result of austerity and commissioning processes that favoured large contracts. All the changes made are gender blind.

Prime minister, if you want to keep mothers out of prison, don't cut the alternative

Katharine Sacks-Jones

Specialist women's services, such as women's centres, are highly effective alternatives to custody, but these very services are under threat

Last year 17,000 children were separated from their mothers by imprisonment. Photograph: Gareth Copley/PA

To read, visit: **www.theguardian.com/society/2016/feb/09/keep-Mothers-out-of-prison-prime-minister**

UK charities warn of 'devastating' council cuts to women's services

Those dealing with violence against women most at risk as local authorities try to balance budgets, experts say

Charities say most aspects of the services are non-statutory, meaning councils do not have a legal obligation to keep funding them. Photograph: kieferpix/Getty Images/iStockphoto

To read, visit: **www.theguardian.com/society/2024/feb/18/uk-charities-warn-of-devastating-council-cuts-to-womens-services**

Lots of talking the talk but not walking the walk.

How much more can be said on women when we have had so many reports over so many years and still not managed to get it right. We have done nothing throughout the current recovery agenda over the last 12 years but get it wrong.

What is glaringly obvious to me in almost all these reports is the continual focus on starting at what I refer to as the letter C – recovery. No wonder it remains out of reach when we skip over what are the fundamentals A and B – engagement and treatment. These are the foundation, and without them nothing is possible for the many. There is no ability to get to C.

Treatment that meets a person's most important need is vital

How can we ever discuss drug treatment if we do not talk about the primary reason that almost all of us access treatment services?

Women have different needs, and this includes the treatment plan that allows stabilisation of illicit drug use as a first priority. The continued narrative that all drug users require the same approach to treatment, and that gender plays no role in this is a pivotal point that shows the gendered nature of the sector. If we do not address this issue, then we will continue to repeat the current damaging cycle. We will see a continued increase in overdose rates for women and a continued decrease in those presenting at services.

"I don't know if people understand how badly women who use drugs are treated"

Anna Millington, *M2M Network*

We will only come into a service that is offering something that works for us.

The consequences of an uncritical application of the recovery model has meant that we are in a continual cycle of failure to engage, failure to properly plan and deliver individualised treatment, failure to understand the need for stability. This leads to an inability to access anything that may be on offer for our additional needs. Life stability is not what services are commissioned to provide, but it is what women are often seeking.

When will we understand that a tailored treatment plan that addresses our most pressing need for stability is what is needed for many of us and the only reason we engage? Accessing treatment currently is humiliating, punitive, controlling, and invasive. Women are being made to feel dominated, forced to urinate on command sometimes while being watched and without any control over their own lives.

How is this in anyway positive and appealing? It is not trauma informed, it is trauma inflicted. Changing where these incidents take place is not a miracle answer. I believe in the sector, and I believe it can make the change that is needed.

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Introduction and summary of findings

2,000

In 2022, over 2,000 women in the UK died of drug-related causes.[2]

114%

Between 2009 and 2022, drug-related deaths rose by 114% for women in England and Wales, compared with a 54% increase in men.[3]

2022

In 2022, drug-related mortality rates declined in men – but increased for women.[4]

x25

Women who use drugs experience gender-based violence at up to 25 times the rate experienced by women in the general public.[5]

40%

Women who used substances or with mental health problems accounted for 40% of maternal deaths that occurred within a year after pregnancy in 2015-2020.[6]

In the face of these devastating statistics, in 2023 Camurus prepared a report called *"Fixing a gendered system: Addressing women's needs to tackle drug-related harm"*. It sought to explore what change is needed to make services encourage and welcome women.

Through the research and interviews which built the report, it became clear that the reasons women are held back are wide-ranging. To fix a system you need to better understand where it may be broken.

Women have additional health needs, including sexual health, menopause, and mental and physical health, and they are more likely to have previous and ongoing experiences of domestic violence and abuse. Crucially, women who are Mothers are persistently stigmatised, judged and excluded.

Fundamentally, women and Mothers are held back by a system that judges them, is seen to take away their children, and fails them time and time again. Persistent funding cuts, short-termism, and failure to prioritise them in national policymaking have all contributed to a system in need of reform and rejuvenation.

This report has been developed in partnership between Camurus and Mothers and women with living and lived experience – we have worked together to examine how the system is broken, why women and Mothers are not in treatment, and what needs to change, creating a clear case for change as well as a series of simple, practical solutions which could make a substantial difference.

The number of women accessing drug treatment services in 2023 fell compared with the previous year.[7] At a time when drug-related deaths among women are rising, there is a critical need to offer care which delivers for women's needs, making access as easy, welcoming, and encouraging as possible.

The Government must work with local authorities and drug treatment service providers to mandate the development of treatment and support offerings which better account for and align with women's needs and enable them the choice of treatment pathways that they deserve.

Women who use drugs' needs must always be considered when designing and commissioning local services. If the sector does not urgently adapt its approach, a whole generation of women is at risk.

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Summary of recommendations

A call to action

Anna Millington

We can continue to avert our gaze, deceive ourselves that this is in the best interests of the children, or we can make drug treatment effective and accessible so that Mothers who use drugs are able to engage at a much earlier point and obtain suitable treatment that will provide a level of safety, acceptability, and stability for both them and their children. The biggest act of safeguarding is positive engagement because you cannot safeguard what you cannot see.

This is not about financing something new for this group or putting money into something they have not said they want. I am not sure why people keep designing or funding things women do not want and then ponder why they are not coming in to access it.

The misguided 'hallmark movie ending' centred on the belief women will simply come in and trust and have no fear because it is a woman only service, underpins how little is understood about these Mothers at the earlier stage in their dependency. We are going to have to go to them. Assertive, targeted and consistent, trained outreach combined with easy access individualised treatment that prioritises immediate needs is the only option that has any chance of working.

This is about understanding their needs, addressing their fears, making them see us as trustworthy so they feel they can engage. It requires us to change our language and use positive messaging. This means having a consistent, clear, honest approach and way of working. It means workers that understand this group and want to work with them proactively, positively and without judgement.

It requires making strong multi agency links and not allowing other agencies to dominate or control their drug treatment pathway.

They want help, they are just trapped with no way of feeling able to get it. I have seen great teams doing the same thing for other marginalised groups. It can be done as evidenced by Project 6 *(see page 20),* Orbit Hackney (see page 22) and the Change Grow Live (CGL) Southampton Outreach Team *(see page 21)*.

The next few pages set out some urgent changes which can make a real and immediate difference, as well as some longer-term calls to action to build for a better future.

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What can be changed now?

Local authorities

1. Local authorities should work with Women's Health Hubs to provide specific clinics that incorporate drug treatment appointments, urine screening for illicit substance toxicology and sexual health, cervical smears, menopause advice and wider health check-ups.

2. Local authorities should facilitate co-working between women's refuges and drug treatment services to support women undergoing drug treatment who have experienced domestic violence and abuse, opening refuge doors to those who desperately need them.

Combating Drug Partnerships (CDPs)

3. CDPs should work with services to establish peer support groups and train peer mediators and mentors with living experience so new patients can be offered a mentor or mediating partner to provide impartial support during their treatment journey.

- **a.** Providers must be enabled to signpost to these groups where they are unable to provide them within their own service, ensuring all women have equitable access regardless of where they access treatment and support.

Providers

4. Drug treatment service providers should establish age-appropriate health screenings, including for menopause, fertility, sexual health and general physical and mental health, as well as providing written information on wellbeing and symptoms to look out for.

- **a.** This could include a simple checklist to run through with service users, identifying needs and enabling signposting to appropriate support where this cannot be provided onsite.

5. In order to provide services tailored to the needs of women, providers should:

- **a.** Offer 'drop in' sessions to provide flexibility to those that may struggle to attend a specific appointment time.
- **b.** Offer women-only clinics at a set time each week.
- **c.** Make provision to allow children on-site during an additional Mothers-only clinic at a set time each week.
- **d.** Offer women access to remote sessions (such as video calls) or off-site sessions (such as in a public setting like a coffee shop), if they choose, to enable flexible access to support.
- **e.** Ensure that, once a Mother has stated that she has a child within her care at the assessment appointment, family safeguarding is shown to be a positive and inclusive choice. She should be given a copy of the family safeguarding policy (including a user-friendly version with a simple terminology chart), which demonstrates how family safeguarding can help to support her family, and that she signs to confirm she has received copies, and that the policy has been explained in detail. Questioning and exploration of the Mother's circumstances should not happen until this has taken place. It is critical that safeguarding is addressed consistently and with respect.
- **f.** Develop plans to reach out to women and Mothers, including positive engagement and relationship building, pathways for transitioning into services, and exit planning which allows for rapid re-entry in the event of a return to drug use.
- **g.** Ensure that discussions about sex work explore a full range of related issues, and not just discussion of safe sex. This should be undertaken with clear patient focused goals, otherwise it risks being an opportunity for further stigmatisation.
- **h.** Commit to safeguarding measures on site, including, for example, staff presence, to ensure women and children are safe from predatory or aggressive attendees at the service.
- **i.** Offer regular opportunities for women to ask questions, including specific outreach sessions around women only clinics, allowing women considering drug treatment to access high quality information so they know what to expect and proactively choose to engage in a formal assessment appointment if appropriate.
- **j.** Ensure that when attending a case conference or related child protection meeting that Mothers and key workers are given a clear opportunity to raise concerns about measures and targets they believe are unachievable and agree an appropriate way forward.
- **k.** Except in cases of immediate risk of harm, key workers should inform Mothers prior to seeking referral to social services and provide clear explanation.
- **l.** Develop training on using non-stigmatising language in partnership with Mothers and women who use services, and regularly refresh internal training for all staff, mentors and volunteers about using non-stigmatising language.
- **m.** Offer harm reduction packs designed specifically around women's needs, for example to include information about women's health or smaller needles, for pick up only by women.

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6. Providers should ensure that women are empowered to choose their own treatment pathway in line with their own understanding, preferences and needs. This could include sharing a copy of the Release Advocacy Toolkit (for further information, please see: https://www.release.org.uk/blog/advocacy-guide-your-toolkit-advocating-drug-treatment).[15]

7. Providers should implement assertive outreach. Effective services demand a staff group that has consistent exposure to the community through attending community hubs and health centres, promoting drug treatment services, answering questions and building relationships with women and Mothers where they are.

What needs to change longer term?

Government

8. Automatic referrals to social services should not be the default policy when a Mother with drug dependency accesses drug treatment or other health provision; referrals should only be made when triggers are met. The Chief Social Workers should provide national guidance to local authorities on reasonable triggers to involve social workers in cases where Mothers are seeking treatment for drug dependence, as well as the right for Mothers to respond to their referrals, helping to rebuild trust and confidence.

9. The Joint Combating Drugs Unit should work with those with living experience and their advocates to establish training resources around understanding the specific needs of women and Mothers with drug dependency, avoiding stigmatising language and attitudes. The outcomes of this training should be considered a core competency and the training should be made available across all public services, including drug treatment teams, housing teams, and education staff.

"Building together a safe place that doesn't leave anybody behind"

Aura Roig Forteza, *Metzineres*

Combating Drug Partnerships (CDPs)

10. CDPs should work with commissioners to ensure access to support groups is measured through key performance indicators, and to secure consistency even in the case of a changing provider.

Commissioners

11. Commissioners should make it a requirement of contracting that providers clearly commit to putting in place a programme of key-worker consistency.

a. As far as practical, each woman's key working appointment should be held with the same person, allowing trusted relationships to develop which in turn support sustained treatment engagement and avoid the necessity of repeating complicated or traumatic case histories.

b. This should include clear contingency protocols, such as pre-appointment preparation, for cases where it is impossible for an appointment to take place with the designated key worker.

Commissioners must hold providers accountable against these indicators.

12. Commissioners should amend their drug treatment service key performance indicators to give greater weight to or incentivise improved outcomes for vulnerable or underrepresented groups, including women. National leadership, like the Joint Combating Drugs Unit, should amend commissioning guidance to make this a mandatory indicator for local authority commissioning performance tracking, empowering local authorities and CDPs to hold providers to account.

a. National leadership should include in commissioning guidance a clear framework for measuring providers on meeting women's needs.

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The system needs to rebuild trust for Mothers and for women more broadly

"Accessing support for health can feel like an unsafe space for someone who uses substances, specifically women, due to the shame and stigma associated with substance use. For many women who have had their children removed from their care, it can feel extremely unsafe to access support from services who can make decisions regarding your care."

Hannah Boyle, *Simon Community Scotland*

Anna Millington

Do services really understand who we are?

Not as abstinent women or women in recovery but as women who are active current drug users. Understanding who we are means being able to effectively engage us because you can fund a woman only service but if you cannot engage us, if we are not willing to access it – it is pointless. Engaging us where we are at, understanding core harm reduction principles that do not push for people to want or need to achieve abstinence as the primary goal. Pushing this agenda when it is not wanted simply leads to disengagement. We have to accept that there are women who for whatever reason do not wish to access treatment services or stop their drug use. Once we accept this then we can identify the key goals that we need to meet.

Hindsight about what you used to be or what you used to do or how you used to feel does not offer current insight into what may be needed now, what is happening now.

It makes little sense to me that the women we want to engage are not the women who we are listening or talking to about what is needed. How can we understand and engage a group we do not connect with? How can we connect with a group if we are not willing to recognise what this may involve and who is best placed to make those bridges.

Shame and stigma

We constantly acknowledge predatory behaviour from men but ignore what else is happening. Women are currently disempowered, shamed and pressured to change their treatment plan, often by people with limited qualifications or limited experience in this complex area. It should not be a requirement of accessing a service to have to listen to others trauma dumping or be shamed by someone who claims they are your peer even though you don't perceive them that way.

A woman only service is not going to provide a safe space if we fail to admit this is happening.

"Drug services across this country vary greatly in their ability to treat people who use drugs as whole humans worthy of respect and adequate healthcare... despite the fact that many drug using people, and in this example, drug using women, are totally capable of self-advocating – the current truth is those women would likely be labelled "difficult" or pathologised as a "complex case" and treated more punitively as a result of their protest. This is sadly why the need for advocacy within these services continues."

Shayla Schlossenberg, *Release*

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Relationship-building and trust between women and drug treatment services is necessary to help women to achieve positive outcomes. Past negative experiences with public services mean that women have lost trust and are unwilling to engage, with implications for treatment access and wider health outcomes.

This is compounded by stigma towards women who use drugs through the language used to describe them, which can alienate people and discourage them from seeking or continuing to seek support.[8] Adapting language approaches that focus on the person can make a significant difference.

"It's about avoiding stigmatising language and how we speak about people, how we're referring to people. Avoiding 'service-user', avoiding the jargon, because that can carry a lot of violence. We're making sure we're not using issue-based language, taking a strengths-based approach instead."

Hannah Boyle, ***Simon Community Scotland***

"You're always the underdog and you're always blamed."

Amy, ***M2M Mother***

"There are other barriers around stigma: lots of people don't want to go to healthcare because they've had bad experiences in the past. Lots of women end up dying prematurely or living with extremely bad health because they're living with preventable long-term conditions."

Hannah Boyle, ***Simon Community Scotland***

The women that we spoke to told us about their lack of trust in wider public services, including in social workers, doctors and nurses. This is exacerbated by repeated negative experiences, the experience of being judged or not being listened to, or even of being lied to when they have accessed these services.

"It's the job of the treatment service to engage women. Lots of times they refer to women as 'hard to reach'. We're not hard to reach we're hard to engage in the current system. Who wants to go somewhere to be shamed, blamed and punished."

Anna Millington, ***M2M Network***

"I didn't feel like I was listened to. When I was there [at the parenting course], there was a magnifying glass on us all the time, which made it even harder... If they'd listened to me I think I would have been more open and honest with them but all the professionals were like that, judging you straight away."

Laura, ***M2M Mother***

"There's a huge stigma, yeah. They'll listen to every word and take it out of context. If you say one wrong word, or you lose your temper, or you're having a bad day and they're not getting what you're trying to say, all of a sudden 'you look manic' or 'you've got an anger problem'. It's not that, it's just frustrating when nobody wants to listen to you."

Amy, ***M2M Mother***

"They didn't listen to what I said, they would ask us a question and then tell us the answer. Ask did I really feel ready for the bairn, and then straight after tell us I must be scared. I wasn't scared. They already had me life, me thoughts, me plans done ... I hate them, I hate them, and I'd never believe them again. I thought I was doing the right thing getting help, but I wish I'd never told them nowt."

Sophie, ***M2M Mother***

"The staff turnover in this sector is wild, you can have five different key workers in a 13-month period. Would you like your deepest painful experiences just passed on to strangers, time and time again. Child abuse - tick, domestic abuse - tick, kid taken - tick... it all just becomes words without meaning, you become numb to it."

Anna Millington, ***M2M Network***

Paula Kearney

Community Development Worker, *Ireland*

The girl was asked for a urine sample, in the clinic, as you do, was asked for the supervised urine sample and then stopped, the general assistant is banging on the door, rushing her out... then when she's out, she's being accused, because was drying her hands under the hand drier, of heating up the sample so it was clean, but when she challenged that, she said that she wasn't, then they were refusing to take the sample, and she was saying I'm going to have [child protection services] on my back, I have to give it.

And the response that girl got was, "so now you care about your kids".

While some of these experiences may happen outside drug treatment settings, such as in hospital, during interactions with the Police or with a social worker, negative experiences of public services can inform opinions and create a barrier for women in accessing the support they need in the future. Non-stigmatising language towards those with drug dependence or other problematic substance use must be applied across all public services to build trust and remove these preventable barriers.

"Some of the women that we have, have had children taken from them in the past and they just hate us. They don't want to engage with us. We try to make them understand that we want to support them but because they've been separated from their child, had such terrible experiences in the past, they just don't want us to engage with them."

Alice Corsi, *Psychiatric Nurse*

"Women who are labelled as criminal and drug users, and who are Mothers, must contend with an enormous amount of stigma from multiple directions in society. Being a woman and being convicted of a criminal offence often means women are viewed as 'doubly deviant'. Add drug use and Motherhood into the mix and they are even more likely to be intensely vilified and discriminated against."

Dr Lisa Williams, *University of Manchester*

"Wouldn't you hate the people who took your bairn from you?"

Sophie, *M2M Mother*

One way to improve trust in the drug treatment system is through peer-based support. These additional services use volunteers to offer encouragement and support for someone in treatment or with ongoing drug dependence.[9]

A form of lived experience support is already available in the majority of local areas. However, it is usually delivered by someone in early or stable recovery, rather than someone with living experience, undergoing treatment at the same time.[10] While there is an important place for support from those who have achieved successful recovery, our interviewees noted the value of peer support from those with ongoing living experience. In particular, it became clear that having a mediator, someone that the women know and trust to sit alongside them and help them navigate the environment, supporting them and keeping them on the pathway they choose, is extremely valuable.

"Peer to peer is not recovered to user. Peers need to be at the same level. If you are not using or medicated then you are someone with lived experience but you are not my peer. You are the other when you are abstinent, you are playing for the other side and not for us. You are only my peer if I feel you are, not when you tell me you are. If you start a sentence telling me immediately how you are not like me - as someone in recovery, etc you are telling me you are not like me at all."

Anna Millington, *M2M Network*

"You need someone who's not part of the system, who's kind of fair, like a referee on the football pitch that's not getting paid extra money. But somebody who legitimately just sees both sides of the story."

Amy, *M2M Mother*

UK-NPR-2400038
May 2024

Harm reduction can be a life-saving tool for women who use drugs, as well as a means for the system to build back trust.

Harm reduction is an approach used across the world, with a series of actions taken to minimise the negative health, social and legal impacts associated with drug use. It is also a bridge which can open discussion about treatment, and what's available; it creates a door which people can push open if they choose. It can include working with people without judgement or discrimination, overdose prevention, needle and syringe programmes, drug checking and more structured treatment.[11] But in the same way that women face barriers in accessing treatment services, they can also face the same types of system, logistical and stigma barriers in accessing harm reduction methods.

"We're really good at tailoring NSP [Needle and Syringe Programme] interventions to the needs of the individual. We regularly reinforce how important this is when talking about harm reduction, but when it comes to injecting advice, how often do we think about gender? Women are physically different to men. Their veins are often deeper, their hands may be smaller, so first of all we need to think about the equipment we offer. And many women are first injected by a partner. This means they will already have vein damage when they start injecting themselves. While encouraging women to take control of their own drug use, we need to consider how difficult it might be trying to learn to inject in already damaged veins. Vein damage can make it more likely that someone will experience missed hits, infections, and worse. We need to think differently about the NSP interventions we offer women who inject drugs. Their needs are different and the service we provide should be different too."

Deb Hussey, ***Turning Point***

"My work is all about people experiencing harm but not seeking treatment; for women, there are so many barriers, many come down to judgement of what a woman does or should be doing. This stops women feeling like they can speak out and get the support they want and deserve and the agency to change their own lives."

Gillian Shorter, ***Queen's University Belfast***

Exchange Supplies

Sharps Disposal

The thought, care, and effort that you put into the presentation of the things you make or give out says a lot about how much you care about the end users of the product. One evening, Anna Millington was telling me about the super positive response she had received from women in her network to our coloured syringes, and she asked why sharps bins have to be black? "They're like a black hole in the midst of all the colours, they stick out like a sore thumb" she said. The answer to the question was that 'the field' had always considered black to be a 'discreet' alternative to yellow... but it was immediately clear what she was saying was true, and they'd be much better hidden in plain sight as a bright colour. The next day we placed an order for pink bins, which were an instant hit with the field, and more importantly women using needle and syringe programmes.

Andrew Preston, ***Exchange Supplies***

"It really matters when an organisation listens and responds to what we may see/feel is stigma and not what they do." **Anna Millington,** ***M2M Network***

Commissioning performance indicators are a barrier which can prevent some providers from repairing damaged trust in public services.

Providers are assessed by commissioners on their performance against a number of key performance indicators (KPIs), often including the number of 'successful completions' and their ability to make efficiency savings, which can supersede the development of more tailored or bespoke services.[12]

"Frontline drug services are bound by money. Services may have access to additional funding, however contracts and KPIs remain the focus and to create women's only spaces can become a secondary priority. I have worked in organisations where women's only services were funded separately such as providing a creche space."

Shoba Ram, ***Transform Drug Policy Foundation***

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This approach fails to recognise differences between patients and can drive a focus on achieving limited results that may not be the best outcome for everyone. For example, for someone to achieve a 'successful completion', they must leave the service fully detoxed from the substance they were referred for.[13] This is not necessarily possible, or desired, for everyone, and if a woman is not engaging in a way that aligns with achieving this goal, that can limit her service access.

"The problem is, everyone assumes that abstinence is the answer – but it depends on each person. If you're stable and in treatment, that's a good outcome too."

Anna Millington, *M2M Network*

"Because of KPIs and targets within the commissioning landscape we're in, repeated non-attendance at appointments may mean you have to go back on a waiting list. As you can imagine, that disproportionately creates a barrier for people for a variety of reasons. It might be someone that's neurodivergent and struggles with timekeeping, it might be a parent with fluctuating caring responsibilities. When you're talking about a system that's quite overloaded and with limited amounts of resource, these policies and procedures can unintentionally do harm to women."

Kate Ashfield-Fox, *WithYou*

While these KPIs are driven by national benchmarks and inform budget allocation, they limit the ability of providers to deliver outreach or clinics which do not directly contribute to targets, such as those tailored to the specific needs of women and Mothers. This reduces the chances of trusting relationships with key workers because the focus is on achieving a generic 'successful completion'.[14]

"Without flexibility we can't build empathy and therapeutic relationships. If we have to see so many people in a day, then it's really hard to give someone the extra half hour that they need while they're in that particularly open state where they were having a really emotional conversation and talking about domestic abuse – but the way services have to align with the commissioning landscape, that kind of thing isn't always possible."

Kate Ashfield-Fox, *WithYou*

Pervasive stigma can increase the challenges women with drug dependency face, creating a barrier to accessing crucial support. This is worsened by a system which focuses on a narrow definition of a 'successful outcome'. Drug treatment and public services must reform their approaches to fostering trust and actively engage women to break the cycle of stigma, reduce harm and improve outcomes. For example, through proactively sharing tools like the Release Advocacy Toolkit, services can help to rebuild trust by helping women to advocate for their needs and preferences (for further information, please see: https://www.release.org.uk/blog/advocacy-guide-your-toolkit-advocating-drug-treatment).[15]

"We must listen to women, what they want, and not what society thinks is best for them. What society thinks is best for women is laden with ideas of the 'women's role' as Mother so that is why stigma is so much harsher for women than men."

Dr Fay Dennis, *Goldsmiths, University of London*

"We went to the women, we were collecting all the information from the women, and when we had everything, we went to the scientific community... we asked what do you think about this, [and they gave us some scientific papers], and we took that back to the women and made it in language that worked for the women, and so we put [an information pack] together, and it's information that is really what is relevant for the women."

Aura Roig Forteza, *Metzineres*

"On one hand they are showing me via their messaging, their language and their focus on the 'ideal' that I am unworthy, must be harming my child, not nice if I am not saying, doing, being who they have decided I should be – then they tell you that you should feel worthy, not guilty, not stigmatised. If the messages you are sending do not match what you are saying then I am not sure how they think recovery can happen."

Anna Millington, *M2M Network*

Motherhood cannot not be treated as an add on

"It is impossible to discuss the needs of women in relation to the criminal justice system, harm reduction pathways, drug treatment services and recovery in any full sense without also including within that as a priority, Motherhood. Whether women have children within their own care or not, they remain Mothers. Motherhood is not an add on.

This sector of our using community has continually been misunderstood, underrepresented, and partially ignored. A tokenistic head nod to 'women' generally without specifics of who we are and what our needs may be as Mothers who use drugs is no longer acceptable. We face harsher restrictions on accessing harm reduction services, face sterner judgements and discrimination, both societally and within professional and peer services, and are required to make unrealistic leaps in both the criminal justice and drug treatment systems and be almost superhuman in our recovery journey."

Anna Millington, *M2M Network*

Anna Millington

So what's the current situation - how do mums who use drugs feel and experience treatment services?

Being a Mother is something you are for the rest of your life and refusing to accept this core aspect is demeaning. The reality is we are viewed as different to other Mothers, as if we love our children less, as if we value them or their place in our lives less. Loving your child has nothing to do with taking a drug. The belief that it matters is an indicator of how Mothers who use drugs are subjected to entrenched untruthful myths and moral hysteria. It is more than stigma. It is a belief that we are bad Mothers, and our children are being hurt or are unsafe in our care. It is not what is happening and who they are in general.

This group has other unique aspects, it is the one group in the using community where there is already a reason to commit to change, a powerful positive link to their children and this is an extraordinary motivational driver and can provide key focus in a short space of time. Instead of identifying and understanding this, their children have been weaponised against them.

We have taken away what could have been a powerful driver for them to make change and used it as punishment, something to dread and fear.

It is impossible to offer effective trauma informed care if there is a refusal to understand and acknowledge what Mothers suffer from society, the sector, and many professionals they have contact with. There is no acceptance that we all play a role, that we have been conditioned to be biased and it is often unknown and unconscious, but it is there. There is nothing but negative portrayals about this group.

There is no other group in the using community that is more stigmatised, vilified, disregarded, or punished than Mothers who use drugs. We face the most severe, unique, and often life lasting punishment for not adhering to required expectations or goals. Whereas all women in treatment face treatment disruption as a punishment if they fail urine screens, Mothers who come forward to access treatment face having their children taken away.

This is so much deeper and darker than people seem willing to face.

UK-NPR-2400038
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Stigma and judgement experienced by Mothers with drug dependency is pervasive and highly detrimental to engagement with drug treatment.

"The majority of women in our community are Mothers, however they are not seen as Mothers as they have had their children removed from their care. The landscape doesn't see them as Mothers and that part of their identity is taken from them."

Hannah Boyle, *Simon Community Scotland*

Mothers who use drugs face judgement based on society's narrow presumptions of what it takes to be a good Mother – society and system expectations lead to contact with social services and, in many cases, children being removed from their Mothers' care.[16]

In 2014, 96% of adoptions in the UK were forced. Since then, no further data has been published on this critical issue.[17]

In *Engaging with Motherhood and parenthood: a commentary on the social science drugs literature*, Fiona Martin notes that "ensuring the wellbeing of children has long justified expert and state attention into the realm of parenting, but, according to a number of sociologists, both have intensified in recent years".[18]

"Women accessing treatment will often have their parental capacity questioned, criticised, or entirely removed by police or drug treatment services if they admit to any drug use, whether it is problematic or not."

Niamh Eastwood, *Release*[19]

Several of the Mothers that we spoke to shared experiences of anxiety, heightened judgement or the experience of being watched that made them apprehensive about seeking help.

"It felt as though I wasn't recognised as an individual until I became pregnant. I was then entitled to support aimed at women and mums specifically. This makes it seem as though my own problems are only important because I could be a negative influence on a child."

Dr Rebecca Tidy, *Journalist and Researcher*

"All they wanted was the bairn, soon as he was born that was it. Just took him and all the stuff was just lies, bare faced lies."

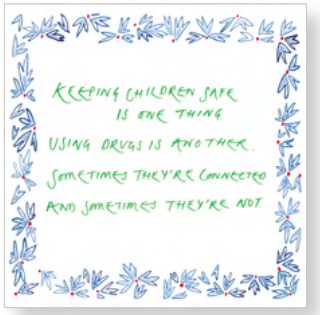
Sophie, *M2M Mother*

"If a man and a woman go into a drug service, with the man on drugs and the woman not on drugs, they won't get a referral to social services. It isn't about parental drug use and children, because if it was, it would happen no matter which parent it is in the home. But referrals really only happen like that for the Mothers."

Anna Millington, *M2M Network*

"When you're poorly, you've gotta get all washed and dressed and look presentable to go and drop your son off at school and be ready by half three to pick him up – you've still got eyes on your head, it just takes the teacher to see you, you know. You can't just go and rock up in a holey pair of leggings."

Amy, *M2M Mother*



Mother 2 Mother

Anna Millington

This sector of our using community has continually been misunderstood, underrepresented, and constantly ignored unless under the guise of a misguided and ill-judged child protection rhetoric. The harm reduction network identifies and provides injecting and smoking equipment to Mothers who are shielding themselves from all services. It also provides practical support where needed. These Mothers often feel locked into a no-win position and know coming forward for help will likely mean referral to social services. This often has a negative outcome. The North East of England has the highest removal of children rates in the country.

M2M was never a thought-out project. It was born from reacting and responding to what Mothers in the community needed.

I've established a network to provide harm reduction equipment and wide-ranging peer support to Mothers who use drugs. Those in hiding and fear, those with extensive needs who feel alone and trapped, unable to come forward. These Mothers may not make up the majority of the using community, but they can be one of the highest-costing sectors societally, generationally, and economically. Providing what may be termed as high-risk support to this group is demanding, and has had both positive and negative outcomes, but I believe that risk is inherent in anything – including doing nothing at all.

I first came across a Mother outside a chemist, as someone with lived experience I had deluded myself that I knew what was going on for Mothers in my community. I was wrong. She told me she was having to pay some guy to get her needles. I was in absolute shock that harm reduction was still locked off from anyone in the community and that this had been going on in the area I lived, and I didn't know about it. It was then I understood the limitations of lived experience and refusal to accept when we become the other. It is when they see us as the other, they stop telling us the truth.

I told her I would get her needles and HR M2M was born. I quickly discovered more Mothers who use drugs in the community who were not accessing services and started providing injecting equipment to them also. I found the whole experience of picking them up and dropping them off seedy. And noticed as soon as I handed the equipment over to the Mothers, they would run away to hide it. I started buying gift bags, this seemed to make a noticeable difference and it became less shameful. It became a way in – an effective engagement tool. I then moved on to providing lock boxes for the equipment, which then led to positive affirmations and motivational cards, colouring books, recipes, ingredients, and naloxone. The more I offered, the more engaged they became. We moved from a situation where they were coming to the car outside of their homes to me being invited into their homes for a coffee. This provided eyes on safeguarding which I would suggest is far more effective than safeguarding provided by services. I also started helping with housing, schools, benefits, partners, and wider family members. My daughter Rain-India started to help out with their children because she has key experience of being a child of a Mother who was using drugs. This has been particularly helpful for those children aged between 10-15 years.

Nearly all of the research relating to Mothers who use drugs and their children is focused on the tipping point or/and beyond. The tipping point is much further into heroin dependency than M2M is engaging them. If these Mothers felt able to access services at this point, they and their children would have a significantly higher chance of success. And harm created to them both would be significantly decreased. However, because treatment remains unrealistic in terms of time frame, focused on recovery instead of life stability, it is punitive rather than positive, and is driven by a hidden harm agenda that is risk reactive and pitches parental drug use as undeniably harmful. There is no suitable pathway out for these Mothers and pretending there is one is both unfair and unethical. If M2M can do this with no resources, no finances, no employed staff and no positive links to services in the community, then one can only imagine what M2M could do if it did have all of those things.

M2M and the Mothers in the network are responsible for an anti-stigma campaign that is now international and changing the gendered injecting equipment for the first time in 30 years.

Meaningful engagement matters.

Amy's story

M2M Mother

I love my son. He's like my shadow, and my best friend – we're always in bed by 7.30 reading stories. He's washed and clothed and fed and loved, and we live with my Mum and Step-Dad. But I can't ask for help, because I'm scared to lose what I have, and I'd be homeless if I had to leave my Mum's. Anyway, I don't go to the services anymore, and I don't go to the doctors even though I've got a problem with my lungs, so I don't know what you can get these days – it'd take an ambulance to get me into hospital, because if you're on methadone in hospital, you're always the last in the queue, and they can never get in me arms. It's so degrading – like at the chemist, where you have to go in a different door, which everybody knows is the junkie door. It's very embarrassing.

This expectation of having their children removed is a consistent barrier to Mothers accessing the support they need. 37.5% of Mothers accessing treatment have children "in alternative care" rather than "under the care of the Mother", despite only 3.5% considered as being "high risk to children".[20] Mothers engaged in drug and alcohol treatment are up to six times more likely to have a child removed from their care than fathers.[21] One interviewee described an example where this had happened at birth, creating an almost immediate mistrust of the child protection system. In *Maternal Substance Use And Child Protection: A Rapid Evidence Assessment Of Factors Associated With Loss Of Child Care*, authors note that "studies suggest that Mothers who use substances and who have a child removed from their care, often become the subject of child protection intervention with the birth of subsequent children".[22]

"Why are Mothers and Fathers not subjected to the same standards?"

Anna Millington, *M2M Network*

When a Mother has her child removed, social services often view this as being a 'wake-up call', or motivation for treatment and recovery.[23] However, research has shown the reverse is often true; the removal of children increases the likelihood of a range of harms that could reduce the Mother's chance of being reunited with her child. Those who have experienced a child removal are more likely to develop depressive symptoms, attempt suicide or experience a relapse in their drug use.[24,25]

Anna Millington

The impact on the women and Mothers

Once your child is taken, you are then suddenly supposed to forget your Motherhood identity, get over it, move on, often denied even admitting to feelings of grief, trauma, and the PTSD that accompanies this because it is positioned as your fault. You are shamed and blamed for making a choice you never had or not taking a chance that was never really offered. Children are subjected to growing up surrounded by false narratives that they were somehow not good enough and that their Mother loved drugs over them, leaving them with a long-lasting feeling of low self-worth and value which is then attributed once again to their villainous Mother.

We are not helping by continuing to use unacceptable language and messaging, we are not saving children from the often used "risk of emotional neglect," the looked after system is not producing happy healthy young people with self-worth when they are kicked out with no one and nothing at 16. When do we ask ourselves honestly whether we are safeguarding anyone from anything?

We would like to believe that children are taken because something has happened, the truth being many children are taken on a maybe, the risk of, on something that may never actually occur.

Mothers are often put in a position where the social services do not look for proof of something occurring but instead the Mother is left trying to prove a negative, that she is not doing something or something is not occurring. What is often the most illogical expectation that is required from a Mother is to prove the future, how can you defend against the position that you 'may' do something in the future.

An entrenched, uncritical view of recovery, has pushed the sector into the belief that we will always be a risk and the disorder model supports this narrative when it claims that we have a chronic relapsing condition. These theories have hit this group particularly hard.

For a group like Mothers, the most important measure that will lead to long term changes is ensuring they are offered tailored treatment and adapting targets to measuring distance travelled. It is not helpful to set arbitrary goals that feel meaningless and will never lead to long term change or keep the family together.

Laura's story

M2M Mother

When my son was a baby, I was forced into accessing social services. But it was a nightmare – I had to work with them for two years just to get him back. I bent over backwards, and did everything they said to do, parenting courses, everything – it was just up to them, whatever they told us to do, for whatever amount of time. Just jumping through hoops. When you keep changing social workers, it's even harder – because if you don't get on with one, they've got so much power to do what they want, and they're judging everything, looking at your fingernails, looking at everything. Just watching you. And the doctors and nurses and people – they do exactly what the social workers say.

But the parenting courses didn't help – they didn't listen to me, what I needed or wanted, and I had no choice. None of it was any use, but it took up so much time, all while I was trying to keep up the contact three times a week, trying to keep my bond going with my son.

It's hard when people don't listen to you. When it's something so important, and you're trying to get back on track and get sorted out, but then you feel like you're powerless. If they'd listened, and if they hadn't judged, I think I would have been more able to be more open and honest. Or even if I could talk to someone who knows what it's like? Someone who's already been through it, and who can understand what you're going through and what you're talking about.

I just don't want to access services because of my past experiences with them, and just the fear of having my son taken off us. Nothing would make me go back. I can't ask for help.

Since we spoke to Laura, police were called to her home because her boyfriend attacked her. While police were present, her boyfriend told them about her drug use. The police raised a flag to social services who requested she undertake a drug screen, which was positive. She had her youngest child taken from her – despite the fact the only reason the police were present in the first place was because of the violent actions of her boyfriend.

All drug treatment service providers rightly have responsibility for child safeguarding and promoting child welfare, but a Mother seeking treatment for drug dependence should not automatically trigger safeguarding concerns. Drug treatment services must also acknowledge their role in engaging with Mothers who may see them as a route to action from social services.

Assertive outreach is a vital but simple step for services and providers to take. It can help to break down barriers by services seeking out Mothers and women where they are, opening the door to positive engagement and building relationships on a foundation of trust and transparency.

"Doing outreach with Spires, South-East London for four years with sex workers, and working with women with multiple needs in Newham, at Your Place, a mixed gendered support service for homeless people now, continues to highlight the strong need for organisations to offer co-located services which are also person centred. Linking in with services such as healthcare, housing, specialist support, and the police, alongside consistent communication, is vital."

Stella Kityo, *Your Place*

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Project 6

Working with women and mums

Project 6 is a charity that works with people affected by alcohol and other drugs across west and south Yorkshire. We offer a number of services that are women only but have recognised we need to do more, particularly around our harm reduction services and engaging with women and especially Mothers.

What we currently deliver

Our organisation delivers a variety of services that are women only and these include a women only SMART group, women's wellbeing activities; groups and and outings. We engage well with women as an organisation, especially in South Yorkshire.

In Sheffield, we support women who have had multiple children removed. Often when Mothers experience this extremely traumatic event all the support then goes with the child and the Mother is left absolutely on her knees. Our team will pick Mothers up and support them, walking alongside them. It will understandably take many months for women to be able to trust professionals again after their experiences so this support is provided on a long-term basis. Our role is to meet the Mother where she is, help her process what she has experienced and slowly rebuild her life, moving at her speed. We act as advocates and challenge on her behalf, ensuring appropriate contact is allowed and the Mother is supported to keep in touch with her children wherever possible.

In Doncaster we provide a lot of support to women who are in their 50s and in need of support around their alcohol use. We have noticed a specific need and trend around women and increased alcohol use due to managing the physical and psychological impact of the menopause. More work is needed around this.

We recently reviewed all of our safeguarding policies and procedures and as part of this recognised the stigma that women and Mothers who use drugs and people of colour face. So we asked people who experience this stigma to help us, to make sure that this was centred in the policy, not buried deep within it. All of the subsequent training has made sure we have a discussion around safeguarding and Mothers to make sure we have a consistent approach.

What next?

We have recognised that our harm reduction services in Bradford and Keighley need to work differently to support women and Mothers to be able to walk through the doors to access support. Women only spaces won't cut it suffice when women face so many psychological and structural barriers to accessing support. We have applied for funding for a van which will take on a women only focus several days a week and literally go to where women are, working in partnerships with other charities and services that are women only. We will make sure it's consistently staffed to ensure that we build relationships with the women and recognise it will take a while to build up trust that has been systemically broken down over the years by a drug and alcohol treatment system that has not focused on the needs of women. This is a national problem that needs action rather than talking.

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Change Grow Live (CGL) Southampton Assertive Outreach Team: Unhoused

Anna Millington

This team is an example of effective assertive outreach. I spent 5 days with them and was able to witness their interaction with the using community, their focus on building a connection and their understanding that took time and was often rejected at first.

Using a non-polite way to say go away was just taken in their stride, not as a personal attack or a verbal insult. They knew their target audience, they knew how they spoke, what that initial rejection was linked to and why not reacting sent as much of a signal as reacting would have done. They clearly understood, accepted and were committed to meeting users where they were in the truest sense and not where they thought they should be, not where they felt suited them best.

I accompanied a member of the team to visit a mixed hostel, this was a weekly event and given how hard it is to engage people there I was surprised at the number of users that called in to chat. At one point a resident came to tell the Change Grow Live (CGL) worker that someone had overdosed in the room upstairs and another resident had given him naloxone. The worker went to inform the hostel staff. I cannot convey how much that interaction signalled how they saw their relationship with the Change Grow Live (CGL) worker. No one had informed any member of staff from the hostel about this incident, it would have gone unrecorded and the resident not taken away in an ambulance! This worker was building meaningful trust and he was making meaningful connections. Nothing works with these unique groups if that is not the foundation. We will not engage with professionals or services we do not trust.

This team moves around to the places that this community gathers at, where they sleep, where they pitch their tents. They go to them and have no expectation users will come to meet them at the service at some scheduled appointment. They encapsulated the model that I would suggest would work for engaging Mothers who use drugs.

This is meaningful & effective assertive outreach – this model is a best practice example.

"It's important to address the stigma of substance use treatment for pregnant women and Mothers. Many women who took part in our study [Stepping Stones] described wanting to detox from OST in pregnancy often against medical advice, because they were keen not to have to queue up for OST medication in chemists, to have to attend substance use treatment services for reviews of their scripts, etc. or generally to be part of the substance use treatment world."

Dr Polly Radcliffe, *Kings College London*

Safeguarding must not be about services judging Mothers – and policies should not be imposed, but developed between social workers and mums who use drugs.

Excerpt from Scoping review: *mapping clinical guidelines and policy documents that address the needs of women who are dependent on drugs during the perinatal period*[26]

Many of the safeguarding documents identified from England which often drew on findings from the 'Hidden Harm' report seemed to have a greater focus on risk of harm to the unborn and new-born baby. While some emphasise substance use does not necessarily mean parents are unable to provide 'good enough' parenting, children's social care policy documents in Scotland, and England and Wales nevertheless suggest women's drug use in pregnancy can be a form of neglect. This focus on harm has been recognised in a recent policy review by Whittaker et al. and could contribute to women's reluctance to engage with services for fear of being stigmatised, and having their baby removed from their care.

Orbit, in partnership with Turning Point, Hackney

Anna Millington

Orbit, in partnership with Turning Point, a service in Hackey under Homerton Healthcare NHS Foundation Trust, is designed around the needs of pregnant Mothers and those with children under 5 where there has also been substance use. This service does not place drug use as the central theme, it does not position their Motherhood as secondary. It is held once a week in a children's centre with a creche, locating it within a community setting meaning that there is no stigma from others or self-stigma from the Mother about being seen attending it. It is an environment that is warm and welcoming for their children and Dads, Grandparents or other care providers can come to sessions. It is family orientated and gives a more holistic understanding of family dynamics, and relationships. Positioning men as the source of all women's trauma and suggesting they are always unsafe is not always positive, especially for children.

These Mothers connect with other Mothers and create positive and trusting relationships with professionals. It is not an appointment-based system and there is no requirement to see a key worker at a scheduled time and then leave. This enables a much more in depth and meaningful relationship with staff. It also translates to a wider increase of trust in other professionals they will have contact with at schools, doctors, women's health screens. This service understands the needs of the Mothers and is based around those rather than expecting these Mothers to adapt to the needs of a service.

Mothers on medication face no stigma, judgment or shame and are seen as equal to those Mothers who are not. Negative approaches have no place within their framework. Mothers and families get to kick back, drink coffee, get their nails done or other social based activities and sessions. No regimented groups where 'everything is about trauma' or recovery. This is positive, this is wanted, and this is somewhere they like to go.

Substance use has played a part in their lives rather than everything else in their lives being a part of their drug use. This is not about a sole focus on recovery, but on positive family integration. Families are supported to develop a more balanced lifestyle and to increase confidence, positive choices. It also offers counselling when wanted and addresses wider health needs.

Drug use or drug treatment, can be something they move forward from and feel empowered to be more than their past choices. This is not effective drug treatment for Mothers, this is outstanding community inclusion for Mothers and their children and families where substances have been involved.

When you get the approach right like this service, you can harness a powerful motivational aspect of the Mothers' lives and place it at the forefront. A Mother is who she will be for life, substances are something she took. One is something you are, one is not.

Anna Millington

Inconsistent safeguarding approaches

Other users do not have their treatment mapped out and decided and directed by a professional from another agency who has no expertise in heroin dependency. For Mothers, the application of safeguarding can feel unpredictable and punitive.

Issues of fear and trust are often invalidated and dismissed as if they were not real, as if they are things left over from the past. They are not.

Mothers' fears are justified and valid and it is impossible to trust in a system that has no consistency at all in relation to the issue of safeguarding and when a referral to social services may occur and for what reason.

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Whilst each case is individual, this does not mean that how measures are understood or applied should have no consistency. The understanding of what safeguarding is, how it should be applied correctly, when confidentiality can legally be breached and what for often varies wildly from one organisation to the other and from one service to another, one worker to another. It can significantly vary each time a Mother is given yet another new key worker. What is it people feel Mothers should be able to trust about this type of unknown inconsistency? How can anyone trust in something that nobody can provide any real clarity on? What is it the sector is asking these Mothers to trust in?

The custody of their children could depend on this. I repeat, keeping custody of their children could depend on this.

They are telling you what their issues are, but people are misunderstanding their message or not willing to face it head on. They need clear information that they understand and consistency in the approach. They need the sector to understand the language they find fearful and positive messaging is needed to encourage and engage. Having links to peers that can create meaningful bridges is important. Peers are not Mothers who are not currently using the service, that is someone with lived experience. They are very different positions.

Childcare responsibilities are not consistently accounted for within drug treatment, meaning Mothers who might otherwise engage with services are unable to do so.

Childcare responsibilities, like school pick-up and drop-off, create schedules and time burdens which reduce a Mother's flexibility. Research shows the rigidity of appointment times within drug treatment can limit Mothers' access, acting as a barrier in a way that is rarely the case for men.[27] This was an issue that was raised consistently through our interviews. That this is raised in discussions and reports focusing on women, and not those focusing on men, is evidence in itself of the gendered nature of the discourse.

"If your appointment time is at the same time as school pick up or you've got no one to care for your child then that is instantly a barrier to engage with services. There is more that services can do to accommodate this."

Megan Jones, *Cranstoun*

"Childcare has always historically been a problem, not being able to get to the chemist or make appointments, not being able to take children with them."

Hannah Boyle, *Simon Community Scotland*

"I always felt like I was the problem. Especially as a child, people seemed to look at me and penalise me for a view they had on my parents... parents would say 'you're not allowed to play with my child'. When you're bullying someone so much, it starts to create a level of dislike in yourself."

Rain-India Millington, *M2M Network*

Most drug treatment services do not allow children on site. For Mothers with childcare responsibilities this is a significant problem, particularly during school holidays.[28]

"You can't bring your children into services, what are you expected to do during the six-week holidays? Leave them with a neighbour? Firstly, social services are going to hate that, secondly, the neighbour doesn't want to speak to the junkie next door."

Anna Millington, *M2M Network*

"If you leave your child outside, your child's at risk of neglect, and that's disgusting parenting. If you bring your child inside, how dare you bring your child to a drug appointment? I mean, where do you leave them?... They would not let me into the appointment with my Mother sometimes, and it traumatised me because I was left in a waiting room on one occasion with a couple of men... they were making me vastly uncomfortable and I begged. I cried to go in with her, She left with me and I didn't know she got punished for that."

Rain-India Millington, *M2M Network*

When children are allowed on site, they often have to remain in the waiting room while their Mother attends her appointment. This means that the only option is for Mothers to leave their children alone in the presence of strangers, who are sometimes agitated or violent.

"You might be allowed to bring children to your key working appointment, which is alright when it's a babe in arms, but when it's a 5, 8, or 10-year-old they can't be left in reception without there being safeguarding issues... if you bring them in, someone is asking you questions about your childhood, or domestic abuse in front of the child."

Representative, *Working With Everyone*

"It seems to me that women's lives tend to be much more complicated than most men's. And if you are a person who uses drugs, then your life is likely to be very demanding and complicated, with a lot of calls on your time, even if you are a man ... it is very clear that many women won't have the time to be learning up about the ever-changing and risky drug landscape. Too busy just getting by. And they may be pushed to the fringes of places where this kind of information is shared."

Dr Judith Yates, *Birmingham GP (retired)*

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In Conversation

Anna and Rain-India Millington

Below is a transcript of a conversation between Mother and Daughter on their experiences of attending a drug treatment service and a pharmacy when Rain-India was a child.

Rain: I'd like to say some people who worked in the chemist and hospital were nice. It wasn't everyone who wasn't.

Anna: From my perspective that's unacceptable. I don't need to be grateful for the staff who did their job and were nice to my daughter. That should be the accepted standard. Everyone should be and it angers me still that some of them weren't. I was trapped and could do nothing about it because they held my medication and they put reports into social services.

Rain: I know now what the situation was, but when I was younger, I didn't understand. I didn't know why my Mum let people be nasty to me or why she was letting them be nasty to her. I felt shame and as if we were nothing, as if we must be bad. My Mum always made me feel safe but never felt safe there. I would beg and cry that I didn't want to go but she made me. I didn't know she had no choice. I didn't understand she felt trapped. I am angry and sad for the younger me but also, I'm so angry they did that to my Mum, and I feel guilty I was awful about it. She wasn't safe there either.

Anna: It's easier for people to think this is a lifetime movie, the sector has some bad workers unless you play the role they want. Yes, victim me, you're the saviour, you're the greatest, I am grateful, I am your fan. Those workers cannot handle a user that does not play the role, and they try to control the situation in any way they want. They could control my medication, and about Rain. Any report to social services about argumentative behaviour, and refusal to engage in treatment would mean Rain being with me was at risk. Argumentative means have an opinion and refusing to engage meaning no I don't want to discuss my whole life with a key worker who has no relevant qualifications. The worst thing was the way they sometimes treated Rain, the voice they used, the sneer, the shaming. That is emotional abuse and pretending it does not happen is unfair, unethical and a safeguarding issue. You've seen her interview at 10 with a child psychologist, you know she's telling you she felt like nothing, she felt like they treated her as if she was the one who did something bad. Not sure how they want to try to explain that away. Refusing to acknowledge it happens means you are not making the right changes to stop it.

Rain: It's not just there, it's at the chemist too. The other people there scared me and sometimes we had to wait so long, and I would plead to go, and I was so confused why she would make me stay. At any other place if I had said I felt scared of the people, the other users, she would have taken me away immediately. I feel bad they created all of that. I don't understand looking back because I was back living with my Mum so she must have been testing negative two times a week for almost two years. Why make her go every day, why make me go when I wasn't at school? Why did they only care about me when it was convenient for them?

Anna: There is a running theme in this sector or the CJS [Criminal Justice System] that they are not responsible for any of that. They blamed what Rain was experiencing on my drug use, even though I was doing everything they asked – but they didn't stop and think about how Rain was suffering from their behaviour, or take responsibility for any of it.

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Anna: Are we trying to say that because a parent did something that it's acceptable their child is subjected to harm? How much punishment were we expected to endure? I'd become the ideal person they told me to be. I was everything they wanted, no crime, no drugs, no opposition, compliant, accessing education. It is a lot of power to wield and to think it is never used as a weapon, that medication is not used as a weapon. It is either extremely naive or just unwillingness to accept a truth that might then have to be dealt with. The problem is not just we can't get Mothers into treatment at any early point, it is keeping them positively engaged in a system that can often be coercive, punitive, demoralising, and harmful. I understood Rain's confusion and I understand why it happened. I also understand that it appears to be pitched as my fault that professionals were immoral and inflicted harm on my child. It is always the Mothers' fault for everything that happens.

Rain: I felt like I wasn't allowed to move at the chemist. I asked Mum if I could look at the hairbands and she said I could choose one thing.

Anna: Everything was 99p I remember, and I had a quid.

Rain: I was turning round the thing to look at everything to choose and the woman shouted at me to stop touching and get away from it and you shouted back at her Mum.

Anna: Why anyone thinks they can shout at my child is ok, no not happening. I had to do a week without medication until it got sorted out, luckily by that point – like most users who have been in the system, I knew to make sure I stashed meds away for 'mistakes' because there are always mistakes. If I hadn't had those stashed meds – what is it people think I would have had to do for that week – be crippled with severe withdrawals, no not like flu. Or, buy heroin. Where is the real risk? What would that have meant for Rain? Would a relapse have been my fault or theirs?

When Rain was 10, in 2005, she gave a recorded interview about her experiences. I was not present. It is not an easy watch, and I only watched it again last year. Not much has changed – if I had not been a user she would not have had to go, same excuses used for Mums today. Workers, thankfully fewer these days, feel it is their right to inflict harm on a child to punish. That just makes me wonder what risk or safeguarding they consider.

"The waiting rooms don't have anything for kids to do there, so the kids have just got to sit, and there's posters on the walls but these are just of needles and dirty spoons. When you sit down, you don't know who you are sitting next to, the only thing that makes you feel a bit safer is sitting next to your parent... It would be nice if there was a separate room for kids because it's not nice to just sit there with all these strangers that you don't know.

Rain-India Millington, *aged 10, in a video shared by Anna.*

Anna and Rain-India credit their successful family treatment outcome to Vicky Anne Major. After many different & often difficult, harsh & punitive treatment regimes imposed on them Anna was allocated to Vicky. This was a radical turning point. Both Anna & Rain-India felt they were treated with respect, honesty, openness, and a willingness to place Motherhood as a central component of treatment. They were a family accessing a treatment service and not a bad Mother who sometimes had to drag along her child. Making this 'family treatment' led to what they describe as "finally being able to trust someone, like someone and feel they that she liked us and wanted us to succeed and be a family unit".

Failing to take account of women's cross-cutting needs is limiting the impact and accessibility of drug treatment

"Women are passed and passed and passed on from service to service and are kind of left. And then it's just like what's the point, where do I go from here?"

Hannah Boyle, *Simon Community Scotland*

Women with drug dependency are likely to have a range of health needs that can impact outcomes if not considered and addressed in tandem with drug treatment.

There is an unmet need for services that can incorporate or effectively link drug treatment with other women's health services. On average, women need more regular access to health services than men throughout their lives; although women live longer than men, they spend a significantly greater proportion of their lives in ill health and disability by comparison.[29] However, if women are prevented from accessing healthcare because they do not trust their doctors or they experience stigma, that is a closed door which will stop them from getting the help they need. If they feel comfortable seeing their GP, when they ask for help for a routine healthcare issue a GP can spot signs of dependence and find a non-judgemental opportunity to refer or signpost to services.

"A focus on women's health which incorporates their substance use as part of and not the sole issue of importance positions engagement more positively. It reinforces to us that our health needs as a whole are the priority rather than a focus upon drug use as a deviant behaviour."

Anna Millington, *M2M Network*

Women who use drugs are more likely to experience poor sexual health and are less likely to receive health interventions such as a smear test.[30] The Government's Women's Health Strategy highlighted the need for better access and joining-up of drug treatment services with other health services.[31] However, several of our interviews commented on the lack of dedicated women's health support or information present within drug treatment service settings.

In *Patterns and Epidemiology of Illicit Drug Use Among Sex Workers Globally: A Systematic Review,* researchers were clear that "Street-based sex workers often have complex health and social needs due to high prevalence of heroin, cocaine, and injection drug use, poor treatment outcomes, high levels of morbidity and mortality, including mental and physical health outcomes, and exposure to sexual and physical violence and homelessness".[32] In this context, understanding and responding to a wide range of needs in a stigma-free environment is critical for engaging this group.

"It's very rare for sex workers to engage with services continuously – they're marginalised, impacted by sexual exploitation, and it's difficult for them to get the support they need. They can have substance misuse, but also mental health issues. This means usually any issues they have, are always put down to substance misuse (bad behaviour), meaning they repeat cycles and don't get the mental health support they need, ending up in prison, or being sectioned – inflicting more trauma! For sex workers, or any woman, making appointments at a Drug and Alcohol Services, can feel near impossible – sometimes appointments are too early, repeated approaches fail, and the lack of resources often mean that women feel like they're being set up to fail..."

Stella Kityo, *Your Place*

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Perspective:

Natalie Finch, *Assistant Professor of Mental Health Nursing at the University of Bradford, Registered Mental Health Nurse.*

"Prioritising People" sits at the heart of the Code of Conduct which all registered nurses are bound by.[33] In order to be able to fulfil this requirement, nurses must provide care which is not only non-judgmental and tailored to meet the needs of the recipient, but that also promotes empowerment and respects choice and autonomy. Sadly, there is a lack of education around substance use in many nurse training curriculums, meaning that judgement and stigma is present during training, which left unchallenged, prevails into qualified practice.[34,35] Further, stigma and prejudice towards women who use drugs is often found to be more significant than for men who use drugs, including that perpetrated by healthcare professionals.[36] Women who use drugs are overtly aware of this, and report being forced into a variety of strategies to hide their drug use from healthcare providers, meaning their needs cannot be effectively met by treatment services.[37]

We can do something about this. Where nurses are given opportunities to hear women's stories, particularly around gender specific experiences such as pregnancy, attitudes, beliefs and knowledge are positively influenced, breaking down barriers to accessing care.[38] Services must be commissioned in such a way that nursing staff are sensitive and responsive to the needs of women, and are trained and supervised to deliver care which removes, rather than creates, gender specific barriers.

"The kind of status quo is that the substance use comes first and everything else comes after and that everything is connected to the substance use. As opposed to seeing that woman as a woman who has reproductive and sexual health challenges and general physical health challenges that need to be seen and catered to."

Hannah Boyle, *Simon Community Scotland*

"There's no screening in place, it's only 'have you got children?', and that's just for safeguarding. There's no smears, no menopause. It's just a transactional treatment system that women are made to fit into. Why don't we come up with a women's health screening questionnaire, that costs nothing!"

Anna Millington, *M2M Network*

"At Your Place [a charity with a mission "to build hope, enable lasting change and end homelessness, one person at a time, for people in East London] we're trying to do things differently for the people we work with, especially our women who experience homelessness differently to men. Whatever their needs, we tailor the support for them – we bring different services in, including drug and alcohol treatment teams, specialist support services, wellbeing sessions, and regularly work with local authorities."

Stella Kityo, *Your Place*

Women who use drugs can also be at risk of earlier onset menopause compared to the general population, the symptoms of which can be exacerbated or complicated by drug treatment interventions.[39]

Despite this, interviewees noted that training on menopause is rarely seen in drug treatment settings, nor is it considered or discussed with women who use drugs.

"A lot of the women I've spoken to, the doctor has never had a conversation with them about menopause. Symptoms can sometimes be confused with withdrawal, or it can cause mental health issues and they won't necessarily notice that it's to do with their reproductive health. There's a lot of misinformation about menopause. A lot of our women don't have the knowledge or understanding about it."

Hannah Boyle, *Simon Community Scotland*

"Often drug and alcohol use can increase during that time as a way to deal with menopausal symptoms... women need education and awareness on the symptoms of menopause. They need support from primary care."

Megan Jones, *Cranstoun*

"I think women's health in general needs to be a training element in drug treatment services. There's little understanding by drug workers around what menopause looks like, for example; what treatments there are and how you would work with someone on OST [Opioid Substitution Treatment] when they are going through the menopause"

Shoba Ram, *Transform Drug Policy Foundation*

"I do believe that maybe I've got the hot sweats and things. My periods are a bit hit and miss now. But nobody has ever talked to me about menopause"

Amy, *M2M Mother*

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North Lincolnshire

Menopause support group

In September 2023, WithYou's North Lincolnshire drug and alcohol service identified a gap in support for women in drug treatment who were going through menopause, and developed a menopause support group to provide specifically for this cohort.

Led by dedicated recovery workers, the menopause support group aims to create a safe and supportive space for women to share experiences, gain information about menopause-related topics and address the unmet needs of those navigating this significant life transition.

The group meets monthly and adopts a dynamic approach, starting sessions with a game of 'symptom bingo' to foster a comfortable atmosphere. Recovery workers encourage organic discussions to emerge from shared experiences, covering topics such as hormone replacement therapy, nutrition, and vaginal health.

The menopause support group has consistently good attendance and has become a vital resource for women seeking information, understanding, and emotional support during menopause. The group also serves as a platform for signposting participants to external support, empowering women with knowledge about available healthcare options.

The challenge created by a lack of integration of drug treatment with wider health services goes beyond reproductive and gynaecological health, to impacting access to other critical care. Women's mistrust and fear of public services, and especially the potential for creating a referral to social services, prevents them from seeking the healthcare they need, potentially putting their lives at risk.

> ***"I've got blood clots and I'm on lifelong blood thinners and I'm bad with my chest, but I'll never go to the hospital because obviously they can never get me arms and I won't stay in hospital because I have an addiction... I'd be scared for them to take my blood, or urine sample if I got a water infection. I've got problems with my breasts and I can't, I'm just so scared to go, anyway I can't do anything at all. If somebody dragged me into a white van, I wouldn't call the police."***
>
> **Amy, *M2M Network***

> ***"They've now got what could have been preventable health problems that have deteriorated to such an extent where they received treatment and they probably wouldn't be dying prematurely or their physical health wouldn't be as bad as it is now. And that's because of fear, because of negative past experiences they've had, because they're seen as drug seeking. When they go to speak to a doctor about their health and about reproductive health and sexual health it's minimised."***
>
> **Hannah Boyle, *Simon Community Scotland***

Perspective:

Shinasa Shahid, *Research Scholar (UK) and Counselling Psychologist (India)*

The lack of ethnicity in addiction recovery is a multifaceted issue deeply rooted in societal structures, systemic inequalities, and cultural norms. Individuals from ethnic minority groups may engage in substance use disorder (SUD) for various reasons, including perceived racism, social isolation, coping mechanisms for unresolved issues like intergenerational trauma or discrimination, and the pressure to conform to societal norms. Moreover, the lack of trust in mainstream services, coupled with the availability of cheap drugs and alcohol, can exacerbate substance use within the ethnic communities.

However, despite the prevalence of SUD, many individuals from ethnic minority groups may hesitate to seek help due to the fear of judgment, shame, stigma, and negative cultural beliefs surrounding addiction. Additionally, language barriers, lack of awareness about available services, and mistrust in the system further deter them from accessing treatment and recovery support. The cultural stigma associated with addiction, compounded by systemic racism and underrepresentation in treatment services and recovery groups, creates significant barriers to seeking help.

To address the stigma, shame, and other sensitive concerns surrounding drug and alcohol addiction within ethnic minority communities, there is a critical need for more open and normalised conversations. Community-based initiatives such as workshops, presentations, and peer education programs can help raise awareness, challenge stereotypes, and provide culturally sensitive support. By engaging community leaders, educators, religious institutions, and individuals with lived experiences, these initiatives can foster a supportive environment where individuals feel comfortable seeking help without fear of judgment or stigma.

Current treatment and recovery services often lack cultural sensitivity and fail to address the unique needs of ethnic minority communities. There is a clear demand for more representation of professionals from diverse backgrounds in addiction and mental health services, as well as the integration of culturally tailored care and holistic approaches. Services should prioritise inclusivity, accessibility, and collaboration with community organisations to ensure that individuals from ethnic minority groups receive the support they need to initiate and sustain recovery. Effective services should be located within the communities they serve, offering personalised, multilingual, and culturally competent care that acknowledges the intersectionality of race, ethnicity, culture, religion, and socioeconomic factors in the recovery process. Such services should be accessible to all minority communities and offer resources and support in various languages. It should be staffed by workers with lived experiences from the minority communities and provide culturally aware training. Services should be in places that celebrate recovery and offer 24-hour support, including during holidays and weekends incorporating culture, faith, and spirituality into their approach.

It is evident that the issue lies with the accessibility and appropriateness of the services offered to the ethnic communities. When services fail to address these barriers adequately, they inadvertently reinforce existing inequalities and exacerbate the marginalisation of these communities. Thus, it is not the community's inherent characteristics that make them hard to reach, but rather the lack of inclusive and accessible services tailored to their needs.

Experience of domestic violence and abuse is a significant barrier to treatment access

"I really struggled with attending groups, as they were male-dominated. In 18 months, I only met one other woman. This meant I was too scared to speak about my issues and challenges, as the men seemed to have very different experiences. I also felt that my issues weren't noticed as much because I wasn't loud and confident. However, I wasn't allowed one to one support unless I also attended a group."

Dr Rebecca Tidy, *Journalist and Researcher*

Domestic violence and abuse, and drug dependence often go hand in hand. Drug dependence is eight times more common in women who have experienced extensive violence and abuse.[40] Early indicators from Dr Polly Radcliffe's Stepping Stones study, *Evaluating models of care: best practice and care pathways for women who are dependent on drugs and their infants from preconception to 10 months postnatal* align with this.

"Of the women who took part in the Stepping Stones study, 63.8% had previously experienced domestic violence."

Dr Polly Radcliffe, *Kings College London*

Despite this, women who have experienced domestic abuse can face additional stigma or treatment barriers, and can be discriminated against or 'written off' because of the presence of additional or complex needs.[41]

With men making up 67% of all those in treatment in England, services and waiting rooms are dominated by male presence.[42] For women who have experienced domestic violence and abuse from men, this can be an intimidating environment. 43% of women see male-dominated spaces as a barrier.[43] This clearly establishes a need for safe, women-only spaces which integrate provision, providing support for drug dependence as well as escapees from domestic violence and access to housing and accommodation.

"The fact that many women coming into the services may know men there, often makes them feel uncomfortable and increases the trauma."

Megan Jones, *Cranstoun*

Women experiencing domestic abuse who are accessing drug treatment may be prevented from leaving their abusive living situation because of restrictions around access to refuges or other aid services. Refuges often work independently rather than in partnership with drug treatment services.[44] Refuge policies may effectively preclude entry to women in treatment for drug dependence: women who have been prescribed medication to help them to treat drug dependence are not allowed to enter many refuges.[45] This means that women are in many cases left trapped and unable to escape from unsafe living situations with abusive partners if they are seeking help for drug dependence.

"You can't access women's refuge centres if you're on medication. You need to be abstinent. Why can't you be in a domestic violence refuge, fleeing kicks and punches, if you're on medication?"

Anna Millington, *M2M Network*

"It's a health issue: you wouldn't ask someone with diabetes to come off insulin."

Megan Jones, *Cranstoun*

Despite rising demand, domestic violence and abuse services remain chronically underfunded.[46] Funding for these services has suffered as a result of wider long-term cuts to local government budgets. As of 2019/20, more than one in five women's refuges received no local authority commissioned funding at all.[47]

These funding cuts have implications for their ability to deliver a full range of support services. As of 2021, only 9.3% of refuge centres had specialist drug use workers, meaning the vast majority of refuges do not have the capacity to accept referrals from women with additional needs, particularly if women are relocating to a new area to escape from abuse and as such are not established with a local treatment team.[48] As a consequence, women in treatment for substance use may need to wait longer for a refuge space (often while homeless or living in dangerous or abusive situations), further increasing the complexity of their needs.[49]

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It is imperative that drug treatment services acknowledge that women's needs extend beyond substance use treatment. There is an unmet need for integration with broader women's health support services, workforce training for menopause and sexual health signposting. Equally, delivery of trauma-informed holistic support must be about delivering care which acknowledges the likelihood that women have experienced trauma without viewing it as exclusively a causative factor for dependence on drugs.[50]

Recognising the added vulnerabilities of women fleeing domestic violence and abuse is crucial to moving away from a one-size-fits-all approach. Women's refuges, vital for those escaping violence, face challenges while services and their commissioning structures remain siloed. Discrimination against women who use drugs can prevent access to necessary support. Local authorities must prioritise funding and support to bridge these services, acknowledging the diverse range of needs in the drug treatment population.

Conclusion

"The women are alive, but they're not living, they are surviving."

Aura Roig, *Forteza, Metzineres*

The barriers for women accessing drug treatment services in the UK are well-documented and well-known by those fighting to improve outcomes for women seeking treatment for substance use. However, amid the continued rise of drug-related deaths among women, immediate practical and systematic action is needed.

Stigma is a pervasive issue for women dealing with substance use. It gives women negative impressions and experiences of drug treatment and wider public services and stops them asking for the help they need and deserve. This stigma is particularly problematic for Mothers and women who have experienced domestic violence. Drug treatment and child social care services must rethink their policies and approach, including how staff view and care for women and Mothers, ensuring that they can access truly stigma-free support.

Services must also allow women flexibility when accessing support. Flexibility can allow women the freedom to adhere to treatment and access support around other commitments. This applies to appointment times and treatment choice. The current provider-led commissioning arrangement has also created an environment where providers are governed by performance indicators that may not reflect the diverse needs of the populations they treat. So, while providers must exercise flexibility to support the needs of women, local authorities must also allow flexibility in service delivery and performance, recognising the critical need for specific care provision for women and expanding their understanding and definition of positive outcomes.

Public services also need to earn trust from women with a substance use treatment need. A lack of trust is often borne out of past negative experiences and can have a detrimental impact on treatment, health and care outcomes. Our interviewees frequently noted that resource constraints in drug treatment services created difficulties in delivering additional appointment times or one-to-one appointments that could be used to develop trusting relationships. However, there are other means of developing trust. Approaching treatment and support with openness and without judgement can go a long way in creating trusting relationships.

Many of the solutions to these access barriers can be found at a macro level, with greater, more sustained funding and political consensus. However, after years of steady cuts to local authority funding, more practical and localised solutions must also be found. This report has been built on narratives from Mothers with living experience and professionals working in the drug treatment landscape. While it has highlighted some of the stark challenges women and Mothers face in accessing safe and equitable treatment for drug dependence, it has also shown that good practice can be established and shared.

Drug treatment providers, local authorities and local CDPs will each have their own strategies and priorities based on the needs of their local population, many of which will acknowledge the needs of women and other vulnerable groups. The recommendations in this report provide a foundation and direction to implement changes that can improve outcomes for women in drug treatment services and reverse the worrying trajectory of drug-related harm.

"I just can't get my head around the fact people don't seem bothered. Why is that?"

Rain-India Millington, *M2M Network*

"If you want to build a ship, don't drum up people to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea."

Antoine de Saint-Exupery

Anna Millington

The quote above has always been how I have pictured the way to best engage us.

Currently what we are asking Mothers to do is build a ship under a guard wielding punishment in the middle of a desert.

Perhaps the simplest answer is the right one – why is treatment for women not working for the many? Because the treatment options being offered to most women do not work. Until those commissioning services are willing to understand this there is little chance of change.

I understand that there is an accepted fiction positioned as fact which is that women who no longer use drugs are somehow able to tell you what women who currently use drugs need and want from a service. Hindsight means you are looking back on a situation, you are making assumptions about what you felt and what you might have thought or needed – the only voice that can tell you what is needed in the now is the women who are going to be accessing that service in the now and if you are unwilling to ask them then stop being surprised they aren't coming in.

It is surely time to start treating these women as if they know what it is they want.

I'm asking that we let them have a view of the sea.

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About Camurus

Camurus is a pharmaceutical company working to improve outcomes for people with opioid dependence. Camurus is proud to partner with drug treatment services across the UK to support healthy communities.

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