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# Stella Project Young Women's Initiative

“It blocks out the problem and becomes the addiction”

The intersections between problematic substance use and domestic and sexual violence experienced by young women in two London Boroughs

Research and Interim Evaluation Report Prepared by Dr Miranda A.H. Horvath, Dr Susan Hansen, Shola Apena-Rogers & Dr Joanna R. Adler, Forensic Psychological Services, Middlesex University 13th April 2012

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## Glossary

ADVANCE	ADVANCE Advocacy Project, Kensington & Chelsea
AVA	Against Violence and Abuse
EDIP	WDP Enfield Drug Intervention Project
EYOS	Enfield Youth Offending Service
FPS	Forensic Psychological Services
INSIGHT	Blenheim-CDP Insight Young People's Substance Misuse Project
LBE	London Borough of Enfield
PSU	Problematic substance use
RBKC DIP	Kensington & Chelsea Drug Intervention Programme
RBKC	Royal Borough of Kensington and Chelsea
SORT IT	Compass Sort It Young People's Substance Misuse Service
SMU	Substance misuse
SPLC	Stella Project London Co-ordinator (Shannon Harvey)
SWA	Evolve Advocacy Projects, Solace Women's Aid
VAWG	Violence Against Women & Girls
VS	Victim Support, Kensington & Chelsea
YW	Young Women

## 1. Background and Origins

AVA's Stella Project has been improving services for adult women affected by overlapping domestic violence and problematic substance use for several years. Through the organisations' training and development work with practitioners, they were increasingly being asked to advise agencies about how these issues affected younger women. Whilst this was an issue which was increasingly being identified by practitioners, the UK evidence base regarding how to effectively support these young women was weak. In 2010, AVA successfully sought funding from the John Paul Getty Jr. Charitable Trust for a research and development project to address this gap in the evidence base.

Following an open invitation to tender, AVA commissioned Middlesex University to conduct the research phase of the project and to evaluate the Stella Project's intervention with agencies working with young women affected by domestic and sexual violence and problematic substance use. The project's scope allowed for the Stella Project to support two London boroughs to develop their response to these young women, and AVA invited all London boroughs to submit an Expression of Interest to be involved. From 14 interested boroughs, AVA selected the London Borough of Enfield (LBE) and the Royal Borough of Kensington & Chelsea (RBKC), based on strategic commitment to the project, the existence of relevant agencies to participate in the project, and differences between the boroughs from which to make an interesting comparison. In both boroughs, the Domestic Violence Co-ordinator and the Drug and Alcohol Action Team Manager nominated four relevant agencies to participate in the project. Within each borough, agencies were selected to represent both the violence against women and girls (VAWG) and substance misuse sectors, and to cover the full age range of young women whose needs the project would address (14 to 24 years). In both boroughs, this resulted in representation from the Independent Domestic Violence Advocacy services, the young people's substance misuse services and the Drug Intervention Programmes (DIPs), and in Enfield, the Youth Offending Service.

## 3. Method

The research design is a triangulated, mixed methods approach, drawing on both prospective and retrospective research techniques.

### c. Literature Review (Objective 1)

We used an adapted Rapid Evidence Assessment (REA) to conduct the review as resourcing limitations (time and labour) prohibited the undertaking of a systematic review of the literature. An REA is a tool for synthesising the available research evidence on a policy issue, as comprehensively as possible, within the constraints of a given timetable. A toolkit for undertaking an REA has been widely implemented since its inception by Government Social Research Network (see [http://www.gsr.gov.uk/professional\\_guidance/rea\\_toolkit/sitemap.asp](http://www.gsr.gov.uk/professional_guidance/rea_toolkit/sitemap.asp) also recently used by Brown, Horvath, Kelly & Westmarland, 2010). One overarching question led the REA:

- What are the intersections between problematic substance use (PSU)<sup>1</sup> and domestic and/or sexual violence (DV & SV) experienced by young women?

Four specific questions provided a more detailed structure for the REA:

1. What is the prevalence and incidence of the intersecting issues of PSU, DV &/or SV amongst young women (nationally and internationally)?
2. Do integrated responses to young women experiencing PSU and DV &/or SV exist? If yes, what are they and what are their successes?
3. What is promising/good practice for frontline practitioners working with young women who present complex, intersecting needs?
4. What is promising/good practice for strategically linking work with young women with overlapping needs, i.e. not frontline practitioners?

In order to find literature for the REA we restricted the search to the last 15 years (1995-2010). To find academic literature 14 search engines were used (see Appendix 1 for the full list). To find grey literature, use the following methods:

- <http://openstg.leinst.fr/>
- <http://www.nationalschool.gov.uk/policyhub/>
- DrugScope online library
- Department of Health website
- Drug and alcohol findings
- evaluation team members and the SPLC sent requests to their extended networks of researchers and practitioners requesting relevant material;
- current holdings by researchers and AVA were drawn on;

- web searches were conducted through Google (and GoogleScholar) using the same terms as the database searches and the first 50 hits from each search term investigated.

### Section 1: Developing the Evidence Base d. Scoping the Prevalence (Objective 2)

Initially the intention was for the prevalence scoping data to be collected over one calendar month from the information already collected by agencies about the young women they see and including some extra information. During the month the agencies involved were asked to add in extra questions to their standard assessment process, frontline workers were provided with training in local referral procedures and in asking questions appropriately, and effectively and a guide was provided for workers giving advice about how to address sensitive topics and references of places to go for further information (see Appendix 2). However, it quickly became apparent that for both boroughs collecting data were challenging (for further discussion of this see section 3.3 Methodological Challenges). As a result in Enfield, we collected data between 1st June - 31st July 2011. In RBKC, we did the same but received no information about any women however it is unclear whether this was due to the agencies not completing the screening or not gaining consent to pass the information to the research team. We then re-ran the screening in RBKC at ADVANCE and INSIGHT, and included the Young People's Substance Misuse Worker from the councils own team (this worker provides satellite services in the Youth Offending Team). The second screening period was 19th September - 31st October 2011.

### e. Young women's experiences (Objective 3)

We used semi-structured interviews and focus groups to explore young women's experiences. Young women aged 14 to 25 who used each service during the prevalence scoping phase were invited (via a letter) to take part in either an interview about how their experiences of substance use, violence and abuse affected them or a focus group in which they discussed their experiences of seeking help for substance use, violence and abuse issues.

Interviews were organised for a day and time that suited the young woman and took place in a quiet room at the agency they were recruited from. The interviews lasted for between 30 minutes and an hour, depending on how much the young woman wanted to talk about. The interviews were audio recorded and transcribed and the young woman's identity kept anonymous. Each young woman was

<sup>1</sup> As defined by Stella Project: "The use of substances (such as illegal drugs, prescription medicines or alcohol) in such a way that results in harm to the individual user or to the wider community. The range of harms includes problems for physical health, psychological health, violence, financial problems, family problems or social problems."

asked to choose a fake name to go with their information that only they and the researchers know. We intended to interview one young woman from each agency in each borough, eight in total. However due to difficulties in both identifying and recruiting young women we were only able to interview five young women.

Focus groups were organised for a day and time that suited the young women and were held at quiet rooms in the agencies taking part. The focus groups lasted for about 45 minutes. Each focus group was audio recorded and transcribed and the young women's identity kept anonymous. Each young woman was asked to choose a pseudonym to go with their information that only they and the researchers know. We planned to run four focus groups (with 4-6 young women in them), two in each borough. However due to problems recruiting young women and organizing the focus groups we conducted one focus group in Enfield and two in RBKC.

At the end of each interview and focus group each young woman was given a debriefing sheet and £10 of vouchers (chosen from a selection) to cover their travel expenses and a goody bag (including toiletries, etc. that had been donated to AVA and leaflets that provided information and additional sources of support).

#### f. Services responses (Objective 4)

Semi-structured telephone interviews were conducted in November and December 2011 with a practitioner from each agency. The practitioners were consulted about: their knowledge of substance use and domestic and sexual violence and how they understand the links between these issues; their views on the how these issues relate to the young women with which they work; the barriers they experience or see in relation to developing practice to address the overlapping issues with their service users and experiences of partnership working (see Appendix 3). We also conducted the semi-structured telephone interview with the SPLC in order to capture the knowledge she has accrued through co-ordinating the project.

## Section 2: Testing the efficacy of the Stella intervention

There are three strands to section 2, each will take place twice, pre and post intervention.

1. An online questionnaire for frontline staff in the agencies involved, which covers issues relating to staff confidence, knowledge and skills in addressing overlapping issues of young women's substance misuse and experiences of domestic and sexual violence; current partnership work taking place with other specialist agencies, etc (see [http://www.avaproject.org.uk/media/89948/survey\\_20979917.pdf](http://www.avaproject.org.uk/media/89948/survey_20979917.pdf) for the full questionnaire). Service managers were emailed by the evaluation team briefing them about the questionnaire and asking them to invite all of their staff to complete the questionnaire online (a link to the website hosting the questionnaire was provided). The service managers forwarded the email to all staff and staff completed the survey between May and November 2011 prior to the intervention beginning. Initially the staff questionnaire was only due to be available for one month but due to poor completion rates the period was extended and numerous reminders were sent to the agencies.
2. An analysis of the policies and procedures from participating agencies and strategic documents produced by the local borough strategic partnerships. The analysis is guided by six questions (see Appendix 4).
3. Monitoring data on disclosures of the intersecting issues by young women accessing services and where referrals are made to partner agencies. These data were collected pre-intervention in the form of the prevalence scoping.

### 3.1 Participants

The tables below represent the services in each London borough involved in the initiative. Table 1 shows each service's specialism, the type of service and the service name. Table 2 shows the age group of the service users and the number of staff.



**Table 1.** Service specialism, type and name in both boroughs

Specialism	Service type	Service name	
		Enfield	Kensington & Chelsea
Domestic & sexual violence	Independent Domestic Violence Advocacy (IDVA) service	Evolve, Solace Women's Aid	ADVANCE Advocacy Project
Substance misuse	Young people's substance misuse service	Compass Sort It Young People's Substance Misuse Service	Victim Support
	Drug Intervention Programme	WDP Enfield DIP	CRI Kensington & Chelsea DIP <sup>2</sup>
Offending	Youth Offending Service	Enfield Youth Offending Service	

**Table 2.** Age group of service users and number of staff for services in both boroughs

Age group of users	Enfield		Kensington & Chelsea	
	Service name	Number of staff	Service name	Number of staff
14-18	SORT IT	10		
	Enfield YOS	15-20		
14-25			NSIGHT	3
			Victim Support	4
15-25			ADVANCE	4
18-25	SWA	2	RBKC DIP	6
	Enfield DIP	8		

The literature review and Section 2, Strand 2, the policies and procedures analysis did not require participants because they used existing literature and documentation. The participants for the remaining objectives are detailed below.

**Section 1: Developing the Evidence Base**

*Scoping the Prevalence (Objective 2)*  
 In the two months that data were collected in Enfield, information about 17 young women was included on the prevalence database. In the three and a half months they were collected in the RBKC, information about 10 young women was added. From the information available it appears these represent the majority of the young women

the agencies saw in the two months but some problems with record keeping and missing information means that we cannot be certain.

*Young women's experiences (Objective 3)*

We intended to interview one young woman who had accessed each agency across the two boroughs. However, we encountered considerable difficulties recruiting young women to be interviewed (for further discussion of this see 3.3). Eventually, two young women from Enfield were interviewed and three young women from the RBKC.

We had planned to run four focus groups, two in each borough, with a minimum of four young women per group. Again significant challenges were experienced recruiting young women and setting up the focus

groups. Three focus groups were completed; two in the RBKC (both groups consisted of 6 young women) and one in Enfield (where 5 young women took part).

*Services responses (Objective 4)*

One member of staff was interviewed from each agency taking part in the project and the SPLC was also interviewed. Therefore there were nine telephone interviews conducted in total.

**Section 2: Testing the efficacy of the Stella intervention**

*Strand 1 – Staff questionnaire*

At the pre-intervention stage, 26 staff attempted to fill in the questionnaire however 6 were excluded

because they had only filled in one or two questions. The final sample was 20, ten from each borough.

The percentage of staff invited from each borough completing the questionnaire was 25% from Enfield and 58.8% from RBKC. A detailed breakdown of the participants across the organisations can be seen in Table 3, which highlights the percentage of staff from each type of organisation that completed the questionnaire and the overall 35.1% of the staff invited to participate that did, which is comparable with other evaluations using online staff surveys which have shown vastly differing response rates (see for example Coy, Thiarra & Kelly, 2011 - response rate =5.4%; Coy, Lee, Kelly & Roach, 2010 - response rate=71%).

**Table 3.** Distribution of staff completing the questionnaire according to area and organisation specialism

	Number of staff who completed the questionnaire	Number of Staff invited	% of Staff completing questionnaire
Enfield	4	22	18
	6	18	33.3
RBKC	3	8	37.5
	7	9	77.8
TOTAL	20	57	35.1

*Strand 2 – Monitoring data*

In the two months that data were collected in Enfield, information about 17 young women was included on the prevalence database. In the three and a half months data were collected in the RBKC, information about 10 young women was added.

who wanted to take part to complete such screening first (an example of the competency materials is in Appendix 5). During interviews and focus groups, key workers from each agency were available (but not present in the room) to provide the young women with support.

**3.2 Ethical Considerations**

The research and evaluation gained ethical approval from Middlesex Universities Department of Psychology ethics committee and the London Social Care Research Ethics Committee. All young women who agreed to take part in an interview or focus group were asked when they arrived to sign a consent form. We did not seek parental consent for those under 16 years old because almost all of the agencies involved use a competency screening tool and their best working practice is that they do not require parents' or carers' consent for young people to access treatment if they can competently (in their professional opinion) consent to this work. The only exception to this is medical treatment. Where the young person is under 15 years and needs medical treatment, then consent would have to be gained from parents or carers. For the few agencies where the competency screening is not routinely used, we requested all young women

**3.3 Methodological Challenges**

In investigating the intersecting issues of domestic violence, sexual violence, problem substance use and young age, the scope of the research was limited to young women accessing specialist services for either domestic or sexual violence, substance use or youth offending.

In RBKC, the local authority re-commissioned its Independent Domestic Violence Advocacy (IDVA) service during the research period, resulting in a change of providers halfway through the first prevalence screening period. Frontline practitioners were required to prioritise obtaining client consent to transfer personal information to the new provider, and did not implement the prevalence screening questions with their clients during this time.

<sup>2</sup> Kensington & Chelsea DIP was re-commissioned in October 2011 and CRI are no longer the provider. The DIP is now provided to both RBKC and HammerSmith & Fulham by Blenheim CDP. No data was collected from the service after the transition.

In another agency in RBKC, the manager of the agency reported that her staff had asked the prevalence screening questions but were unable to obtain consent from any young women to pass this information on to the researchers. The explanation provided by the service manager was that young women arrived at their service 'in crisis' and were not prepared to think about involvement in research. This lack of consent may warrant further investigation, in order to identify the key factors that assisted other agencies participating in the research to obtain consent from young women in similar 'crisis' situations.

In the DIP services in both boroughs, the service managers reported that they had had very low numbers of women aged 25 years and under accessing the service during the prevalence screening period. Both services also reported instances of a young woman attending the service but not engaging long enough to complete an assessment, including screening.

Finally, although the young people's substance misuse services in both boroughs did implement the screening, service managers and staff in both areas reported that their clients are disproportionately young men and that, similar to the DIPs, young women often attend on a drop-in basis but do not engage to the point of assessment.

Practitioners across all agencies reported difficulties recruiting young women to participate in focus groups or semi-structured interviews. Reasons provided by service managers and staff for this difficulty in engagement included: gang-involved young women being concerned about confidentiality, particularly for participating in focus groups; young women not being willing to set appointments; young women not wanting to talk about sensitive issues; young women no longer being engaged with the service.

## 4. Findings

### 4.1 Summary of Key Findings from Rapid Evidence Review

#### 1. What is the prevalence and incidence of the overlapping issues of PSU, DV and/or SV amongst young women (nationally and internationally)?

**The connection between DV, SV and PSU is complex.** Young women's use of substances may be associated with current or historical experiences of abuse. PSU may develop partly as a way of coping with trauma symptoms and for managing the stress of living in a violent situation. Women who use substances problematically are also more vulnerable to violence due to their relationships with others who use substances and because of impaired judgment while using substances. Furthermore, for substance-abusing women with histories of childhood abuse, there is an increased risk of re-victimisation (DV and SV) in adulthood.

Literature on the prevalence and incidence of the overlapping issues of PSU, DV and/or SV for young women originates mostly from North America. UK statistics suggest that around 60% of 14 year olds and 80% of 15 year olds have consumed alcohol. Early drinking appears to increase risks for progression to problem use in young adulthood. Early transitions such as younger age at first drink are linked with risk for substance use disorders and have been associated with sexual victimisation. Adolescent girls and young women are four times more likely to experience sexual coercion than older women.

Many adolescents use substances other than alcohol. Cannabis is the most frequently consumed drug with 8.2% of 11-15 year olds reporting having consumed it in the past year. Childhood abuse has been found to be associated with or to predict adolescent substance use disorders. Sexual abuse, physical abuse, and witnessing violence are associated with increased pre-teen alcohol use and also associated with binge drinking. Young women leaving state care are especially susceptible to PSU and to commercial sexual exploitation.

US data indicate that young women between the ages of 16 and 24 are at greater risk of domestic violence than any other age and gender group. UK data suggest that 88% of adolescents have experienced IPV. Exposure to interpersonal violence (physical assault, sexual assault, or witnessing violence) increased risk for posttraumatic stress

disorder, depression, and substance misuse/dependence. For adolescents, abuse by an intimate partner is associated with increased illicit substance use, antisocial behaviour, risky sexual behaviour and suicidal behaviour. DV puts young women at risk for subsequent heavy drinking to reduce negative affect or as a response to stress. Sexual victimisation also increases the likelihood of non-medical prescription medication use of opioid analgesics and sedative medication amongst adolescent girls.

There are competing explanations for the relationship between substance use and sexual violence. One that substance misuse leads to vulnerability and victimisation, and increased risk of exposure to violence, including sexual victimisation. Another is that assault leads to substance misuse as a coping strategy. There may be a reciprocal relationship between substance use and victimisation, whereby victimisation places young women at risk of substance misuse, which may place them at risk of subsequent victimisation and so forth.

#### 2. Do integrated responses to young women experiencing PSU and DV &/or SV exist? If yes, what are they and what are their success rates?

**There are very few evidence based integrated programmes that address co-occurring issues such as PSU and DV and/or SV experienced by young women.** One exception is Wenzel,

D'Amico, Barnes and Gilbert's (2009) 'The Power of YOU' a program targeting "Alcohol and Other Drug" (AOD) use, HIV risk behaviours, and Intimate Partner Violence among homeless young women ages 18-25. This was based on social learning theory, decision-making theory, and Motivational Interviewing. The results from the pilot study suggest that the integrated response of "The Power of YOU" programme may hold promise in helping homeless young women in the transition to adulthood make healthier choices and plan for a variety of high-risk situations.

Another example of an integrated response to young women who are sexually assaulted or exploited and are displaying risk factors such as substance misuse is the Runaway Intervention Program (RIP) which was created for runaway girls ages 12 to 15 to re-establish positive developmental trajectories, reduce girls' traumatic responses, and improve health and coping behaviours. RIP provides a comprehensive forensic assessment and health examination at baseline, and up to 12 months of home visiting, healthcare, health education, and case management by Advanced Practice Nurses (APN), plus access to

an optional weekly girls' empowerment group. There were significant improvements by 6 and 12 months, such that all measures of positive development, trauma responses and risk behaviours more closely resembled non-abused girls' responses.

In the UK, since 1995, Barnardo's have run sexual exploitation services for young people up to the age of 18. These services aim to prevent sexual exploitation, increase protection for young people being sexually exploited, and support young people out of exploitation. Many of the young people engaged with the services had experiences of drug and alcohol misuse. Specialist services for young people affected by sexual exploitation achieved substantial reductions in risks related to sexual exploitation and going missing.

Factors in the Barnardo's service model which demonstrated positive benefits for young service users included:

- Having a clearly understood 'pathway' into the service;
- Developing local protocols between professionals and agencies;
- Establishing ongoing contact with young women "on their own terms";
- Offering a physical, safe space for young people;
- Flexibility to provide outreach and support;
- Having a named worker who can form a relationship with the young person;
- Working in partnership with other agencies, such as substance use services;
- Acting as an advocate for the young person to other professionals and agencies;
- Providing opportunities for young people to participate in service development (Scott & Skidmore, 2006).

#### 3. What is good practice for frontline practitioners working with young women with overlapping needs?

**To be more accessible to hard to reach young people, services should be delivered in a respectful, non-stigmatised way.** Consultation with groups of children living in special circumstances carried out by the NSPCC found that the most important aspect was that someone listened to them. They did not want to be made to feel different to their peers and preferred services that had clear policies on confidentiality and were based in attractive, welcoming places where they could have fun and not just focus on their difficulties (Thorpe, 2003).

Connection is vital to providing support to young women impacted by violence, mental health and/or substance use issues. Parkes (2007) asserts that it is essential for frontline workers to develop a relationship with women before asking questions about substance use or mental health issues.

However others (e.g., Boyle & Jones, 2006) assert that early routine enquiry is regarded as an 'acceptable' practice by women, and further allows the rapid identification of such issues and the offer of appropriate forms of support. Parkes outlines a number of suggestions for working with women with mental health and/or substance use issues, however it is not clear how applicable these are to younger women. These include:

- Providing information about the impact of trauma on substance misuse and mental health issues;
- Taking cues from the women herself on how she wants her problem to be described;
- Helping women to identify the structural, social and economic factors placing them at risk;
- Helping to lessen any self-blame for the violence, trauma, mental health and/or substance use problems in their lives;
- Helping women to recognize and respond to their distress signals;
- Supporting the development of self-efficacy;
- Addressing safety issues;
- Supporting the development of safe relationships and connections.
- Providing information and referrals to appropriate support groups or resources in the community;
- Explaining the limits of confidentiality during the initial intake.

**4. What is good practice for strategically linking work with young women with intersecting needs i.e. policy, rather than frontline practitioners?**

**A key example of good practice for strategically linking work with young women with intersecting needs is The Communities That Care (CTC) approach.** CTC involves bringing together local community representatives, professionals working in the area and senior managers responsible for service management in a

bid to tackle substance misuse and other anti-social behaviour in young people. CTC incorporates many of the lessons of international research on community drug/ alcohol interventions. These include: devolving decision-making to the community while supplying research-based knowledge; rapid feedback of results motivates participants and keeps projects on track; recruiting influential and respected local leaders; and partnership working between organisations. However the impact of CTCs have been mixed. Godard, Cory and Abi-Jaoude (2008) recommend:

- Using a holistic approach – and acknowledging the connections between abuse, substance use and mental health;
- Helping to build collaborations between the various sectors;
- Reducing barriers to ensure greater accessibility for women to resources.

Coordinated, multi-agency approaches to supporting survivors of violence against women and girls are widely subscribed to throughout the UK, reflected in approaches such as Multi-Agency Risk Assessment Conferences (MARACs) for adult survivors of domestic violence and, in child protection, Team Around the Child (TAC) and/or Team Around the Family (TAF). These approaches are based on an assumption that those affected by violence often have a range of needs that require the cooperation of a range of services and practitioners in order for those needs to be met. A focus on young women's needs would build on connecting these existing, multiagency approaches, with attention to the areas where young women may currently 'fall through the cracks'.

#### **4.2 Literature Review (Objective 1)**

This literature review is based on a rapid evidence review. The terms of that rapid evidence review, and the set of search items employed to identify key literature, were carefully delineated in advance in order to systematically address Objective 1.

**1. What is the prevalence and incidence of the overlapping issues of PSU, DV and/or SV amongst young women (nationally and internationally)?**

The links between domestic violence (DV) and problematic substance use (PSU) experienced by women are increasingly coming to the attention of agencies, and whilst initial studies seek to address this issue (Humphreys, Thara & Regan, 2005), the evidence base remains largely undeveloped within the UK. Furthermore, an increase in awareness of the levels of sexual violence (SV) experienced by women in particular accessing drug and treatment services





has led to the recognition that research is needed to address these intersecting issues, especially with regards to young women (aged 14-25) who are often not the focus of research in this area.

The Stella Project does not use a clinical definition of problematic substance use (PSU), but rather defines it as 'the use of substances such as illegal drugs, prescription medicines or alcohol, in such a way that it results in harm to the individual user or to the wider community. The range of harm includes physical health problems, psychological health, violence, financial problems, family or social problems' (Stella Project, 2004). Sexual violence (SV) encompasses a range of behaviours, including a completed non-consensual sex act (i.e., rape), an attempted sex act, abusive sexual contact (unwanted touching), and non-contact sexual abuse (e.g., threatened sexual violence, exhibitionism, verbal sexual harassment) (Basile & Saltzman, 2002).

Domestic violence typically involves a pattern of physical, sexual and emotional abuse and intimidation which escalates in frequency and severity over time. It can be understood as the misuse of power and control by one partner over the other in an intimate relationship, usually by a man over a woman, less frequently by a woman over a man and also occurring amongst same sex couples (Humphreys & Mullender, 2000). The UK government defines domestic violence as:

*Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. (Home Office, 2011).*

This definition is problematic in that it excludes those under the age of 18 years. However, the Government has recently launched a consultation regarding the broadening of this definition to extend to all 16- to 17-year-olds, or to extend to encompass all those under 18 (Home Office, 2011).

The connection between DV, SV and PSU is complex. Women's use of substances has been found to be associated with current or historical experiences of abuse with between

55-99% of women with substance use issues reporting a lifetime history of abuse (Najavits, Weiss & Shaw, 1997). There is also a strong link between victimisation or traumatization in women and PSU and dependence disorders (Grella, 2003; Najavits et al., 1997; Rees et al., 2011). Furthermore, for substance-abusing women with histories of childhood maltreatment, there is a reported increased risk of re-victimisation in adulthood (Clotire, Tardiff & Marzuk, 1996), which may occur as domestic violence (Colman & Widom, 2004; Deisol & Margolin, 2004; Noll, 2005), sexual violence (Casey & Nurius, 2005), and/or sexual coercion (Casey & Nurius, 2005; Noell, Rohde, Seeley & Ochs, 2001).

A British study by Mirreeds-Black (1999) found that victims of domestic "assault" had higher levels of alcohol consumption than non-victims and that the risk of violence increased with increasing levels of drinking. However, it should be noted that this is associative, not causative research. A UK study undertaken by the Stella Project found that all the women with substance use problems who accessed domestic violence services acknowledged a connection between their substance use and their experiences of violence (Humphreys & Regan, 2005). Nearly two thirds of these women shared that they began using substances problematically following experiences of relationship violence. Women who have experienced physical and psychological abuse are fifteen times more likely to abuse alcohol and nine times more likely to abuse drugs than are non-abused women in industrialised countries, furthermore there is evidence that for some women this is attributable to partner violence (Stark, 1996). There is also evidence, from these women, that substances may be used as a coping mechanism (Scottish Women's Aid, 2005; Tucker, Wenzel, Strauss, Ryan, Golinelli & Elliot, 2005). The latter findings support the notion that women experiencing violence may develop PSU partly as a way of coping with trauma symptoms and for managing the stress of living in a violent situation. Women who use substances problematically are also more vulnerable to violence due to their relationships with others who use substances and because of impaired judgment while using substances (Covington, 2003). Thus, a cycle begins of "victimization, chemical use, retardation of emotional development, limited stress resolution, more chemical use and heightened vulnerability to further victimization" (Steele, 2000, p.72).

With regards to young women, literature on the prevalence and incidence of the overlapping issues of PSU, DV and/or SV originates mostly from North America. Numerous studies have been conducted

with college student populations and have found that alcohol use and sexual assault on campuses are highly prevalent (Kaysen, Neighbors, Martell, Fossos & Larimer, 2006; McCauley, Ruggiero, Resnick, Conoscenti & Kilpatrick, 2010; Nabors, 2010), especially with regards to alcohol involved rape (Abbey, Zawacki, Buck, Clinton, & McAuslan, 2004; Mohler-Kuo, Dowdall, Koss, & Wechsler, 2004) and coercive sexual experiences (Palmer, McMahon, Rounsaville & Ball, 2010).

Many surveys have demonstrated that adolescent alcohol use is common, but the extent to which it is problematic remains uncertain. Current UK statistics suggest that around 60% of 14 year olds and 80% of 15 year olds have had an alcoholic drink, boys and girls were equally as likely to have drunk alcohol (Sutton & Bridges, 2011). Further, around 20% of 15 year olds surveyed in 2010 had had a drink in the last week with mean consumption per week around 14 units (Sutton & Bridges, 2011). On the one hand, experimenting with alcohol is widely regarded as a normal part of adolescent development without adverse consequences (Hawkins, Catalano & Miller, 1992) and it appears that most teenagers develop a degree of self-control over their alcohol consumption through trial and error, with mistakes occurring along the way (Percy, Wilson, McCartan & McCrystal, 2011). However a recent report by the National Treatment Agency for Substance Misuse (2011) argues that "Any substance misuse among young people under 18 years old is a cause for concern. Drugs and alcohol can damage their health and development, disrupt their education, and devastate their families." (P.2). As is the case for adults, associations are consistently found between alcohol consumption and risky behaviours and the ability to assess risk, particularly when alcohol has been consumed (Percy et al., 2011). Early drinking appears to increase risks for progression to problem use in young adulthood with surveys in adults indicating that the onset of alcohol disorders occurs in adolescence (Nelson & Witichen, 1998). Early transitions such as being at a younger age at first drink are not only linked with risk for substance use disorders (Grant & Dawson, 1997), but have also been associated with sexual victimisation (Rickert & Wiemann, 1998). Adolescent girls and young women are four times more likely to experience sexual coercion than older women (Catalano, 2006; Koss, Gidycz & Wisniewski, 1987), and early use of alcohol may play a role in this heightened vulnerability. Surveys have shown that many adolescents use substances other than alcohol, but the extent to which use of these other substances is problematic remains uncertain. A recent survey of 11-15 year

olds in England found overall similar proportions of girls and boys said they had ever taken drugs (18%) and taken drugs in the last year (12% of girls, 13% of boys) (Omole, 2011). Cannabis is the most frequently consumed drug with 8.2% of 11-15 year olds reporting having consumed it in the past year (Omole, 2011). A logistic regression was conducted to identify the factors associated with drug use, it found that smoking and drinking alcohol were associated with drug use in the last year, highlighting the need to address different types of substance use together (Omole, 2011).

Childhood abuse has been found to be associated with or to predict adolescent substance use disorders. Among 3,559 students in grades 7 through 12, Hamburger, Leeb and Swahn (2008) found that sexual abuse, physical abuse, and witnessing violence were associated with increased pre-teen alcohol use and also associated with binge drinking (Shin, Edwards & Heeren, 2009). Although substance use disorders (SUDs) are not highly prevalent among young adults, epidemiologic data suggesting that approximately 67% of individuals with a lifetime history of alcohol dependence met criteria prior to age 25 years (Hingson, Heeren & Winter, 2006). Young women who are leaving the state care system are especially susceptible to commercial sexual exploitation, and women with a history of state care are disproportionately represented amongst women with PSU involved in street-based sex work (Coy, 2008, 2009; Cusick, 2002).

Surveillance data in the UK and the US indicate that adolescents and young women between the ages of 16 and 24 years are at greater risk of domestic violence than any other age and gender group (Smith, Coleman, Eder & Hall, 2011; Rosewater, 2003; Tjaden & Thoennes, 2000). A recent UK study conducted by Barter, McCarry, Berridge and Evans (2009) on behalf of the NSPCC used a sample of 1,353 thirteen to seventeen year olds and found that over 88% of adolescents had been in a relationship, and amongst this group, 25% of girls had experienced physical partner violence, 31% sexual partner violence and 71% had experienced emotional partner violence. Prevalence was found to be higher amongst females and more likely to occur when there was an older partner (Barter et al., 2009). The onset of dating violence among adolescents is said to be around ages 15 or 16, however, acts of pushing, verbal threats, and hitting may be seen as signs of affection and love amongst younger girls. These girls who are dating older boys may interpret these violent acts as examples of a deeper commitment to the relationship that will result in long-term positive benefits (Wekerle

& Wolfe, 1999). One in ten adolescent females reported a history of dating violence (Howard & Wang, 2003). In a survey of 4023 adolescents between the ages of 12 and 17 years, Kilpatrick and colleagues (2003) demonstrated that exposure to interpersonal violence (physical assault, sexual assault, or witnessing violence) increased risk for post-traumatic stress disorder, depression, and substance misuse/dependence. Roberts, Klein and Fisher (2003) also reported that amongst adolescents (11–21 years) abuse by an intimate partner is associated with increased illicit substance use, antisocial behaviour, and suicidal behaviour among females. A number of risk factors and behaviours have been identified among adolescents who have experienced violence, specifically, those who report sad/hopeless or depressed feelings, substance use, risky sexual behaviours (e.g. multiple sex partners, and unprotected sex) are also likely to report being a victim of dating violence (Howard, Wang, & Yan, 2007).

Numerous studies provide evidence of an association between alcohol use and sexual victimisation among adolescent females (e.g. Champion, Foley, Durant, Hensberry, Altham & Wolfson, 2004; Basile, Black, Simon, Arias, Brenner & Saitzman, 2006; Howard & Wang, 2005). The results present a clear pattern of increased risk of sexual victimisation associated with substance use. Several alternatives have been proposed to explain the relationship between substance use and sexual assault victimisation (Wiltsack et al., 1997; Kilpatrick et al., 1997). One explanation is that substance misuse leads to victimisation, thus there are a number of reasons why young women who use drugs or alcohol problematically may be more vulnerable. Firstly, their ability to detect potential assailants (especially when they are 'trusted' acquaintances, friends or boyfriends) and identify risky situations may be impaired as a result of their substance use. Second, there may be an increased exposure to assailants due to their lifestyle (e.g., if they drink in mixed groups, the link between alcohol use and violence may increase the risk of exposure to violence, including sexual victimisation). Finally, those who use drugs or alcohol problematically may be targeted because they are seen as vulnerable by potential assailants. Another

explanation of the relationship between problem substance use and sexual assault is that assault leads to substance misuse. Problem substance use may be a method used to self-medicate or mentally cope after being assaulted (Kilpatrick et al., 1997; Wiltsack et al., 1997). A final explanation is that there is a reciprocal relationship between substance use and victimisation, whereby victimisation leads to substance misuse, which leads to subsequent victimisation and so forth (Kilpatrick et al., 1997; Wiltsack et al., 1997). Findings from a study by Martino, Steven, Collins and Ellickson (2004) suggest that after controlling for prior victimisation, marijuana use predicted women's subsequent sexual victimisation, and that heavy alcohol use predicted women's subsequent physical assault victimisation. However, a subsequent study to examine the longitudinal relationship between substance use and intimate partner violence (IPV) and perpetration among a sample of young women found that substance use does not increase women's long-term risk of experiencing or perpetrating IPV but that victimisation by IPV puts women at risk for subsequent heavy drinking (Martino, Collins & Ellickson, 2005). In a drinking-to-cope model, individuals may drink to reduce negative affect or as a response to stress (Cooper, Russell, Skinner, Frone, & Mucdar, 1992). Therefore, victims of dating violence may subsequently engage in heavy drinking as an attempt to cope with problems in the relationship (Testa, Livingston, & Leonard, 2003) or because of the emotional consequences associated with dating violence victimisation (Kilpatrick et al., 1997). Young, Grey Boyd and McCabe (2011) suggest that sexual victimisation increased the likelihood of non-medical prescription medication use of opioid analgesics and sedative medication amongst adolescent girls, however, these relationships varied based on the severity of sexual assault. It highlights the importance of increasing awareness among health professionals, researchers, and the wider community of the increased risk for prescription medication misuse among adolescent girls who have a history of sexual violence.

## 2. Do integrated responses to young women experiencing PSU and DV &/or SV exist? If yes, what are they and what are their success rates?

Evidence based programmes to address issues co-occurring issues such as PSU and DV and/or SV experienced by young women are not in abundance and there is a distinct lack of interventions that have an integrated response. Godard, Cory and Abi-Jaoude (2008) stress that "when women's substance use and mental health are not identified as rooted in gender-based violence their experiences are often compartmentalised, their safety may be compromised through inappropriate treatment and the impacts of abuse may be misdiagnosed as mental health or addiction problems in isolation from her unsafe life context. Similarly, if substance use and mental health issues are not acknowledged as impacts of abuse, women seeking safety and support from anti-violence services may not receive appropriate services" (p. 7).

Wenzel, D'Amico, Barnes and Gilbert (2009) developed through collaboration with homeless young women and service providers "The Power of YOU," a program targeting "Alcohol and Other Drug" (AOD) use, HIV risk behaviours, and Intimate Partner Violence among homeless young women ages 18–25 years who were staying in shelters. "The Power of YOU" was guided by a theoretical framework based on social learning theory (Bandura, 1986), decision making theory (Kahneman, Slovic, & Tversky, 1992; Kahneman & Tversky, 2000), and Motivational Interviewing (Mi; Miller & Rollnick, 2002). The results from the pilot study suggested that the integrated

response of "The Power of YOU" programme may hold promise in helping homeless young women in the transition to adulthood make healthier choices and plan for a variety of high-risk situations (Wenzel et al., 2009). Another example of an integrated response to young women who are sexually assaulted or exploited and are displaying risk factors such as substance misuse is the Runaway Intervention Program (RIP), which was created for runaway girls ages 12 to 15 to re-establish positive developmental trajectories, reduce girls' traumatic responses, and improve health and coping behaviours (Edinburgh et al., 2008). RIP provides a comprehensive forensic assessment and health examination at baseline, and up to 12 months of home visiting, healthcare, health education, and case management by Advanced Practice Nurses (APN), plus access to an optional weekly girls' empowerment group conducted by licensed psychotherapists. Prior to RIP, girls were most like their sexually abused peers in the general student population, with lower levels of protective factors and higher levels of risk behaviours than non-abused girls. They saw significant improvements by 6 and 12 months, such that all measures of positive development, trauma responses and risk behaviours more closely resembled non-abused girls' responses. Finally since 1995, in the UK, Barnardo's have run sexual exploitation services for young people up to the age of 18 years. These services aim to prevent sexual exploitation, increase the protection for young people being sexually exploited, and support young people out of exploitation. Whilst not all these young people are affected by intersecting problem substance use, this experience is very common amongst the client group. An evaluation of ten of these Barnardo's services found that 30 of 42 young people engaged with the services had experiences of drug and alcohol misuse (Scott & Skidmore, 2006). The same evaluation found that specialist services for young people affected by sexual exploitation achieved substantial reductions in risks related to sexual exploitation and going missing, however low levels of survey completion around experiences of substance misuse and violence means that the impact of the specialist services on these factors was not evaluated (ibid). Factors in the service model which demonstrated positive benefits for young service users included: having a clearly understood 'pathway' into the service, involving developing local protocols between professionals and agencies; establishing ongoing contact with young women "on their own terms" as a way of building trust; offering a physical, safe space for young people to feel comfortable in; flexibility to provide assertive outreach and support when it was most needed; having a named worker who can forge a relationship with the young person;

working in partnership with other agencies to provide the services young people need, such as around substance use; acting as an advocate for the young person to other professionals and agencies; and providing opportunities for young people to participate in the development of the service (ibid: 51-61).

### 3. What is good practice for frontline practitioners working with young women with overlapping needs?

A review of the needs of 'children in special circumstances', which include those who have experienced PSU, DV and/or SV, found that accessibility to good quality services that promote their health and well-being is a major priority (Statham, 2004). In terms of making services more accessible to so-called "hard to reach" young people, it was identified that services provided had to be what the young people want and are delivered in a respectful, non-stigmatised way. Consultation with groups of children living in special circumstances carried out by the National Society for the Prevention of Cruelty to Children (NSPCC) found that the most important aspect was that someone listened to them. They also did not want to be made to feel different to their peers and preferred services that had clear policies on confidentiality and were based in attractive, welcoming places where they could have fun and not just focus on their difficulties (Thorpe, 2003).

When considering women in general, rather than young adults specifically, a report by the British Columbia Centre of Excellence for Women's Health (2004) stresses the importance of the support for women provided by shelters in the areas of health, income, housing and related issues and how this support can have "a pivotal impact in helping women restructure their lives and reduce their use of substances" (p. 11). The Women's Mental Health and Addictions Action Research Coalition (2007) outlined a number of best practices in providing services to abused women with concurrent mental health and addiction issues. Recommendations include: adopting a woman centred approach, collaboration between addiction services, abuse services and mental health resources, sharing of resources including staff and space, dealing

with concurrent issues, providing a continuum of services that should be trauma informed and provision of cross training opportunities. Baker and Cunningham (2008), suggest that shelters develop expertise in screening and treating substances or else work in conjunction with addiction assessment and treatment agencies. They stress the importance of viewing women in all of their complexities and addressing their multitude of struggles and needs.

Connection is vital to providing support to women impacted by violence, mental health and/or substance use issues. Parkes (2007) asserts that it is essential for frontline workers to develop a relationship with women before asking questions about substance use or mental health issues. However, others (e.g., Boyle & Jones, 2006) assert that early routine enquiry is regarded as an 'acceptable' practice by women, and further allows the rapid identification of such issues and the offer of appropriate forms of support. Parkes outlines the following suggestions for working with women with mental health and/or substance use issues, however it is not clear how applicable these are to younger women, something this project hopes to clarify:

- Help women to make links between structural and social inequalities like poverty, unemployment, demands of childrearing and their PSU
- Do not make assumptions about how issues or challenges are interconnected to individual woman
- Provide information about the impact of trauma on substance misuse and mental health issues
- Take a positive attitude no matter what unusual mental states a woman is experiencing or has experienced – all women need acceptance
- Watch your language. Take your cues from a woman on how she wants her problem to be described.
- Help women lessen their self-blame for the violence, trauma, mental health and substance use problems in their lives. Use statements like "It is very common for women who have experienced abuse to ..." "You are not the only one to ....." "You are not to blame for the abuse in your life".
- Help women to recognize and respond to their distress signals. Ask questions like "What are the warning signs that you are moving into an emotional crisis?" or "What helps you when you are distressed" or "How can I support you when you are feeling emotionally overwhelmed?"
- Support self-efficacy. Honour where women are at and affirm them for how they have survived. Acknowledge and encourage all efforts moving towards safety.
- Address safety issues – both internal and external.



Assist women to recognize and manage their cues for using substances, their triggers for mental health issues and/or trauma responses.

- Support the development of safe relationships and connections. Provide information and referrals to appropriate support groups or resources in the community.
- Support women who are mothering. Acknowledge the importance of mothering in their lives regardless of whether their children are with them or not. If possible refer women to mental health supports or substance use resources that are flexible and responsive to the needs of mothers.
- It is essential to explain the limits of confidentiality during the initial intake. If you have to report to Children's Services it is recommended that you inform women of your requirement and why. If at all possible involve women in making the calls.

#### 4. What is good practice for strategically linking work with young women with intersecting needs i.e. policy, rather than frontline practitioners?

The Communities That Care (CTC) approach involves bringing together local community representatives, professionals working in the area and senior managers responsible for service management in a bid to tackle substance misuse and other anti-social behaviour in young people. CTC incorporates many of the lessons of international research on community drug/alcohol interventions. These include: devolve decision-making to the community while supplying research-based knowledge; rapid feedback of results motivates participants and keeps projects on track; recruit influential and respected local leaders and partnership working between organisations. However the impacts of CTCs have been mixed, Godard, Cory and Abi-Jaoude (2008) recommend the following:

- Using a holistic approach – recognize woman as whole people, taking women's lives into consideration and acknowledging the connection between abuse, substance use and mental health.
- Helping to build collaborations between the various sectors

- Reducing barriers to ensure greater accessibility for women to resources.

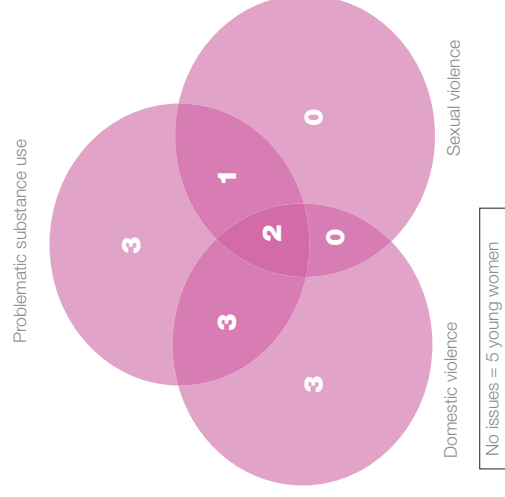
It is not however clear whether these recommendations are for adult women or women of all age groups. Coordinated, multi-agency approaches to supporting survivors of violence against women and girls are widely subscribed to throughout the UK, reflected in approaches such as Multi-Agency Risk Assessment Conferences (MARACs) for adult survivors of domestic violence and, in child protection, Team Around the Child (TAC) and/or Team Around the Family (TAF). These approaches are based on evidence which suggests that those affected by violence often have a range of needs that require the cooperation of a range of services and practitioners in order for those needs to be met (Crisp and Stanko, 2000).

#### 4.3 Prevalence Scoping (Objective 2)

Of the 27 women across the two boroughs for whom prevalence data were collected, ages ranged from 14-25 (M=17). Ethnicity data was collected for all participants, with around half (n=13; 48%) identifying as white (10 British, 1 Irish, 2 other white ethnicities), around a fifth (n=5; 18.5%) identifying as being of mixed ethnicity (1 White & Black African, 4 other mixed ethnicities), around a sixth (n=4; 14.8%) identifying as black (1 African, 1 Caribbean, 2 Black or Black British), 1 (3.7%) identifying as Asian (Pakistani) and a sixth (n=4; 14.8%) identifying as belonging to other ethnic groups (Turkish, Latin American, Moroccan and not specified). Data is presented according to the borough the women were from to allow comparison across them. However, due to the small amount of data collected, no analysis has been done between the types of agencies in each borough.

Figure 1 shows young women's experiences of PSU, DV and SV in Enfield.

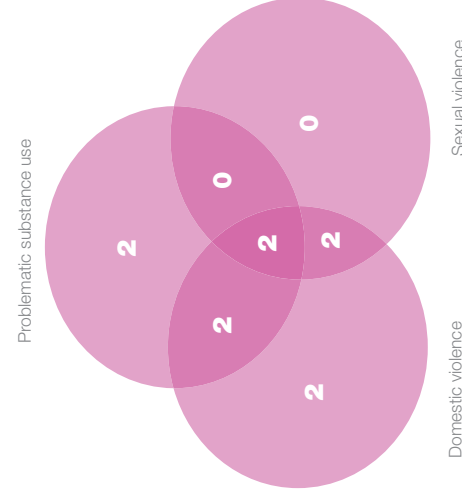
Figure 1. Young women's experiences of PSU, DV and SV in Enfield



Perpetrators of previously experienced DV in Enfield included: "dad hit mum"; ex-boyfriends and partners; and ex-brother in law. Current domestic violence was being perpetrated by partners and ex partners. Previous sexual violence experienced by the young women was perpetrated by: "Dad's best friend"; ex-boyfriend; stranger.

Figure 2 shows young women's experiences of PSU, DV and SV in the RBKC. Perpetrators of previously experienced DV in RBKC included: boyfriends, husbands and partners; brothers; ex-partners; family members' boyfriends. Current domestic violence was being perpetrated by ex-partners and husbands. Previous sexual violence was perpetrated against the women by: ex-partners; husbands and uncles. Current sexual violence was being perpetrated by a friends' partner.

Figure 2. Young women's experiences of PSU, DV and SV in RBKC



Young women were asked if they ever take drugs or drink alcohol to cope with their experiences of violence. In Enfield five young women (29.4%) said that they did, a slightly lower number of women from the RBKC said the same (2; 20%). Interestingly when the practitioners conducting the interview were asked if they perceived any links between the young woman's PSU and experiences of violence the figures were lower, in Enfield for two women (11.8%) practitioners saw a link but in the RBKC it was only perceived for one woman (10%).

Young women were asked why they used alcohol or drugs to cope with their experiences of violence and their reasons included:

*Using drugs to mask/cover the abuse I was faced with.*

*They make me forget everything.*

*Smoke cannabis to deal with gang related violence.*

One young woman described after a violent outburst with her partner that they smoked skunk to calm themselves down then they would make up. Another described drinking and binging on skunk and cocaine but did not describe why.

One young woman described after a violent outburst with her partner that they smoked skunk to calm themselves down then they would make up. Another described drinking and binging on skunk and cocaine but did not describe why.

Practitioners' reasons for their perception of links between PSU and violence amongst the young women were 'to cope with feelings' and as a result of 'gang involvement'. Another stated that the young woman told her she was introduced to crack by her ex-partner who also physically abused her. Finally one practitioner felt that there was so much to uncover she did not know at this time.

#### 4.4 Young women's experiences (Objective 3)

Three focus groups were completed: two in the RBKC (both groups had six young

women) and one in Enfield (five young women took part). Two young women from Enfield were interviewed and three young women from the RBKC were interviewed. The transcripts were thematically analysed in order to gain insight into young women's experiences of both substance use and violence and abuse as well as their experiences of help seeking and referral pathways.

#### Experiences of substance use

The major themes in young women's accounts of problematic drug and alcohol use were: To deal with problems; Peer pressure; for fun; to deal with stress; because addicted; may lead to health problems; may lead to depression and behavioural and personality changes; may lead to loss of self control and self awareness; may lead to violence; may lead to sexual violence.

#### To deal with problems

A primary reason for drug and alcohol use given by the young women was 'to deal with problems':

Is it because of the problem.... if they have got a problem and then they turn to drugs and alcohol, using it as fun and then they realise that it blocks out the problem and becomes the addiction and it becomes a problem in their life. (Enfield focus group)

#### Peer pressure

Many young women asserted that they used alcohol and drugs because of 'peer pressure':

*Everyone else is drinking and taking drugs, so you feel like you have to in order to be a part of what's going on for that age group.* (RBKC focus group 1)

The young women also talked about the intersections of gender, sexuality and peer group pressure:

*A: If you're with boys and say you're with a boy that you like and he is sitting there smoking drugs and you don't wanna do it, but you feel that you have to do it to impress him because you like him.*

*B: And if he knows that you like him as well, then he's expecting you to do it and will pressure you more.* (Enfield focus group)

Others agreed that young women may be especially susceptible to peer pressure when in the company of young men:

*If the girl is in a situation where she is outnumbered by boys e.g. 2 girls to 5 boys, a girl will feel more pressured to drink and smoke with the boys because she doesn't want to be insulted by them and told to get lost or anything, so girls will just conform to what everyone else is doing.* (RBKC focus group 1).

However, as this young woman further explained, young men experience peer pressure in such situations differently to young women. She asserted that it seemed easier for young men to "say no" in mixed gender peer group settings involving alcohol and drugs but that they may also, conversely, "take advantage" of "drunk girls":

*When girls are taking drugs, a boy can step back easily and (say) no even if he is out numbered, but then he can also take advantage as there are some drunk girls and he can do what he wants.* (RBKC focus group 1).

Some young women reported that young men may encourage them to smoke cannabis in an attempt to make them sexually aroused and more amenable to 'doing what they want':

*It is known from girls and guys that I know that cannabis makes girls horny so boys like to get girls high so it is easier to get girls to do what they want.* (RBKC focus group 1)

The young women also reported their belief that drug or alcohol use may lead to a loss of self awareness and self control:

*When you get to the point that you don't know what you're doing and you are out of control* (RBKC focus group 2)

They further noted that excessive drug and alcohol consumption may lead to violence:

*An excessive amount can lead to violence.* (RBKC focus group 2)

#### Violence in relationships

The young women identified several themes in their discussion of violence in relationships. These included, verbal abuse; physical violence; controlling behaviour; emotional abuse; sexual coercion; sexual violence; and the perceived influence of alcohol on perpetrators.

#### Sexual violence

Although rape was mentioned by the young women as a form of intimate partner violence, there was some disagreement as to the status of sexual violence within coupled relationships. Rape was seen by some young women as something committed by a stranger, not by a partner:

*A: If a husband has sex with his wife when she does not want it, I do not see how that's classed as rape*

*B: Yes it is, if she doesn't want to do it she doesn't want to do it.*

*A: Yeah, but I wouldn't say it was rape as rape always sounds like it's a stranger.* (RBKC focus group 2)

The young women also talked about some young men regularly 'using girls for sex' by 'telling them they love them' in order to convince them to have sex.

*Quite a few boys that I know they use the girls for sex and they tell them that they do love them, so anytime they do something wrong they blame it on the girl saying "it's your fault", so in her head she believes that everything she is doing is wrong so she thinks that having sex with him is making up for everything she's been doing wrong.* (RBKC focus group 1)

More 'extreme' forms of sexual coercion, deception and 'manipulation' by young men were also described by the young women:

*A: Sexual abuse – manipulating someone – a man saying that he is in love with a girl when he is actually abusing her when she was under 18.*

*B: Or when a man coerces a girl to have sex with his friends for different reasons by saying he loves her and receiving money for it – prostitution.* (RBKC focus group 1)

#### Emotional abuse

The young women also identified young men's 'emotional abuse' of their girlfriends, and the impact of this on their self esteem and confidence, as a form of 'abuse':

*Emotional abuse, you could literally make the person feel like they're nothing, like they are crap and that counts as abuse.* (RBKC focus group 2)

This was also extended to encompass forms of controlling behaviour.

#### Controlling behaviour

*A girl's phone rings and the boy says "who's that? I don't want you speaking to nobody" grabs the phone and dashes it on the floor and starts fighting her.*  
(RBKC focus group 2)

The young women discussed the links between young men engaging in controlling behaviour and the onset of physical violence. In the example above, the violence is described as part of a young man's attempt to control his girlfriend's use of her mobile phone, and her ability to speak to others.

Alcohol was described as being associated with aggressive, violent and abusive conduct.

#### Association with alcohol use

*I had a friend, her boyfriend when they go to parties and drinks too much he becomes extremely aggressive and he will grab her, hold her, pushes and shouts at her.* (RBKC focus group 1)

However, young women's identification of alcohol consumption as being linked to young men's violent behaviour was then mitigated. Excessive alcohol and drug consumption were identified as 'the problem', and perpetrators 'under the influence' were described as not being aware of, or responsible for, their abusive conduct:

#### Perpetrators' lack of awareness due to substance use

*When people are really unaware because of too many drugs or too much alcohol, what they say to other people – their parents, sisters, wives, children etc. It can really affect them because they might say "I hate you" or "I don't want to keep a relationship with you". But they are unaware – it is not them speaking but it hurts the other person.*  
(RBKC focus group 1)

Here excessive drug and alcohol consumption, and a consequent lack of awareness and self control is described

as giving rise to abusive conduct. However, by insisting that, "it is not them speaking" this young woman removes responsibility from young men acting abusively while under the influence of drugs or alcohol, even whilst she acknowledges the negative emotional impact of such conduct on "the other person."

#### Peer pressure on young men

The young women also talked about the impact of peer pressure on young men's coercive sexual behaviour:

*A: Nowadays boys know how to work girls mentally, they know "ok, this is what girls want so I need to do this, this and this" for this kind of girl and this other girls will just be easy.*

*B: It's not always like that – I know I should be sticking up for boys but sometimes they do know what they are doing but sometimes they don't. Sometimes they think "I should do it too because other guys are doing it".*

*A: Just like girls might be "my friend's doing that so, let me just do it or I'll get called a wuss for not doing it and the other boys will be like you're still a virgin.. oh my gosh".*

*C: Both boys and girls do get peer pressure but boys have the upper hand. [...] So he has control – if he is being pressured, the girl has his pressure and her pressure from him to do it.* (RBKC focus group 1)

#### Blaming young women and excusing young men for violence and sexual violence

There were a number of ways in which the young women 'excused' the violent behaviour of young men. These included placing the 'blame' onto the young man's alcohol or drug use – e.g., "it wasn't him talking."; references to the peer pressure on young men to lose their virginity and to coerce young women into having sex; and that young women who have "had too much to drink" will use this as "an excuse to have sex":

*If a girl is being pressured, if you add alcohol it's gonna give her the excuse to have sex – she will be like "I didn't mean to I was drunk.... I didn't know what I was doing"*  
(RBKC focus group 1).

The young women thus offered two contrasting interpretations of the effects of alcohol. Both of these accounts reinforce existing cultural beliefs about



gender, and in particular (young) women's culpability in their own 'victimhood' and young men's mitigated responsibility for the perpetration of violence.

#### Help seeking and referral pathways

Young women attending a young people's substance misuse service reported a range of referral pathways. These included being referred by school or college; being referred by mother; being referred by CAMHS (after mother referred them to CAMHS); attending 'with a friend'. One young woman reported on her experience of being referred to a problematic substance use agency:

*I used to go in school drunk and stoned so she (the keyworker) used to come and see me. The school referred me. They have been helping me since the end of last year.*

#### Activities for young women

The young women reported enjoying the activities available to them, including 'gendered' activities such as 'getting their nails done' as these removed them from situations where they would have been using drugs. However, some young women reported their desire to engage in less stereotypically feminine activities, including paintballing and go kart racing.

*Things like make-up, I've always wanted to chuck a massive ball of paint at a big board, but no-one ever does that. The person who works with me gives asks for ideas about stuff I wanna do, I'm like can you please get a big board for us to throw paint at, but she didn't do it... stuff like that is just fun, like paintballing and go-karting and trips out.*

#### Issues around confidentiality

The young women expressed some anxiety about the repercussions of disclosure, both in terms of the threats of retaliation by a violent partner, and also in terms of the limits to the 'confidentiality' available to them:

*A: Sometimes it's not easy because if you are getting physically abused and being threatened that if you tell someone you will be hurt even more, so not everyone has got the courage to speak up and tell someone.*

*B: I just get scared that people won't keep it confidential – people say it's confidential but sometimes it ain't (Enfield focus group)*

They identified a disjuncture between the assurances of confidentiality offered to them, and the reality of the limits of that confidentiality:

*B: Our school tells us that things are confidential but when we tell them they end up telling their head of year that then tell our parents.*

*A: Someone came in to try and talk to us and they tried to get social services involved*

*B: That's why some of us don't like speaking up because it's gonna cause even more trouble at home for us (Enfield focus group)*

That is, some young women discussed their 'reluctance' to disclose as self-protective, in that they saw this as an action that would lead to their parents being involved, and thus 'trouble at home' or the involvement of social services. Others discussed young women's reluctance to disclose to their parents, and their concerns about peer judgement should their 'personal issues' become 'public knowledge':

*R: If they have been in an abusive relationship sometimes they don't want anything to happen – if they tell their parents, they don't want their parents to start getting angry and causing a whole big scene- they just want to stop but they don't want a whole big theatrics about it. They just want it to be over instantly*

*S: They might be scared because they think people will judge them and they won't look at them in the same way (RBKC focus group 1)*

The young women asserted that many young women were not fully aware of the issues surrounding confidentiality, and may not realise that certain issues can not remain confidential:

*L: They say confidentiality and even at certain counselling services they still say confidentiality but I don't think that unless you know, a lot of young women don't exactly know what confidentiality is because there are a few things they'll say that they can't*

*keep confidential and then it all blows up again. But they were told its confidential, but there's certain things that become a CP (child protection) matter and it has to be passed on. (Enfield focus group)*

The young women described how services explained the issues around confidentiality:

*E: They say some bits if it's concerning them then they'll inform your parents or tell somebody else.*

*A: But if you wanted your parents to know then you would tell them yourself... that's the whole reason why the services are there. (Enfield focus group)*

Some young women asserted that they were cautious when interacting with services, in terms of actively managing the level of detail they were willing to disclose. They regarded such 'controlled' conversations as detrimental, and as inhibiting them from disclosing "the worst bit":

*A: And even when you do talk to someone, you're sitting there thinking right I better not say that in case they tell someone, so you're talking, but you're still not getting it all out so there's not point in talking*

*E: It can almost make it worse... you may be telling them but then you'll be missing some bits out.*

*B: Cos you just ain't got the courage to say that one bad bit and that's the bit that's bugging you... its the worse bit. (Enfield focus group)*

Some young women noted that their concerns about confidentiality would inhibit them from accessing services and from talking to 'some sort of professional'. Instead, they asserted that they would prefer to talk to their family, a friend, or a friend of the family in an established position of trust:

*Sa: I'd speak to my family, or like someone I know that I could trust – a friend or member of family rather than a professional because I would worry that it's not confidential or that they might say something or judge me or call some other services like Social Workers. I would much rather prefer to talk to a friend or family member. (RBKC focus group 2)*

However, other young women noted that although they might prefer to talk to friends rather than services, friends may not be an ideal source of help as they can regard such issues as "none of their business" and may not wish to get involved:

*A: People don't like getting involved in stuff like that and it's none of their business as well. You could tell your friends to help you but they actually won't want to get involved because it's such a delicate situation. (RBKC focus group 2)*

Young women's concerns about accessing services  
Some young women were openly distrustful of 'people in authority'. Involving services was described as "bringing big trouble.":

*I am a bit paranoid about services because they always bring big trouble. When you talk to Social Workers or people in authority they always bring up your whole life story... maybe they are good sometimes but I've heard a lot of stories about authority and them kind of services so I don't know if I can trust them. (RBKC focus group 2)*

Other young women expressed concern that they would not want to be 'seen walking into services'. To do so was regarded as a 'public admission' of a stigmatised 'personal' problem with violence or substance use, and was linked to feeling 'shy', 'embarrassed' and 'ashamed':

*A: ... people don't want to be seen walking in...*

*C: Especially when everyone knows what it is that you are going in for.*

*Tr: Most of the centres round here – they wonder why people don't go into them – they need to realise that some of them are barriers if you are shy – with the possibility of walking in and seeing someone that they know – when going in about a serious problem. (RBKC focus group 2)*

Some young women were also uncertain about the kinds of assistance and support that they might be able to access. They felt that given more information about the practical sources of help and advice that might be available, young women might be more willing to access services, when they felt that they were not simply going in order to 'tell them your problems':

Sa: *What are they going to do about the problem anyway once you talk to this person?*  
*I don't know how these services work, if you tell them your problems what exactly are they going to do for you? Are they going to help you? What can they do? Maybe young people aren't aware of what they can actually do for them, maybe if they knew what opportunity or what they could achieve by going to see them, more people would go. But if you are just going to tell them your problems and are feeling all embarrassed and ashamed, what's the point of people going? ( RBKC focus group 2)*

Here, the act of 'telling them your problems' – in the absence of young women's confidence in, and knowledge of, the forms of practical assistance that may be available – is described as a potential source of 'embarrassment' and 'shame', and as a deterrent to young women accessing services. These concerns, coupled with young women's anxieties about the limits of confidentiality, and the repercussions of disclosure, represent significant barriers.

#### 4.5 Service responses (Objective 4)

One member of staff was interviewed from each agency taking part in the project (3x PSU practitioners, 3x DV practitioners, a youth offending practitioner and a children and families practitioner) and the SPLC was also interviewed. There were nine telephone interviews conducted in total. The nine interviews with practitioners were thematically analysed in order to assess current service responses to the overlapping issues young women experience and how they could be supported to improve responses.

Knowledge of the interlinking issues All practitioners interviewed were able to provide working definitions of problematic substance use, domestic violence and sexual violence. Practitioners working with women over the age of 18 discussed issues related to young women in the context of issues relevant to adult women. The major themes raised by practitioners in their discussion of these interlinking issues were:

- Young women may use alcohol to cope with being in, or having exited, an 'abusive' relationship;
- Young women may become 'trapped' in a relationship with perpetrator due to shared substance dependency;
- Problematic substance use by young men may lead to 'aggressive behaviour' which may put young women 'at risk' of violence;
- Young women may be 'at risk' of sexual coercion and sexual violence due to their own substance use;
- Young women experiencing domestic violence may be 'at risk' of experiencing sexual violence.

Although most of the practitioners interviewed asserted that they could identify the links between domestic violence, sexual violence and problematic substance use, some practitioners were less certain about their knowledge of these interlinking issues:

*I imagine statistically research says there is, I'm not up on that. I work with sexual health, not all my young people that I work with are using substances so I can't really answer that one, I've not done the research on it myself. (Enfield, practitioner no. 3)*

Other practitioners asserted these interlinking issues were not common for their clients:

*There can be but I don't want to make it seem as if that is a common thing within the clients that I see because it's not – there can be links, yes, but I wouldn't want to say that there is permanent links as I feel like I'm generalising and I wouldn't like to generalise any client that I've ever supported [...] I'm so fortunate as I don't really have that many disclosures from the clients that I support with regards to substance misuse. (RBKC, practitioner no. 5)*

Some practitioners discussed these links primarily with relation to the perceived impact of problematic substance use on young men's 'aggressive' behaviour, and the consequent 'severe risk' to young women:

*Often when people drink too much or use some of the harsher drugs it can change their temperament and bring out some of their worse characteristics, paranoid, misunderstandings and aggressive behaviour. Some young people do have quite bad reactions to substances in terms of it affecting their behaviour and it can lead to*

*difficult situations and young women being put severely at risk from their partners. (Enfield, practitioner no. 1)*

Another practitioner asserted that the 'type' of abuse experienced by young women may be influenced by the particular substance being used by the perpetrator:

*The nature of the abuse changes when the perpetrator is using drugs or alcohol or when the perpetrator can't get drugs or alcohol. One woman described to me how when he's drunk he physically hurts her and when he is doing crack instead it's sexual abuse. (Enfield, practitioner no. 2)*

Young women's 'resistance' to disclosing intersecting issues

Practitioners described a range of reasons why young women may be reticent to disclose intersecting issues and to involve other agencies. These included a desire to 'keep it private'; new services being 'intimidating'; anxiety about the consequences of disclosure (from the perpetrator; from the community; from social services); anxiety about the impact on custody of or access to children; lack of trust in practitioners; lack of self-identification of intersecting issues (through minimisation, normalisation and denial; lack of 'understanding'/'recognition' of problem). Young women may not wish to 'involve other agencies', as:

*Many young people [are resistant] to involve other agencies, they want to keep it private. They are ashamed "no, I'll be alright, I've got you to talk to". Sometimes the housing provider might be important or getting them involved in positive distractions might be their priority [...] I wouldn't be able to take it any further unless they are in agreement, so if there are resistant to involving other people I can't involve other people without their consent. (Enfield, practitioner no. 1)*

Some practitioners reported that many young women were intimidated at the prospect of being referred to other services, and were also often anxious about the repercussions of disclosure of sexual violence.

*The services that are provided are really, really good but they seem quite intimidating for the girls, they don't really want to go and speak to someone about it because for example, [...] we did encourage her to go to the Haven and speak to the police – she didn't want it to be taken any further and*

*because of the nature of the allegation it was taken further without her consent and then she got threats from the perpetrator and all his friends because she made this allegation, so I think that's another thing would stop someone... like her in the future getting more help. (RBKC practitioner no. 4)*

Other practitioners recognised that the level of client disclosure may be influenced by whether or not their clients had children and were likely to be concerned with safeguarding issues:

*I'm so fortunate as I don't really have that many disclosures from the client that I support with regards to substance misuse and that is probably to do with the fact that a lot of clients that I support have children and they may have concerns with regards to disclosure and safeguarding issues, which was one of the key factors when I first did the training with the Stella Project was that I did not have many clients that were disclosing PSU to me. (RBKC practitioner no. 5)*

Some practitioners asserted that young women's disclosures of domestic violence required that there be a significant amount of trust established in the client-practitioner relationship, and noted that it may take a prohibitive length of time to reach this point:

*I think it is a very sensitive issue... it is through the building of trust that the client is able to disclose that sort of information. Some clients may feel over a period of time that they might be able to discuss these personal sensitive issues. (Enfield, practitioner no. 7)*

Other practitioners frankly admitted that they would not ask about intersecting issues and would leave it 'up to the client' to disclose these:

*it is not a question that I would fundamentally ask [re problematic substance use] so unless someone actually discloses it as a problem or it comes in as part of the ... referral, then it's not something I would be made aware of unless someone actually brings it up during the session. (RBKC, practitioner no. 5)*

Others were critical of placing the burden of disclosure on young women. They regarded this as a product of the guidance provided by their core assessment instrument:



At present, on the Core assessment there is nothing that prompts you to talk about DV/SV, so it is up to the young person to bring it up or if there are any signs for the Social Worker to pick it up. So if I'm doing a core assessment or any other assessment there isn't anything to just go, "is that an issue?" or "has it been an issue or know of anyone with an issue with that?" – I haven't seen that anywhere. (RBKC, practitioner no. 6)

For other practitioners, there was also some uncertainty as to what, in practice, constituted a disclosure of 'problematic substance use', and the status of clients' own assessments of their substance use:

*I have not had a definite disclosure of problematic use – yes I have had people say I was drunk on occasion or have taken drug on occasion but it never from their perspective seen as problematic. I would not view it differently from them because my role is to initially be non-judgemental and if someone is telling me it is non-problematic and their support network is fine, they are employed, the other aspects of their life is ok, it is not linked to the DV or the perpetrator, then so be it. (RBKC, practitioner no. 5)*

Other practitioners were critical in identifying the ways in which young women normalised and minimised both their problematic substance use and their experiences of domestic violence:

*She has very much normalised the behaviour and normalised the substance use – their expectation that this is just normal life. [She has] seen a lot of violence in her upbringing, so she doesn't think it's concerning when it happens to her. (RBKC practitioner no. 4)*

Some practitioners noted that young women often also 'made excuses' for the young men involved. This echoes the tendency, noted in our analysis of the focus groups and interviews with young women and themselves, that while young women sometimes blame young men for coercive or violent conduct, they also often 'excuse' or minimize such violence. The following practitioner noted that:

*[Young women] are often apologetic for the male involved "ah yeah he had a really bad day he didn't mean it, he's not usually like that" and if I react in a way that says 'you shouldn't be having to put up with that' "oh, he's never usually like that", they try to justify it and dumb it down to make it more acceptable – but really I think they know that it's not, but are hoping to improve that relationship or the dynamics – they feel that's their role to do that. (Enfield, practitioner no. 1)*

#### Experience of partnership working

Most practitioners described their experience of partnership working as positive and productive, however some practitioners qualified this and identified areas where partnership working was challenging, for instance, in working with police, housing and social services:

*...when a woman has these issues, partnership working with the police, housing or Social Services, I think they*

*can often have a real preconception – "she's not going to change, she's not going to be able to do anything for herself, what a waste... nothing can really be improved, she's just going to go back... she's going to drop the charges, so did it really happen in the first place". Those are some of the things I hear with women who have problematic substance misuse and often with young women as well. There is a lack of empathy, lack of understanding of the additional issues that they are trying to deal with. (Enfield, practitioner no. 2)*

Others described their experience of partnership working as constraining, possibly limiting their ability to conduct work they see as more core:

*We don't all have the time to link up together and work together. We can share information and ideas with each other, but actually doing a solid piece of work is limiting. (Enfield, practitioner no. 3)*

Others discussed the difficulties of working together to assist young women as they grow older, and become ineligible for services and sources of support they may have relied on when younger:

*It could be difficult when they are 16/17 as they are no longer on the Child Protection conference. Even if they are in the LAC (Looked After Care) Team, they are no longer going to have a Social Worker and once they*

*hit 18 they are an adult, so there is a little gap or shortfall for some young women where we try and bridge that gap by talking to Social Services and police. (RBKC practitioner no. 8)*

Some practitioners indicated a lack of knowledge of other potentially relevant services, and a need for up-to-date, accessible information, especially given the impact of changes in funding provision on the availability of services:

*It's just about us having the information, maybe some up-to-date accessible information<sup>2</sup> that we can then pass on. A lot of the time we don't necessarily know exactly what the services do. (RBKC, practitioner no. 4)*

#### 4.6 Testing the efficacy of the Stella intervention – Pre-intervention Findings

a) *Strand 1 – Staff Questionnaire*  
Twenty practitioners completed the pre-intervention

**Table 4.** Types of training practitioners from both boroughs had taken part in

	Watched a video	Web-based programme	Lecture or talk	Skills-based training	Other in-depth training	University course	Other
SV	4	0	11	7	7	1	3
DV	9	0	12	14	9	2	1
PSU	11	3	14	12	13	3	3
YW	2	0	7	7	3	1	2

Approximately three quarters of participants felt that there were gaps in their training on SV, DV and YW, whereas only half thought this for PSU. Participants lack of training in certain areas was reflected in the confidence they reported feeling when talking about each of the following issues with a service user who is young woman. Participants felt most confident responding to young women affected by PSU issues, followed by DV and least confident with clients experiencing SV. The pre-intervention data suggest practitioners lack skills and training in relation to SV in particular, and in both domestic and SV as they relate to young people. They also show that there are specific areas within this that require particular attention and development. For example participants reported knowing the least about risk indicators for

SV (compared to DV and PSU) and just over half reported having only an 'average' level of knowledge about how to respond appropriately to young people who had experienced SV.

Participants answered questions on their knowledge of each of the issues. All participants were aware that young people who experienced violence were at higher risk of abusing drugs and alcohol than those who have not. However surprisingly three quarters of participants (n=15) incorrectly believed that alcohol and/or drugs can make people violent. Just under half of the participants (n=8) incorrectly believed that 'As a practitioner, I am legally obliged to report a young person's use of illegal substances', this suggests that a significant proportion of staff may not

<sup>2</sup> Despite this interviewees belief that such information is not available, RBKC actually do have an online service directory.

be equipped with accurate knowledge about their obligations in order to be able respond appropriately to disclosures from young women.

Participants were also asked about their knowledge of services and networks that specialise in each of the three issues. Out of a possible 11 types of services and networks they could be aware of for DV and SV on average participants knew about 4.1 for DV and 3.15 for SV. There were only 6 types of services and networks for PSU and on average they knew about 2.7. When asked what referrals they would make if faced with a young person who had experienced SV, just over half of participants identified either the police and/or specialist SV services such as the Sexual Assault Referral Centres (SARCs) and Rape Crisis. However, all other participants identified inappropriate, or less appropriate, referral pathways, such as young people's substance misuse services, specialist DV services, social services, and even second tier services such as AVAs Stella Project.

*b) Strand 2 – Policies and Procedures*  
As stated in the method the policies and procedures analysis was guided by 6 questions. Pre-intervention data collection was challenging, there was very little available to allow us to answer the questions. In fact we were not able to find any documents for any agencies that outlined the procedures for receiving a referral for a young woman with the issues other than those that the organisation specialise in. For example policies about how a SM service would deal with a young woman who had experienced sexual violence.

The second question focused on the procedures for supporting/working with a young woman with the overlapping issues. For this only one service from the RBKC had any procedures, these stated:

*Services for families and young people support the victims of domestic abuse and abuse related to drugs and alcohol. A holistic approach encompassing housing, health and nutrition, money, education, training and employment. They provide intensive practical interventions to include information and advice on parenting skills, sexual health and drugs awareness*

Moving from procedures to policies we found three policies for supporting/working with a young woman with the overlapping issues of problematic substance use, sexual and/or domestic violence all from the RBKC. These were:

*Continued working with the Domestic Violence partnership, to ensure that access to appropriate services is available to those affected and the perpetrators.*

*Ensure domestic violence provisions are considered and included, where possible in the Drug and Alcohol Action Team Treatment Plan, Child and Adolescent Mental Health Strategy*

*(Name of Organisation) must take steps to develop positive working relationships with substance misuse and mental health services programmes. They must maintain appropriate links with specialist agencies, use multi-agency networks to promote access to services, and offer victims and witnesses information about the range of services available to them, and allow them to express choices*

At the local borough level the only indication of any strategic partnerships for responding to women with overlapping issues came from two statements, again from the RBKC, shown below. However it should be noted that these responses to the overlapping issues are targeted around responses to adult women and do not necessarily reflect specific responses to young women.

*The Kensington and Chelsea DAAT is represented on a number of other partnerships including the domestic violence partnership*

*Services to victims of domestic violence and abuse are provided in partnership with other relevant agencies.*

There was however no indication from the policies and procedures we had from the RBKC of any policies emerging from the strategic partnerships for responding to young women with the overlapping issues of problematic substance use, sexual and/or domestic violence. Due to the limited information we have been able to gather it is perhaps unsurprising that we could not find any indication that where local boroughs policies did exist whether they were being



adopted by individual agencies. However, as our literature review identified, this is not an area of work that has received much attention. Both boroughs have engaged in this project because they recognised a deficit in this area and a desire to make changes, and we would expect to see greater evidence of strategic-level policies and implementation of procedures at the agency level by the end of the project in 2013.

#### c) Strand 3 – Data Monitoring

See the prevalence scoping section for the pre-intervention data that will be compared with the post-intervention data in the final report.

### 5. Indicative Issues for Further Discussion in the Final Report

#### *Beliefs about the 'causative' effects of drugs and alcohol*

Both the young women and the majority (75%) of the practitioners expressed the belief that alcohol and drugs could 'cause' violent behaviour. The young women offered two contrasting interpretations of the effects of alcohol. Both of these accounts reinforce existing cultural beliefs about gender, and in particular (young) women's culpability in their own 'victimhood' and young men's mitigated responsibility for the perpetration of violence. That is, alcohol was described as 'causing' young men's violence, and as 'causing' young women to 'lose control' and thus encourage the sexual violence of young men.

Some practitioners discussed this in terms of young people's 'bad reactions to substances' leading to 'difficult situations' where 'young women are being put severely at risk from their partners'. Alcohol and drug use was regarded as 'bringing out some of their worse characteristics', which include 'paranoia's, misunderstandings and aggressive behaviour'. Others went further to suggest that the 'type' of abuse experienced by young women may be influenced by the particular substance being used by the perpetrator. Alcohol was described as 'causing' physical violence, and 'crack' as 'causing' sexual violence.

The role of these beliefs about the causative effects of drug and alcohol use will be investigated in more detail in the final report.

#### *Confidentiality and disclosure*

There was some disagreement amongst practitioners as to the length of time necessary to establish the level of trust that would encourage young women to disclose intersecting issues. Some asserted that this would take a significant period of time, whilst others admitted that they would not feel comfortable ever asking about such issues, and would leave it 'up to the client' to self-identify and disclose these. Others were critical of placing the burden of disclosure on young women, and thought that core assessments should be adapted in order to prompt practitioners to ask about these intersecting issues. While most of the practitioners acknowledged that young women seemed 'reluctant' to disclose intersecting issues, the 'reasons' given for this reluctance diverge, in some cases, from the reasons given by young women themselves. Many practitioners asserted that young women's reluctance was due to their feelings of 'shame' and of being 'intimidated' by the 'formality' of services, however 'shame' did not feature as a major theme in young women's accounts. When shame was mentioned by young women, this was in the context of their discussion of what it would feel like to talk to service providers about their problems if they were unsure whether the service provider would be able to offer them any practical assistance, and of the stigma of presenting at particular services in terms of their peers 'seeing them' and becoming aware of their 'personal problems'. That is, shame was associated with the act of presenting at services, and of the disclosure of problems, but not with the act of help seeking itself. Rather the issues that young women discussed in relation to their 'reluctance' to access services centred around their concerns about the negative consequences of disclosure, the limits of confidentiality, and the repercussions of this in terms of the involvement of their parents, or of other agencies without their consent. Young women admitted that even when talking to service providers, they limited their self disclosure of problems that they felt would not be held in confidence.

The similarities and differences between young women's and practitioners' understandings of the 'causes' of young women's reluctance to engage with services, and to disclose intersecting issues, will be investigated in more detail in the final report. These issues will also be interrogated with an in depth analysis of any differences between young women from different age brackets; between services engaging with different age ranges; and with reference to the influence of a 'needs focused' or 'risk focused' framework.

## 6. Recommendations for areas of strategic and operational focus

### SERVICE MANAGERS

Investigating Low Prevalence Figures

- The very low numbers of young women identified through the prevalence screening suggests a number of possible explanations which need to be explored with the agencies involved, including:
  - Young women are experiencing these issues but do not know where to seek help.
  - Young women are experiencing these issues and are seeking help but the agencies are not seeing them or if they are seeing them are not identifying their issues with them, this could be for a number of reasons:
    - Agencies are not asking young women about the intersecting issues.
    - Young women are not disclosing intersecting issues when asked.
    - Young women experiencing the intersecting issues are seeking help through more generic services or institutions, such as schools and colleges, but are not being referred on to/accessing specialist services.
    - Young women experiencing intersecting issues are not engaging sufficiently with specialist services in order to complete an assessment and be asked the screening questions
    - It may be that the agencies did not have the time or willingness to engage with the research and evaluation so young women with the overlapping issues are being seen by the agencies but that information was not passed on to us.
    - Young women did not give consent to being involved in the research

### *Engaging and Informing Young Women and Addressing their Concerns about Confidentiality*

- Engaging young women is challenging, as is encouraging them to disclose these intersecting issues. Young women may normalise and minimise these issues, and may even 'excuse' young men from responsibility, while also sometimes engaging in a degree of self-blame.
- Young women may also be anxious about disclosure, and about having to visit a new agency and talk to new people. Young women may benefit from further information on these intersecting issues, and the options available to them, and the practical sources of assistance that may be available to them.
- Young women's concerns about the limits of confidentiality and the repercussions of disclosure need to be addressed from the outset. This is a priority area for the Stella intervention to work on.

### *Further Training and Support for Practitioners*

- Practitioners may normalise and minimise the SV, DV and PSU. They may even be excusing young men's behaviours by blaming them on their consumption of substances and to some degree holding women responsible for their victimisation experiences. Furthermore practitioners may not always be confident to ask about intersecting issues, and may not consider these relevant to their clients.
- Practitioners may benefit from further training and support focused on how to identify and acting on these intersecting issues, and the referral options appropriate to young women available to them.
- Practitioners may benefit from a clearer understanding of young women's own perspectives regarding their apparent 'reluctance' to disclose. Both young women and practitioners note this 'tendency', but the sense practitioners make of this may influence whether they are willing, for example, to engage in early questions about these issues; whether they feel it best to rely on young women to self-identify; or whether to invest further time in 'building a connection' prior to asking such questions.
- Practitioners may benefit from a regularly updated directory of relevant agencies. However an updated directory alone is not enough, in order to be able to use it effectively and respond to women appropriately practitioners require a more integrated understanding of, and responses to the issues and the ways the issues intersect in each service. As well as referring young women to other services each service should be able to do some work with each woman on the intersecting issues.

#### *Developing Services in Response to Young Women's Needs*

- Services should spend more time identifying the differences between the younger and older women, and develop their work in order to ensure they respond to their needs more appropriately. For example do services for women aged 16+ sufficiently address the differences in needs for younger women (e.g. 16-18) compared with adult women (over 18)?
- If young women are still in education, what partnerships exist and can be developed between specialist services and generic services/institutions?

#### **POLICY MAKERS**

##### *Developing Policies and Procedures for Working with Young Women*

- Policies and procedures addressing young women with overlapping issues appear to be virtually non-existent in both boroughs and both an agency and borough level. Alternatively it may be that they do exist and we were not provided with them. This should be a key area for the Stella intervention to address – ensuring that policies and procedures for working with the young women and between the agencies are drawn up and implemented for each borough.
- If young women are still in education, what partnerships exist and can be developed between specialist services and generic services/institutions?

#### **COMMISSIONERS**

- More recognition is needed that being young is an intersecting issue, and that services need to develop specific responses for young women that are different to the service they provide to adult women experiencing the three overlapping issues. This should be reflected in policies and procedures.
- Little is still known about the differences between the younger and older women, nor about how services are responding to their needs. For example are services for women aged 16+ sufficiently addressing the differences in needs for younger women (e.g. 16-18) compared with adult women (over 18)? Many young women aged under 16 expressed concerns about the limits to confidentiality, which warrant further exploration. If young women are still in education, what partnerships exist and can be developed between specialist services and generic services/institutions?
- Many of the young women and practitioners held inaccurate and sometimes even untrue attitudes and beliefs about the intersections of drugs (particularly alcohol) and violence. Challenging these should be a priority area for the Stella intervention to address.



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## Appendices

**Appendix 1:** Search Engines used for the Literature review

**Appendix 2:** Questions added into standard risk assessment process

**Appendix 3:** Telephone interviews with Practitioners

**Appendix 4:** Questions for policy and procedures analysis

**Appendix 5:** Competency Assessment (14-15 year olds)

## Appendix 1:

**Search Engines used for the Literature review**

Academic literature was found from the following search engines:

1. PSYCHINFO
2. PsycARTICLES
3. Medline
4. Lexisnexis
5. ScienceDirect
6. ISI Web of knowledge/Web of Science
7. Social Science Abstracts
8. J-Star
9. Ingenta Connect
10. Home Office/RDS/Scottish, Welsh and NI equivalents
11. Cambridge Scientific Abstracts (Illumina)
12. RAND/JRF/Barnados. websites.etc.
13. ESRC/EDS archives
14. Academic Search Premier

## Appendix 2:

**Questions added into standard risk assessment process**

*Permission to use responses to screening questions in research*

(Staff member please read this section to the young woman and ask her whether she is happy for her responses to be used.)

The \_\_\_\_ (name of research site) \_\_\_\_\_ is taking part in research looking at the links between problem substance use sexual violence/abuse and domestic violence.

This month, we are asking every young woman (aged under 25) some extra questions to the ones we usually ask. Your responses to the questions will be anonymised (no name/address) and passed to the research team. No information that might identify you will be given to anyone else.

However if you tell us that you are being hurt by someone else, or that someone else is being hurt, we might have to pass this information on to social workers so that they can find ways to help you be safe and protected. We will always tell you before we pass any information on to anyone else.

Do you/your parent or carer (delete as appropriate) consent to your responses to these questions, and basic data about you (age, ethnicity) being used in research?

Yes I am happy for my responses to be used

No I do not wish my responses to be used

## Demographic Information

**1) Age:** \_\_\_\_\_

**2)** Which group best describes the young woman's ethnic origin or descent by ticking ONE of the boxes below:

White

British  Irish  White Other

Mixed

White and Black Caribbean  White and Black African  White and Asian  Mixed Other

Asian or Asian British

Indian  Pakistani  Bangladeshi  Asian or Asian British Other

Black or Black British

Caribbean  African  Black or Black British Other

Chinese or other ethnic group

Chinese  Other Ethnic Group

**3)** How does the young woman define her sexuality?

Lesbian/gay  Bisexual  Heterosexual  Not sure

## Prevalence scoping questions

**1)** Does the young woman use substances problematically?

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

Never experienced

Previously experienced

Currently experienced

Previously & currently experienced

2) Using the table below please ascertain what substances the young woman has tried, the age she first tried them, the number of days used in the past 30 days and the average amount per day?

	Ever Tried?	Age at first use	Number of days used in past 30 days	Average amount per day	units
Alcohol*, type					
Amphetamines					g
Anabolic Steroids				g/£ spent	
Cannabis				g/ # joints	
Cigarettes				Cigs/roll-ups	
Cocaine powder				g/£ spent	
Crack				g/£ spent	
Club Drugs (eg: Ecstasy/MDMA, GHB, Ketamine), type				g/hits	
Hallucinogens (eg: LSD, psilocybin/magic mushrooms) type				g/hits	
Opiates, (e.g. heroin, methadone, codeine) type				g/£ spent	
Other Drugs, (eg: solvents, mephedrone) type					
Prescription Medications (e.g. SSRIs, benzodiazepines) type**				g/tablets	

\*Unit Guide: 1 small glass wine~1 unit, 1 large glass wine ~ 2 units, 1 pint lager 4.5% eg: Stella ~2.5 units

\*\* Please note whether obtained with or without a prescription

3) What are the young woman's experiences of domestic violence/abuse?

Please refer to the accompanying Procedure and Guidance for Asking Additional Questions, which gives guidance on how to ask about experiences of violence. The UK government defines domestic violence as: "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality." This includes so-called 'honour' based violence, FGM and forced marriage. For the purpose of this research, please also include violence that happens in young people's intimate relationships (i.e. not necessarily between adults), abuse from a parent, and experiences of witnessing domestic violence between adults as a child.

Never experienced     Previously experienced     Currently experienced     Previously & currently experienced

4) Who was/are the perpetrators of the domestic violence described in the last question?

Previously: \_\_\_\_\_

Currently: \_\_\_\_\_

5) What are the young woman's experiences of sexual violence/abuse?

Please refer to the accompanying Procedure and Guidance for Asking Additional Questions, which gives guidance on how to ask about experiences of violence. For the purposes of this research, we define sexual violence as "any sexual act that is perpetrated against someone's will. Sexual violence encompasses a range of offenses, including a completed nonconsensual sex act (i.e. rape), an attempted nonconsensual sex act, abusive sexual contact (i.e., unwanted touching), and non-contact sexual abuse (e.g. threatened sexual violence, exhibitionism, verbal sexual harassment)" (Centers for Disease Control & Prevention).

Never experienced     Previously experienced     Currently experienced     Previously & currently experienced

6) Who was/are the perpetrators of the sexual violence described in the last question?

Previously: \_\_\_\_\_

Currently: \_\_\_\_\_

7) Does the young woman think that she ever takes drugs or drinks alcohol to help her cope with her experiences of violence?

Yes     No     Don't know

If yes, why / what?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Procedure and Guidance for Asking Additional Questions

This should be given to each worker in each agency but also the SPC will take them through it

Forensic Psychological Services at Middlesex University has been commissioned by Against Violence and Abuse who are funded for this project by the John Paul Getty Jnr Foundation to explore the links between young women's experiences of problematic substance use, sexual and domestic violence. As well as the research we will be providing a basic evaluation of the training and consultancy provided by the Stella Project to the agencies involved. The research and evaluation will contribute to the evidence base in London on young women experiencing problematic substance use, sexual and/or domestic violence and wider policy initiatives aimed at improving outcomes for young people.

As part of this project we hope to assess how many young women who use agencies like yours have experienced problematic substance use, sexual and/or domestic violence. To do this we have recruited eight specialised agencies in two London boroughs to pilot a screening tool that identifies the number of young women who disclose problematic substance use, sexual and/or domestic violence. This will take place over one month in 2011 in order to give us a snapshot before Stella provide your agency with training and consultancy and over one month in 2013 to provide a snapshot after the intervention.

The screening tool questions should be incorporated into existing assessments taking place at each agency. Every young woman under the age of 25 within the specified month will be asked 8 additional screening questions, and will also be asked if they consent for their responses to be used anonymously for research purposes.

All responses will be anonymously passed onto the research team, but no personal identifiable information will be passed on. Basic anonymised data such as age and ethnicity will be captured on the screening questionnaire.

The staff conducting routine assessments at each site will ask each young woman if she consents for her responses and basic demographic data to be used for research. They will then ask her the required questions and note down her answers. When these forms are completed they should be stored in a secure place until Shannon Harvey from the Stella project comes to collect them at the end of the month.

### Advice about how to ask the questions

We appreciate that you will be collecting some of the information we're asking for already in different ways, for basic demographic information it is fine to just copy the answers you have for those questions across onto our sheet. However for the other questions it's really important for the research to be considered reliable and of a high quality that each young woman is asked the rest of the questions in the same way.

If you are feeling at all unsure about how to ask any of the questions you can contact Shannon Harvey at the Stella Project or Dr Miranda Horvath from the evaluation team at any time (our contact details are below). It's really important that each young woman has the opportunity to answer each question, if you find that the way a question is worded means a young woman can't understand it try wording it slightly differently or give some examples that might make it clearer. Please don't assume that just because a woman has not previously mentioned any of the issues the questions touched on that she won't have experienced them. Please just make sure you ask each young woman each question. It is unlikely that young women will disclose domestic or sexual violence if they are asked about it explicitly, because they may not be identifying their own experiences in that way. Always ask these questions in a confidential environment. In addition to the training you will receive from the Stella Project, we have provided some guidance for asking about domestic and sexual violence below. It is up to you to decide which questions are most appropriate to use with each service user, depending on their age, maturity and circumstances, but if you would like further guidance, please call or email Shannon Harvey.

Shannon Harvey  
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AVA (Against Violence & Abuse) University  
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Forensic Psychological Services, Middlesex  
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## How to ask about domestic violence

It is best not to ask directly about domestic violence, but to ask questions that can help young people identify their experiences. You might like to try using different Power & Control Wheels, to help the young person identify patterns of abusive behaviour that they're experiencing as domestic violence:

- Teen Power & Control Wheel: [www.endingviolence.org/files/uploads/Teen\\_P\\_C\\_wheel.pdf](http://www.endingviolence.org/files/uploads/Teen_P_C_wheel.pdf)
- Power & Control Wheel for Substance Use: [www.ncdsv.org/images/WomensSubAbusewheel-NOSHADING.pdf](http://www.ncdsv.org/images/WomensSubAbusewheel-NOSHADING.pdf)
- Abuse of children wheel: [http://www.csswashtenaw.org/aca/resources/Duluth\\_child\\_abuse\\_wheel.pdf](http://www.csswashtenaw.org/aca/resources/Duluth_child_abuse_wheel.pdf)

Sample questions:	
Children (14-16)	Young adults (16-24)
Does anyone ever make you feel afraid?	
Does anyone ever threaten to hurt you?	
Do you ever feel afraid of anyone in your family, or someone close to you?	
Does anyone ever pressure you to use drugs or alcohol when you don't want to?	
Have you ever been threatened or hurt by your partner/boyfriend/girlfriend, or by your ex?	
Lots of parents disagree or argue and often this is OK but sometimes it can be scary or someone can get hurt. Does that ever happen in your family or in your home?	Do you ever feel afraid to make a particular decision or to do certain things because of what your partner/boyfriend/girlfriend might do or say to you?
Is there anyone in your family who is being hurt or frightened by someone else in the family or someone else they know well?	How do you and your partner/boyfriend/girlfriend work out arguments?
Do you ever see one of your parents looking scared of the other [or of their partner/your step parent etc]?	Do arguments ever result in you feeling put down or bad about yourself? Does anyone ever make it difficult for you to attend this service?

It is important that you are familiar with your agency's safeguarding procedure, and that you explain this to your service user before they disclose abuse. If a child answers yes to any of these questions, you will most likely need to make a social services referral. If an adult answers yes to any of these questions, you should ask whether they would like to be referred to your local domestic violence agency, and depending on what is disclosed, you may choose to complete a risk assessment with them to determine whether their case is appropriate to be referred to the multi-agency risk assessment conference (marac).

### How to ask about sexual violence

It is often extremely difficult for anyone to talk about their experiences of sexual violence. Young people may feel ashamed, they may blame themselves, or they may not realise that what they experienced was sexual violence. As with domestic violence, it is best to ask questions that can help the young person identify their experiences.

Sample questions:	
Children (14-16)	Young adults (16-24)
Have you ever felt pressured to do something sexual that you didn't want to do? (e.g. watch pornography, perform oral sex, being made to stimulate yourself using hands or fingers i.e. masturbate)	
Has anyone ever done something sexual with you that you didn't want them to do?	
Has anyone ever pressured you to have sex?	
Has anyone ever touched you in ways that don't feel okay, or make you feel uncomfortable?	Do you ever feel pressured into having sex (by your partner/boyfriend/girlfriend/anyone else)?
	Do you feel like you have to have sex with your partner/boyfriend/girlfriend even when you don't want to?
	Has anyone ever forced you to have sex when you didn't want to?

It is important that you are familiar with your agency's safeguarding procedure. If a child answers yes to any of these questions, you will almost certainly need to make a social services referral. If any young person – whether a child or adult – answers yes to any of these questions, you should ask whether they would like to be referred to your local rape crisis service, sexual assault referral centre (the haven), and/or make a report to the police. If they disclose something that has happened recently, you should also encourage and support them to seek immediate medical care (available either from the haven, or local health services).

The Havens produce a booklet for 13 to 16 year olds called 'Coping with Sexual Assault: a guide for young people', which is available here: [http://www.thehavens.org.uk/docs/young\\_people.pdf](http://www.thehavens.org.uk/docs/young_people.pdf).

### Appendix 3: Telephone interviews with Practitioners

Thank you for agreeing to be interviewed, I realise that you very busy. The purpose of this interview is to explore your knowledge of substance use, and sexual and domestic violence and how you understand the links between these areas. We are also interested in your views on how these issues relate to the young women you work with. Finally we would like to discuss any barriers you see or experience in practice when addressing the overlapping issues with service users and partnership working.

Before we start the interview, I need to remind you that you will be audio recorded and thank you for returning the consent form (participants should have been sent the information sheet which includes informing them that they will be audio recorded in advance and asked to return the consent form prior to the interview). If you have any questions, please ask them now.

I'm going to start the recorder now. (Start audio recorder). Interviewer will have completed this before the interview and should check it is correct

Can you please confirm the following information:

1) Organisation: \_\_\_\_\_

2) Role in the organisation: \_\_\_\_\_

3) How long have you worked at the organisation? \_\_\_\_\_

4) Which of the following does your organisation specialise in? (tick one)

- Violence against women (incl. sexual and domestic violence)
- Substance use
- Other e.g. youth offending

5) Which borough is your organisation based in?

- Kensington and Chelsea
- Enfield

6) How do you define domestic violence?

7) How do you define sexual violence?

8) How do you define problematic substance use?

9) Are there any links between sexual, domestic violence and problematic substance use?

10) Do the issues we've been discussing relate to the young women you work with?

11) What barriers do you experience or anticipate in relation to developing practice to address the issues we've been discussing with young women?

12) How do you experience partnership working on these overlapping issues in young women?

Thank you very much for taking the time to be interviewed today, by sharing this information and working together this will help improve partnership working and your work with clients. You have contributed to one of the first studies in this area.

**Appendix 4: Questions for policy and procedures analysis**

- with the overlapping issues of problematic substance use, sexual and/or domestic violence?
- 1) What are the procedures for receiving a referral for a young woman with the overlapping issues of problematic substance use, sexual and/or domestic violence?
  - 2) What are the procedures for supporting/working with a young woman with the overlapping issues of problematic substance use, sexual and/or domestic violence?
  - 3) What are the agency policies for supporting/working with a young woman

- 4) Does the local borough have strategic partnerships for responding to young women with the overlapping issues of problematic substance use, sexual and/or domestic violence?
- 5) If the local borough has strategic partnerships for responding to young women with the overlapping issues of problematic substance use, sexual and/or domestic violence what are their policies?
- 6) Has the agency adopted the local borough's policies?
  - a. If yes, how?
  - b. If no, why not?

**Appendix 5: Competency Assessment (14-15 year olds)**

*This form should be completed with young women aged 14 or 15 who wish to participate in the Stella Project Young Women's Initiative, but don't want to obtain their parent or carer's consent to do so.*

Has the young woman agreed to involve her parent/s or carer/s?	<input type="checkbox"/> YES If yes, proceed to obtain consent to participate in research from parent/ carer.	<input type="checkbox"/> Why do you not want to inform your parents/carer of your participating in the research? _____ _____
Is the young woman:	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Currently intoxicated <input type="checkbox"/> NO <input type="checkbox"/> Has a serious learning disability <input type="checkbox"/> NO <input type="checkbox"/> Has complex mental health issues <input type="checkbox"/> NO	<i>If the answer is yes to any of these questions, the young woman will not be assessed as competent to consent to participating in the research.</i>
Why does the young woman want to participate in the research?		
Does the young woman understand the risks and benefits of being involved in the research?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>Details</i>	
Does the young woman understand the consequences of her behaviour?	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>Details</i>	
What are the implications for the young woman not being involved in the research?		

- Competent to consent  
 Not competent to consent

Assessor's signature:

Young persons signature:

Date:

Date:



