Responding to women with complex needs who use substances

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The MQI Women's Project

This briefing paper is based on an action research project led by Merchants Quay Ireland (MQI) in partnership with the UCD Community Drugs Programme as part of the MQI initiative to explore the issues and challenges surrounding access to homeless, addiction and health services for women. The MQI initiative aims to create and implement responses that will improve access, and ultimately outcomes, for women experiencing multiple levels of disadvantage or exclusion. The action research project had two elements, a review of the academic and grey literature on women with complex needs and action learning sets with key practitioners to map the current landscape of service provision, client presentations, perceived gaps and initiatives and innovation in regards to women, substance use, domestic violence, women's health and homelessness. In this briefing paper we draw together the themes from the literature review and from the action learning sets with practitioners and key agency representatives, with a view to informing policy and practice around five key aspects of responding to women with complex needs, as shown below.

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1. Themes From The Literature: Population, Access Barriers & Pathways Out

Description of the Population

Complex needs

Women often present to services at a crisis point, with complex needs coinciding with deteriorating physical and mental health (National Women's Council of Ireland, 2018). Issues may include substance misuse, domestic violence and mental health challenges (Mayock et al., 2013; Cope Galway, 2019; Mayock et al., 2015a; Merchants Quay Ireland, 2019a; National Women's Council of Ireland, 2018). Another challenge to staff and services is meeting the needs of service users with physical and intellectual disabilities. Recent data indicates that people with disabilities form 27.1% of the homeless population - double that of the population in general (Central Statistics Office, 2016). These needs may be further compounded by compromised poor emotional, coping, and life skills (Babineau & Harris, 2015).

General health

Poor self-reported health is a common complaint among homeless women in Ireland (National Women's Council of Ireland et al., 2019). Diseases such as Hepatitis and HIV are frequently seen among the homeless population (Glynn, 2016). The health impact of chronic illnesses on homeless women may be worsened by a) the homeless population's general tendency to engage less with the health system (Scott et al., 2013), and b) multiple factors specific to homeless women which can reduce their engagement with services such as lack of women-specific services, difficulty finding childcare (Merchants Quay Ireland, 2019c, 2019b), and past negative experiences interacting with service providers (Mayock et al., 2015a).

Income, poverty and sex work

Women presenting to services may be experiencing difficulties due to low income, or other more complex challenges such as financial abuse (Mayock et al., 2013). The pressures of maintaining rent payments, childcare costs and fluctuating incomes may also lead women and families into homelessness (Focus Ireland, 2018; Mayock et al., 2014). Women with complex needs may also be engaging in sex work, either through financial need or as a result of coercion, trafficking or exploitation. Ruhama found (2018) that among sex workers contacted during their outreach activities 34% were either homeless or at risk of homelessness and 50% reported themselves to be experiencing problems with drugs or alcohol.

Migrant women

Migrant women may present to services with additional challenges, including language issues or worries about their legal status may make it difficult for them to speak openly about their challenges or to navigate health, homeless, and addiction services (Mayock & Sheridan, 2012). Social stigma and ostracization of women who are not meeting social norms in certain migrant communities can also compound the challenges experienced (ANEW Support Services, 2019).

Groups less well-represented

The LGBTQI community is under-represented in the literature although they can experience homelessness due to specific gender/sexuality issues (Focus Ireland, 2019) which service providers may not necessarily be sensitised-to. Regular services and accommodation may not necessarily be appropriate or safe for LGBTQI individuals. Older adults were also not well-represented and may experience added risks due to chronic health conditions or frailty. Focus Ireland have noted a trend of growing numbers of homeless older adults aged 65+, and a lack of research that addresses this segment of the population (Focus Ireland, n.d.).

Cyclical homelessness and addiction

Lack of support after initial rehabilitation can lead to relapse and re-entry into the system (Babineau & Harris, 2015). Women who leave residential rehabilitation, the care system, psychiatric hospital, or prison, and those who have entered private stable accommodation, but are then unable to pay rent or maintain childcare costs, are all at risk of cyclical homelessness. Domestic violence may also be a factor, where women may leave refuges without adequate support and end up returning to the homes of abusive partners, only to have to seek refuge again (Cope Galway, 2019; Mayock et al., 2015a, 2015b; Mayock & Parker, 2017).

Barriers which limit women's access to services

Knowledge of services

Some women can have difficulty getting to know what services are available to them, and often desire more information before commencing treatment and may also have misconceptions about services, such as fear of commencing methadone treatment (Merchants Quay Ireland, 2019c). Certain agencies may be presented in the media as a "drug service" with negative connotations, and their other services might not get reported or advertised as prominently, subsequently being overlooked by potential service users (Merchants Quay Ireland, 2019c).

Safety

Coercion, abuse, and domestic, sexual, and gender based violence (GBV) are safety concerns for women attempting to access services. Fear of physical harm from abusive partners can act as a barrier to women accessing homeless or substance misuse services or leaving a relationship (Mayock & Sheridan, 2012; O'Carroll & Wainwright, 2019). In the same vein, a perceived negative reputation of hostels or refuges can deter women from seeking them out due to safety concerns for themselves and/or their children (Mayock et al., 2012; O'Carroll & Wainwright, 2019). A lack of gender specific areas in the homeless services may also lead to safety and protection issues, as many services are very male dominated/focused, or gender-blind (Mayock et al., 2013).

Service Configuration and Provision

Service restrictions may impact on service users' access, particularly those with complex needs. Such restrictions might include a barring of women with histories of anti-social behaviour, active drug users, and migrant women who do not satisfy the habitual residency condition (Mayock et al., 2013). A need to fulfil criteria to access services - such as catchment areas, being drug-free and undertaking mandatory counselling as a condition of entry - can be a major barrier to engagement with services (Canavan et al., 2012; Mayock et al., 2013). Overburdened capacity and long waiting lists throughout services often lead to service users regularly being turned away (Canavan et al., 2012; Mayock et al., 2013; SAFE Ireland, 2016). Overburdened services can also increase insensitivity to individual needs - for example, women in recovery may be placed alongside active drug users. Female problem drug users require access to drug treatment programs, as well as the creation of women-focused programs (Mayock et al., 2015). During service navigation, there are burdens on the service user due to the application process, literacy issues that may be present, attitudinal aspects such as negative past experiences with service providers, and feelings of hopelessness or fear of authority figures which could also limit women's engagement with services (O'Carroll and Wainwright, 2019).

There are also a number of child-specific issues that affect service engagement. There is a definite need for support for pregnant women/women with children in service engagement (ANEW Support Services, 2019; Mayock et al., 2015a). Fear of becoming 'visible' and children being taken into care can also be a barrier to seeking help (Merchants Quay Ireland, 2019c; O'Carroll & Wainwright, 2019). Despite the frequent presentation of homeless families (Focus Ireland, 2018), there is a lack of appropriate emergency homeless services for women with children (Mayock et al., 2013), while single homeless women without children can be driven into general services that are male-dominated, unsuitable or unsafe (Mayock et al., 2015). The need to accommodate women with children also extends to a need for child-friendly spaces in services to occupy whilst their mothers are accessing supports, or counselling (Babineau &Harris, 2015), and spaces for visitation for women whose children have been placed in care (Greenwood, 2016; Mayock et al., 2013).

Stigma

Stigma may be amplified by gender-specific factors, for example the stigmatisation of homeless or substance using women as "bad mothers" (Savage, 2016) and stigma around addiction can also be a barrier to engaging with healthcare services (O'Carroll & Wainwright, 2019). Perceived stigma about GBV can be a barrier to those seeking domestic violence support (Mayock & Sheridan, 2012) and for marginalised groups such as the Travelling community (Murphy et al., 2017). Women engaging in sex work and experiencing addiction may feel the need to hide both their drug use and their connection to prostitution, thus adding to health and wellbeing risks by not seeking out health services (Whitaker et al., 2011). Even disruption of basic needs, such as poor self-hygiene, can be a source of embarrassment for homeless women engaging in healthcare services (O'Carroll and Wainwright, 2019).

Challenges for migrant women

As previously noted, migrant women face specific challenges - these may be social, cultural, legal, and language-related. Migrant women in abusive relationships are socially isolated, particularly if they come from cultures where domestic violence is normalised. This can be a barrier to accessing information about services and entitlements. If migrant women have no immigration status, they have no right to work or to access social welfare. This can also be a barrier to leaving abusive relationships if they have a work permit through their husband's immigration status which is then lost if the relationship dissolves. Together these factors compromise migrant women's ability to access housing and other services (Mayock et al., 2015a; Mayock et al., 2012; National Women's Council of Ireland, 2018).

Pathways Out

Issues relating to pathways out of treatment, homeless and residential supports for women

Service users' pathway through services and into stable accommodation may be impeded at various stages of the journey, including during service access and navigation, moving on, and maintaining stability after recovery (National Women's Council of Ireland, 2018, Dermody et al., 2017, Mayock et al. 2015, Mayock and Parker, 2017). There are a number of key challenges which fall into broad categories of support and access to services, access to housing, and family life and responsibilities. These are summarised below. Responding to these needs will require following cross-sector and cross-service actions as follows:

1. General reconfiguration and training to ensure services are gender sensitive and address the particular needs of women of varying age.
2. Specific and context-appropriate improvements such as training in trauma-informed care for staff, sensitisation to minority issues affecting migrants, the Travelling community, or the LGBTQI population.
3. Improved mechanisms of bridging between services - the role of well-trained and supported staff, especially case workers, also should not be understated, particularly in linking service users to external supports and navigating the landscape of service provision.

KEY CHALLENGE 1 DISRUPTIONS IN SUPPORT AND ACCESS TO SERVICES CREATE OPENINGS FOR RELAPSE	KEY CHALLENGE 2 ACCESS TO HOUSING FOR THOSE EXITING RESIDENTIAL SETTINGS IS LIMITED	KEY CHALLENGE 3 FAMILY LIFE AND RESPONSIBILITIES MUST BE ADDRESSED
Providing a continuum of support for women will give the best chance of success and protect against relapse. Adequate resourcing of services in this area will be necessary, for example to give safe, substance-free, and supportive accommodation and services for those leaving residential rehabilitation, and those leaving care, or being released from prison. Where such services exist, there can be issues of waiting lists and availability, detoxification beds being a key example. Absence of services in a particular region is also a challenge.	Getting established in stable accommodation is a critical factor for women in their journey out of homelessness and addiction, but there is a lack of affordable and appropriate housing options for those leaving the residential services. Administrative burdens might be overwhelming, say when applying to local authorities for accommodation, and the loss of family and friend networks can cause difficulty in finding even short term places to stay (Merchants Quay Ireland, 2019a). There issues are compounded by long waiting lists for social housing.	A focus on her role as mother and availability of childcare is often a central component of recovery from addiction, and for some women this became a main driver for adherence to programmes. Structural barriers may undermine this linkage - lack of affordable childcare options to allow women to re-enter the workforce has been cited as a significant limitation to women's successful progression. Supports for reintegrating into family life, parenting and re-establishing relationships with children are often required.

2. What Practitioners Say: Themes From The Learning Sets

Engaging with services

It was agreed by the practitioners that women tended to present for specific issues. In terms of health, the practitioners felt women were most likely to present with acute or enduring health issues. In some cases, although over time there may be disclosures in regard to sexual and reproductive health issues, as well as trauma and previous experiences of violence, women tended not to engage in follow up supports for these issues. There was a particular dynamic within the night café, where women would present and then disclose during the night, especially in relation to sexual and reproductive health, as well as trauma, but then not present to the nurse or GP based services the next morning, despite displaying motivation and/or need to access care. A number of further points emerged in relation to what and how women present. The first was that women often present to the MQI services intermittently, so therefore it was felt to be challenging to build relationships, maintain contact and to maintain consistent care. As one practitioner pointed out:

> *When women are new to services, it can be challenging to engage them effectively and establish rapport – sometimes it feels like they 'come and go'. They often come with a partner or a new partner, which makes it difficult to discuss particular issues. It can often be obvious or there may be subtle signs of control from the male partner. At these times it can be difficult to 'unearth' the woman's needs.*

The practitioners felt that stigma, shame and fear were key issues for women in terms of engaging with and maintaining contact with practitioners and services. In addition, the practitioners highlighted the fact that women with complex needs often did not meet the referral criteria for further services or agencies in regard to following up on key issues. Finally, the practitioners noted that women were sometimes subject to exploitation and control from others, both men and women. This can occur within personal relationships, and include seeking the protection of a man especially if homeless, which in turn often resulted in lack of consistent engagement with practitioners and services.

A wide range of issues emerged from the learning sets in regard to how women present and engage in services. These issues were multiple and inter-related and connected to internal processes such as shame and guilt; to relational issues such as abusive and controlling relationships; and to practitioner and agency issues such as fear of social work intervention. Societal and cultural factors were felt to be key in affecting how and whether women presented to and engaged with services. These included fear, shame and stigma, especially in relation to her substance use. It was highlighted that in many ways it was easier for men to access services if they were a father, than it was for a woman who was a mother or caregiver. It was

felt that women with no children also experienced isolation and exclusion, due to the fact that many of the societal factors that constituted female identity were in relation to mothering and motherhood. The 'silo' approach to substance use and mental health services was felt to compound difficulties for women in terms of what issues they presented with, and how they engaged with services. Fears women may hold over child protection and welfare responses were felt to be a further barrier. In addition, the practitioners felt that women with complex needs often never went beyond the referral stage in terms of progressing within the support and intervention structure for substance use.

In terms of some of the dynamics in regard to engaging with practitioners, it was felt that women with complex needs often seek or obtain service in more indirect ways, perhaps because of the issues outlined above, and particularly because of internalized shame or stigma. The practitioners stated that it could often be challenging to establish a connection and relationship with a woman when she first presented to a service. As one practitioner questioned:

> *Why are we not seeing women before they get to these levels of trauma and trouble? Women are hugely under represented at the start of their difficulties, they present when something drastic has happened, a hospitalization, an overdose, the loss of children. Why are they not asking for help way before that?*

It was generally agreed that women often did not meet the referral criteria for additional specialist services, meaning they were either not referred or that the referral was not well responded to by the other agency. It was pointed out that women will often present with both tangible needs, but these were underpinned by more complex issues. The practitioners felt that the tangible and immediate needs were often the only ones that were met as women were not in a position to wait to even attempt to access supports or interventions for more complex issues. They pointed out that the language used to refer to women with complex needs could often compound shame and stigma, with the term 'chaotic' often utilized where it was perceived there was little stability and complex needs in a woman's life. Finally, it was identified that women often present after leaving prison as short notices with no care plan or follow up in place.

Disclosures from women

A number of points were raised in relation to the dynamics of disclosure, particularly of violence, abuse or trauma. It was felt that the disclosure of such issues required a safe space, such as a gender specific service or intervention, and that women would disclose in more recreational settings where they were spending more time with practitioners and there was some opportunity to build trust. The practitioners pointed out that coercive control and other types of domestic violence and abusive relationships were harder for women to acknowledge and talk about, whereas obvious injuries or impacts from physical violence were both easier for practitioners to ask about and women to disclose or discuss. The practitioners also raised the question of whether they themselves as well as other practitioners and agencies inadvertently reinforce gender roles, norms and identities, particularly within residential services.

There were a number of points made about how women with complex needs may or may not verbalise their needs, or react to situations:

> *It works better if the women don't have to name their problems straight away, if we can meet them where they are at, and help them first with what they want to disclose.*

The practitioners also identified that women can be challenging, loud or 'acting out' when there are issues going on, and that these behaviours can be an indicator and an opportunity to discuss trauma experiences and impacts with the woman. These situations could be viewed as 'gateways to getting women to talk' as opposed to reinforcing labels of her as 'chaotic' or 'unstable'. They agreed that often if women were engaging in behaviours and responses typically described as 'drama', that something else was going on that the practitioners could assist with. They noted that there was little experience of women opening up about engaging in sex work, particularly in clinical settings such as with the nurse or GP, where it might be expected to arise in terms of sexual or general health.

Dynamics, challenges and issues

There were a range of sub-themes identified in regard to the dynamics and challenges of responding to women with complex needs. Trust was viewed as key issue for women with complex needs as they have 'often been at the receiving end of so much hurt'. There was great fear of children being removed from a woman's care if she sought help or intervention, and if child protection or welfare processes did not go well, then it could be very difficult to maintain a relationship and connection with the woman:

> *Women in treatment have been on the receiving end of so much hurt, they require different interventions and require trust, because it takes so much work to get them to engage with another person, let alone a whole service.*

A particularly difficult dynamic was identified in relation to domestic violence and child protection and welfare, as in some cases it was very difficult for the woman to meet the requirements of Tusla where if the abusive individual was not being held to account also during any intervention process. It was also argued that often the child protection system is one of the few that actually responds to women where there are complex needs.

As was noted above in relation to how women present and disclose, there was a definite dynamic in regard to women presenting to either the night café within MQI or to more innocuous services like the hairdressing or mindfulness group, with the identified tensions in then ensuring women access services that are designed to meet their health and trauma needs. A key question was raised about the high number of pregnant women presenting to the night café and the safety and welfare issues for women in this setting. It was pointed out that women could be 'running on fear' and may access treatment because of some sense of duress or because they are 'fleeing something':

> *They are running on fear. We need to stop treating homelessness and addiction as separate issues…….most women in treatment are fleeing something – there is very little self-referral.*

It was noted that more men tended to self-refer to treatment. Vulnerability of women with complex needs was discussed, and it was highlighted that young women leaving care could be particularly vulnerable to becoming entrapped in unhealthy relationships, substance use, crime and violence. One practitioner noted:

> *We need to look at how we are communicating and promoting services. You don't see women coming to drug services that much, especially not for alcohol or prescribed drugs. There is something out there in the messaging that is putting them off, something in how services are promoted that is not speaking to women or inviting them in.*

3. How Do We Respond?

Five key themes emerged from the literature and learning sets that may underpin actions for practitioners and organisations to improve the responses and interventions to women with complex needs.

Acknowledge and address structural inequalities

Structural inequalities undermine the work done by services that support women experiencing complex needs, and they can create difficulties at all stages of the journey through services. Women may already be disadvantaged compared to men when they first become homeless or experience complex situations - for example they may have dependent children, require care for health issues that are more prevalent among women than men, or have experienced domestic violence at a greater rate than their male counterparts. These pre-existing inequalities dictate that women's experience of multiple forms of disadvantage that is radically different from that of men. Addressing these structural **inequalities** as key contextual factors in the response for women will likely increase the chances of success, but specific approaches and sensitivity are required (National Women's Council of Ireland, 2018).

Inequalities may arise within the services themselves. There may be a degree of gender-blindness with mixed gender accommodation, lack of female-focused care, or simply a male-dominated gender disparity among service users (Mayock et al., 2013). To address this problem, approaches could include the introduction of specific days where women-only services are provided, in addition to expansion of designated **women-only areas** or creation of more **women-focused facilities** (mapped in 2013 by Mayock et al.), but these are of course significantly limited by availability of resources. That notwithstanding, reconfiguration of services to accommodate the needs of women, guided by **gender-sensitive policies and training for staff**, will help to address existing challenges of gender-blindness. Whilst mainly focused on healthcare, the broad lessons and contextual points contained in the **National Women's Council of Ireland's Training Handbook on Mainstreaming Gender in Health** may provide a useful starting point for diverse organisations aiming to build or adapt policy (Pillinger, 2014).

Among women with complex needs, there may also be those who are even further marginalised such as individuals from the LGBTQI or migrant populations, and services may not always have the best training, resources, or organisational links to respond to their needs. Even when not homeless, these groups may face greater risk of poor health and furthermore may have service access challenges due to discrimination and stigma (McCann and Brown, 2019, National Women's Council of Ireland, 2019). Such inequalities add to the upheaval of entering services, and in this regard the sensitisation of service providers to the specific circumstances of women experiencing complex issues would allow for smoother transition and journey through services. This might be delivered by regular inter-agency gatherings to help share best practice

approaches, combined with service user feedback. Tools such as the **"Nobody Left Outside" Service Design Checklist** might also help in the planning stages for creating or adapting services to be more inclusive and accessible (Lazarus et al., 2020).

Structural inequalities may also increase the risk of relapse. Conditions such as poverty and unemployment which can contribute to homelessness are a persistent risk, and these compound the challenge of finding affordable housing, which is often lacking. Here, targeted supports would be of obvious value, such as **financial or life skills training** which in addition to improvements to coping and employability, may have the additional benefit of improving women's self-esteem and efficacy (Nelson et al., 2012). Expanding the availability of long term housing options is another necessity although the Irish government's commitment in Budget 2020 was noted to have fallen short of that requested by homeless agencies, and furthermore includes reliance on private sector providers who have contributed to the scarcity of affordable accommodation options for those leaving homelessness (Ryan, 2020, SVP Social Justice Team, 2019).

There are also accessibility challenges that directly affect women's interaction with health services (McGeough et al., 2020). Clinics may only be held during narrow time windows, creating an additional burden on those who may have entered employment or training, but then must take time out to address health needs. A similar situation may arise with regard to provision of childcare. **Co-location of services that cover physical health, mental health, and social supports in an integrated care model** may offer the potential to address this issue, reviewed recently by Jego and colleagues (Jego et al., 2018). Additional inequalities in care provision could also arise due to lack of sensitisation of health providers to the needs of homeless women, and stigma may cause disengagement from services (McGeough et al., 2020). Steps taken to address this issue would be similar to those for addressing gender-blindness among services, and might include **sensitisation of healthcare providers as well as training for staff to challenge stigma and preconceptions about homelessness and those experiencing it.** For organisations who may not yet have formalised training around homelessness stigma, potential materials and concepts for training may be accessed via the academic institutions and professional colleges - for example the North Dublin City GP Training Scheme and the Partnership for Health Equity supported by the Irish College of General Practitioners, University College Dublin, University of Limerick (https://www.healthequity.ie/). Tools such as the **Health Professionals' Attitudes Toward the Homeless Inventory (HPATHI)** scale might also be helpful in identifying staff competencies around non-stigmatisation in the care context (Buck et al., 2005).

Build trust

The issue of trust between women with complex needs and the practitioners and services they engage with came up within the literature and repeatedly within the learning sets. 'Trust' has been identified as a key component within low threshold substance use[1] provision more generally and usually includes trust between the service user and the practitioner and between the service user and the agency (Edland-Gryt and Skatvedt, 2013). How trust is built is a key question. **Positive client and practitioner interactions** can be the key to engendering trust (Morton & O'Reilly, 2019; McNeil & Guirguis-Younger, 2012). The **values of practitioners** may also underpin trust building, so where these values centre on addressing inequality, unconditional positive regard, and relational caring (Wright, 2004) conditions for trust can be created. **Attending to language** in regard to women with complex needs (e.g. "chaotic") may also be key.

1 The concept of low threshold refers to drug services that do not require abstinence and that seek to reduce barriers to access as much as possible. Interventions typically focus on ensuring that basic needs are being met (housing, food, medical) and where a collaborative style is used to implement harm reduction strategies (Fernandez et al., 2006).

Attend to safety

Safety tends to be considered as safety in regard to practitioners and the organisation and connected to intoxication, violence and drug dealing within low threshold services or those dealing with complex needs (Morton & O'Reilly, 2019) or in relation to personal safety for clients in relation to domestic or sexual violence, sex working or risks in relation to drug acquisition. Attending to safety can require the practitioner to stay both **vigilant yet relationship-focussed,** and clarity in regard to staff responsibilities within organisations has found to be key to ensuring safety when service users have complex needs (Morton & O'Reilly, 2019).

Consider immediacy and pathways

Immediacy is key for the successful pathway through addiction, homelessness, residential and support services. Overall, pathways through services and out of homelessness need to be flexible, with speedy access, integration of services and above all else, inclusivity. Services must be inclusive of women with complex needs, women with or without children, migrant women, LGBT women etc. Service providers must also be cognisant of the vulnerability of women with complex needs leaving care to becoming entrapped in unhealthy relationships, substance use, crime and violence. Actions that would help improve pathways and attend to immediacy:

- Speedy access to **affordable housing and appropriate services** is vital for ensuring safe pathways out of homelessness.
- Addressing waiting lists for **detoxification services** and absence of such services in particular regions.
- **Seamless referrals** is a challenging process to achieve – but the **dedicated caseworkers** are identified as key in improving mechanisms of bridging services and navigating the complex landscape of service provision.
- The question of why women are less likely to self-refer or engage with certain services was raised by many practitioners. One immediate tactic that could be employed here is caution in the naming of different groups. Women often assume they are ineligible for certain supports because they do not fit certain criteria, for example, "domestic violence" or "addiction". Practitioners noted that women often do not engage with drug services. Keeping these more general may promote inclusion.
- There may be additional difficulty in accessing support services where women may not fit certain criteria - homeless women experiencing substance use challenges may become excluded due to lack of low-threshold service provision in their **immediate community,** resulting in an additional burden of travel. Expanded delivery of services would once again be limited by resource constraints, and access to transportation remains a challenge.

What constitutes success?

Questions remain about how work with complex needs understood within the context of outcome driven funding (Fursova, 2016) there is a need to recognise **subtle positive changes** (Timpson et al., 2016) such as **improved psychosocial functioning** and increased **wellbeing** and **stability** for those presenting to services with complex needs (Tomkins and Neale, 2018:53). Or as was described by one practitioner within this research, 'there is often no room for the recognition of small victories' which may be crucial turning points for a woman with complex needs as she engages with services. Attending to wellbeing, stability and psychosocial functioning may be key success indicators (Tomkins and Neale, 2018), but also ongoing **engagement** with services, as well as **trust in practitioners** and improvements in **safety** (Morton & O'Reilly, 2019).

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