



*The Scylla state: an alternative understanding of survival sex work and addiction*

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The Scylla State:  
An Alternative  
Understanding of  
Survival Sex Work and Addiction

Rebecca Elizabeth Hamer

A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam

University for the degree of Doctor of Philosophy

June 2022

## Candidate Declaration

I hereby declare that:

I have not been enrolled for another award of the University, or other academic or professional organisation, whilst undertaking my research degree.

None of the material contained in the thesis has been used in any other submission for an academic award.

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## Abstract

This thesis explores women's addiction (PDU) and survival sex working (SSW) through a socioeconomic lens that focuses on the exacerbation of deprivation and consequent multidimensional trauma that correlates with neoliberal policies. Instead of bolstering the dominant yet problematic medical, moral or behavioural models, I take an alternative route. I examine PDU and SSW as survival strategies in response to the inequality and distress that emanates from responsibilising, individualising discourse and practice.

This began in earnest from 1951 with socioeconomic upheaval and challenges to the welfare state. While the history of socioeconomic deprivation in marginalised communities is long, this thesis focuses particularly on the practices and associated structural changes of neoliberal politics prominent from the tenure of Thatcher and which reached new heights following the 2010 election of the Coalition government.

I argue that the associated policies and practices, and their reinforcement by individualising, responsibilising models of PDU and SSW, have contributed to the exacerbation of poverty and multidimensional trauma. Therefore, the impact of these policies and practices is to exacerbate SSW and PDU as women's struggles for survival become amplified.

I conducted in-depth biographical interviews with twenty-three women from post-industrial cities across England and Scotland, including Yorkshire, Lanarkshire and the South-West. All the women have experienced addiction to substances and thirteen identified as having taken part in sex working in order to survive during this period.

The research provides several original contributions to knowledge:

First, echoing the academic literature that connects women's PDU and SSW with self-medication and survival strategies it advances this position, using it to directly query dominant individualising and responsibilising models. As a result of these models' ill fit, I argue that policy and practice is inappropriately underpinned and thus ineffective.

My thesis also indicates how policy and practice underpinned by these models can further exacerbate SSW and PDU by responding inappropriately and even adding to women's deprivation and trauma.

I advance the concept of multidimensional trauma to describe the harms that act as drivers behind addiction and barriers to recovery for women, denoting trauma of individual, community and systemic iterations.

Finally, I propose the concept of the Scylla State to complement Wacquant's Centaur State (2009) and provide a much-needed gendered understanding of the consequences of living in neoliberal post-industrial society as a marginalised woman.

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# The Scylla State: An Alternative Understanding of Survival Sex Work and Addiction

## Preface

This thesis explores the experiences of women with histories of street sex work (SSW) and/or problem drug use (PDU), how they meet their needs and how individualising, responsibilising discourse and practice, neoliberal policies and other socioeconomic factors affect their ability to do so. These populations of women (of whom there is overlap but not homogeneity) frequently face exclusion, poverty, and violence.

PDU and SSW are argued herein to comprise their coping and survival responses to this in the increasing absence of appropriate formal support. These strategies in turn serve to embed and exacerbate women's marginalisation and experiences of trauma at individual, community and systemic levels. PDU and SSW frequently intersect in terms of function, criminalisation<sup>1</sup> and are subject to similarly responsibilising and individualising policy and practice. This is despite the relationship suggested in the evidence base between unmet need, trauma and these 'social problems'.

Therefore, while this thesis is focused on women's PDU and/or SSW, it explores them in the context of women's experiences of deprivation and the traumas correlated with this. Policies that have accompanied periods of socioeconomic upheaval during heightened periods of neoliberalism<sup>2</sup> are conceptualised as exacerbating the poverty and inequality that contributes to the various traumas that PDU/SSW are posited as symptoms of.

The literature discusses the evidence relating to policies that would have been significant during the women's lives, such as those related to austerity. This is partly due to constraints in terms of word count but also due to the focus of data collection

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<sup>1</sup> Although the act of selling sex itself is not criminalised, aspects of sex work including brothel keeping (working indoors with more than one worker), soliciting and loitering are, with the latter two especially relevant for SSW (Scoular, 2010)

<sup>2</sup> From the election of Thatcher in 1979, particularly during the mid-1980s and the election of the Cameron-Osbourne Coalition Government in 2010.

on women's self-expressed experiences and their lives in the context of contemporaneous socio-political events.

It is, however, worth making note of the wealth of research on the impact of the previous period of the intensification of neoliberalism in the UK in the 1980s, especially as we will see evidence of this in the Findings of the perhaps correlated traumas and deprivations of the women's families. The correlation between mass unemployment, the destruction of traditional working-class communities and the voracious spread of heroin from London to the North of England has been widely attested to in literature throughout the 80s and 90s (Seddon, 2006). This coincided with an increase in post-industrial areas of street sex workers, who were similarly faced with an influx of heroin and crack alongside the destruction of community and opportunity (Campbell, 2016; Morgan, 2014; Parker et al, 1988). Pertinently, Parker (2004) has since attested to the link between heroin epidemics and of social exclusion. Although not within the scope of this thesis, it is pertinent to bear this in mind as we later consider the histories of women's families and communities and the legacy of this.

## 1 Street Sex Work and Problem Drug Use: Intersecting Populations and Intersecting Deprivation and Exclusion

In chapters 1 and 2 of this thesis we explore the dominant models that inform political, social, and practice-based responses to street sex working (SSW) and problematic drug use (PDU) and the ways they can be argued to intersect to entrench disadvantage and trauma. Thus, we set the scene for the exploration of alternative theories and their potential contribution to the development of new conceptualisations of and approaches to women's criminalised responses to poverty and trauma.



Before examining dominant explanatory and curative models, it is useful to set the scene regarding the correlation between SSW, PDU and shared experiences and needs. The relationship between PDU and SSW is multi- directional and entrenching. Many sex workers who engage in traditionally street-based sex work<sup>3</sup> have been evidenced to do so primarily as an economic strategy underpinned by desperation with between 75-100% of street earnings going on drugs, and a high percentage using drugs intravenously

(Cusick, 2006; Cusick and Hickman 2005; Cusick and Martin, 2003; Hester and Westmarland, 2004; May et al, 1998; McKeganey, 2006b; Miller and Neagius, 2002). This suggests that most women engaged in SSW are at advanced stages of addiction, often typified by intravenous heroin and poly drug use, particularly crack. (Gilchrist, 2005; McKeganey and Barnard, 1996; McKeganey, 2006b; Reeve, 2017).

The relationship between PDU and SSW has been shown to operate in a trapping, mutually reinforcing cycle(Cusick and Hickman, 2005). Earnings from SSW permit far higher levels of drug use than acquisitive crime, and as SSW commonly cite needing to use drugs to cope with the danger and trauma of the work itself, this in turn exacerbates the severity of addiction (Cusick, 2006; Cusick and Hickman, 2005; Edmunds et al, 1999; Gilchrist et al, 2005; McKeganey, 2006b). The PDU/SSW attendant intersection of unmet need, distorted priorities and desperation is argued to contribute to the prevalence of risk taking in drug use, sexual behaviour and decision making (Gilchrist, 2005 ; Gilchrist et al, 2001; Gossop et al, 1995; McKeganey et al, 2006b). Risks include higher levels of sharing of injecting equipment, unprotected sex, robbery of clients and tendency to work for longer and take less precautions when screening clients (Gilchrist, 2005; Gilchrist et al, 2001; Gossop et al, 1995; McKeganey, 2006b; McKeganey and Barnard, 1996).

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<sup>3</sup> Due to technological advances allowing women to advertise online and be contactable through mobile phones, there has been an increase in transition from street to indoor, although the commonalities of SW as a functional survival strategy persist (Sexton, 2003). 'Street' sex work is discursively distinguished from 'indoor' sex work as its common drivers are poverty and addiction, and women also experience greater levels of violence, abuse, stigma and intervention by the state and its agencies

This entrenching dynamic can be viewed as an unintended consequence of a practical and emotional survival strategy. The likelihood of conviction or punishment for acquisitive crimes increases as criminal and drug using careers progress, whilst sex work is less likely to result in arrest than shoplifting and has greater earning potential and longevity (Cusick et al, 2003). Women also have fewer opportunities to acquire money legally and illegally than men. This is rooted in gender inequality as women are limited by the availability of fewer low/unskilled positions in women's labour markets and possess less physical strength to commit burglary/robbery (Cusick et al, 2003; Cusick and Hickman, 2005). Women are also keener to avoid custodial sentences due to children, partners, and family which, as we see in Chapters 3.5 and 6.5.3 seems a sad irony given that SSW and PDU mothers also experience a notable degree of attention from child protective services (Hester and Westmarland, 2004). SSW have also been evidenced to work due to perceived or actual pressure from (often) male partners whose drug habits they also finance (Cusick, 2006; Malloch and McIvor, 2010 and 2011; Smith and Marshall, 2007).

Despite this, SSW is still often conceived of as a deviant behaviour rather than a functional strategy (Ellison et al, 2019; O'Neill, 2003, 2013 and 2017; Vanwesnbeeck, 2001). However, the experiences they share (discussed below) demonstrate how it is *need* that places them in this position, which responsibilising and individualising discourse often entrenches or fails to address (Melrose, 2009).

We see in the following chapters how these dominant models conceive of PDU and SSW as signs of deviance and dysfunction, seemingly neglecting the relationship described in this chapter of the correlation between PDU, SSW and unmet need. However, we then proceed to examine the alternative models which *do* factor in the impact of poverty and inequality, opening up opportunities to recognise PDU and SSW as symptoms of deprivation.

Below, the thesis roadmap details my core research questions and how these are explored. The result is an interrogation of the suitability of dominant and alternative models, and of the reality of women's experiences.

**Table 1: Thesis Outline**

Chapter 2: Setting the Scene	This chapter explores the dominant paradigms that are used to inform approaches to SSW and PDU.
Chapter 3: Analytical Framework	Chapter 3 presents an alternative framework for exploring PDU and SSW, incorporating the impact of Neoliberalism and Austerity Politics.
Chapter 4: Methodology	Chapter 4 discusses why and how to adopt a research approach to SSW and PDU that locates women's experiences and histories at the centre of inquiry while being trauma informed.
Chapter 5: Findings 1: Before Addiction Chapter 6: Findings 2: During Addiction Chapter 7: Findings 3: Recovery and Onwards	The findings chapters describe the experiences and opinions of the women interviewed and each chapter depicts a different stage of the women's journey. The chapters are all organised according to the concept of multidimensional trauma (proposed in this research) which comprises individual/interpersonal trauma, community trauma and systemic trauma.

<p>Chapter 8: Conclusion and Discussion</p>	<p>The concluding chapter draws together the main findings, contextualising them against the literature and proposing alternative perspectives and approaches. These are presented explicitly in three discussion points and in terms of the original contribution to knowledge.</p> <p>The research process is reflected upon, future research possibilities are discussed, and implications of the research for policy and practice described.</p>
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## 2 Explaining the Unthinkable. Women, Addiction and Street Sex Work: Dominant Paradigms

This chapter examines the dominant theories and definitions of problem drug use (PDU) and street sex working (SSW), beginning with PDU (2.1) and moving on to SSW (2.4). This sets the scene against which to consider an alternative; that these models are inadequate due to a lack of recognition of socioeconomic and environmental factors, including the relationship between neoliberal policies and practices and the exacerbation of poverty and trauma.

### 2.1 The Dominant Conceptualisations of Addiction: Can't Stop Won't Stop

'Addiction' and 'problem drug use' are often used interchangeably in policy, practice, and research. The development of the term 'problem drug use' and its popularity over 'addiction' reflects transition in the framing of addiction; from a moral problem, to a medical one, to a hybrid 'official view' incorporating the moral, physiological *and* psychological (Alexander, 2010). A host of theories purport to 'explain' addiction or problem drug use, couched in notions of volition or lack of, compulsivity and harm done to self, others, and the state: these models also underpin the various approaches in policy and practice trends that effect the realities of services and service users (Duke, 2013; London, 2005; Luty, 2003; Maté, 2012; McKeganey, 2006a; Neale et al, 2015; Nutt, 2010; Nutt et al, 2010).

The following sections (2.1-2.3) explore the genesis and development of the theories that inform mainstream definitions and understandings of addiction. Correspondingly, the theories that underpin treatment approaches are explored, followed by a discussion of the particulars of women's experiences of addiction and the suitability of these models. In doing so, we begin to see how PDU, especially among women, appears subject to tensions and inconsistencies in its definition and operation in UK policy and practice.

Although in statute, drug possession, distribution and use are illegal, the law can be argued to operate with a sensitivity to status. For example, the majority of drug related arrests and prosecutions target the visible poor such as the homeless, recidivist 'petty' criminals, or those committing anti-social behaviour in deprived areas already under intensified scrutiny (Anderson et al, 2015; Flanagan, 2013). Policy and practice are also premised on economic and social order concerns that focus on the non-compliant or non-productive in society (Bacon and Seddon, 2020; HM Government, 2010, 2017 and 2021). While the 2010 and 2017 (HM Government) drug strategies recognise that drug-related crimes are most often acquisitive, they don't acknowledge the role of socioeconomic deprivation and instead emphasise the correlation between addiction and criminality. We can observe the presence of these underpinning concerns in the dominant definition of recovery which includes abstinence from drugs of addiction and is expanded upon by outcome measurement to incorporate employment, tax paying, desistance from offending and retention of parental rights (Bacon and Seddon, 2020; Duke et al, 2013; Fomiatti et al, 2019).

The origins of the current dominant approaches can be traced in the developing concepts of drug addiction and recovery that have emerged in official discourse over the last century (Alexander, 2010; Clark, 2011).

### 2.1.1 The Flaw Within: Individualised Models

Much of the vast library of addiction theories and attendant policy tend to focus on individual level explanations as opposed to structural, social or economic (Alexander, 2010; Clark, 2011; HM Government, 2010, 2017 and 2021; London, 2005; MacGregor, 2017; Smart, 1984 ). These concentrate on biological, psychiatric, or psychological processes and factors (Heather, 2017; Orford, 2001; West, 2001). There is some divergence over the extent to which addicts are culpable for and in control of their addictions, polarising between assertions that addiction is a disease, and those which frame it as a disorder due to behavioural, moral and social dysfunction (Orford, 2001; West, 2001). These traditional theoretical camps are popularly known as the Brain Disease Model of Addiction (BDMA), which medicalises addiction and conceives of the addict as a victim of their physiological sickness, and the moral/behavioural

model which holds that addiction is a behavioural deviance within the control of the addict (Courtwright, 2010; Goodman, 1990; Henden et al, 2013; West and Brown, 2013).

Neither theory considers the role of the addict's individual, environmental and socioeconomic histories when observing their behaviour. Below, we explore in greater details the responsabilisation of the individual that characterises these models.

### 2.1.2 Going Upstream: Was She Pushed, or Did She Jump?

The moral/behavioural model asserts that addicts are neither victims nor powerless, but hedonists who prefer not to exercise self-control or willpower (Ettorre et al, 2008; Frank and Nagel, 2017). This depicts addiction as a moral and behavioural choice by one who prioritises their pleasure over its costs to society (Frank and Nagel, 2017; Heather, 2017; Pickard, 2017; Siegler and Osmond, 1968; Wilbanks, 1989).

The American Therapeutic Community Synanon is a noteworthy antecedent of the contemporary moral model. Synanon was founded by an AA member whose approach created a culture of condemnation, chastisement and, in instances, abuse, to shame and correct the moral and behavioural turpitude of its members (Batiste and Yablonsky, 1971; Siegler and Osmond, 1968). Proponents of a contemporary moral model draw upon psychological theories to add a cognitive behavioural dimension, placing responsibility solely upon the addict. Placing greater emphasis on motivational-behavioural hijacking than defiance, West (2001, p. 3) defines addiction as a disorder of motivation: a behaviour over which an individual has impaired control with harmful consequences' (medical, psychological, and social), which 'violates the individual's freedom to choose'. This approach lessens attribution of blame and draws somewhat on the medical model's compulsion argument (West, 2001).

However, most permutations of the moral/behavioural model are based on evidence emphasising the role of choice in drug use, addiction, and recovery (Henden et al, 2013). For example, decisions are made as to what drug to use, where and in what quantity, according to a variety of (dis)/incentives such as fear of arrest, allaying



withdrawal or maximising a high (Henden et al, 2013). Also, a significant percentage of addicts have been proven to quit *unassisted* by their mid-30s<sup>4</sup> (Anderson, 2008; Alexander, 2008; 2010; Henden et al, 2013; Keane, 2002). However, dominant interpretations maintain that while addicts' actions may be risky, they choose these behaviours through a deliberate cost-benefit analysis (Benn, 2007; Foddy and Savulescu, 2006 and 2010; Heyman, 2013; Hyman, 2007; Leshner, 1996; Levy, 2006; Pickard, 2012). Interestingly, this finding is most frequently used to emphasise the capacity of addicts to recover should they choose. Paradoxically, Alexander (2008) points out that a notable quantity of addicts recover unaided by formal treatment by their mid-30s, while others die or remain entrenched in addictions. Consequently, Alexander (2008) proposes that while choice is a factor, the most significant implication of this evidence is of the unsuitability of conventional drug treatment.

Elements of the moral model can also be detected in political and cultural attitudes in which they are employed to justify the criminalisation of addiction, where punishment acts as a deterrent and is a just and equitable response to the deliberate transgressions of addicts (Heather, 2017; Pickard, 2017; Pickard et al, 2015). A highly popular iteration of the moral model today is that of 12 Step Programme, which similarly to Synanon, are grassroots groups focusing on the admission of individual fault and submission to a higher power (Borkman et al, 2007). Within professionally led treatment we see the influence of moral behavioural models in the motivational interviewing and cognitive behavioural therapy intended to equip addicts to correct their behaviour and priorities (DiClemente and Velasquez, 2012; Howatt, 2003; Markland et al, 2005 White and Kelly, 2010).

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<sup>4</sup> Though Alexander (2010) points out it is the not insignificant minority of addicts who experience greatest difficulty recovering and lifelong relapses who are the most visible and the true concerns of policy

### 2.1.3 The Brain Disease Model

The Brain Disease Model of Addiction (BDMA) conceives of addiction as a chronic relapsing disease caused by changes in the brain structure and functioning, resulting in uncontrollable compulsions among addicts regardless of harms (Hall et al, 2015; Leshner, 2001; NIDA, 2010; Sharpley, 2017; Wise and Koob, 2014). The BDMA describes a cyclical 3 stage process of intoxication, withdrawal, and relapse, which is accompanied by neurological processes and responses (Sharpley, 2010). It is theorised that the stress of withdrawal, in addition to existing stressors, triggers relapse due to re-intoxication's partial relief of withdrawal pain (Sharpley, 2010; Volkow et al, 2016; Volkow and Li, 2005).

This cycle is argued to be positively reinforcing as neural-circuitry and neuroplasticity become increasingly effected as positive associations are amplified. (Volkow et al, 2016). Resultantly, the brain's reward pathways alter, incorporating drug use into learned cues, leading to valuation of intoxication over natural rewards such as food and sex (Volkow et al, 2016). Consequently, the BDMA argues, the brain is consumed by an uncontrollable appetite for intoxication, leading to increasingly chronic routes of acquisition and administration, despite the costs (Henden et al, 2013; Leshner, 2001; Kreek, 2007; Sharpley, 2010; Volkow et al, 2016).

Proponents of the BDMA endorse a correspondingly medical solution. The most prevalent of these is substitution therapy where (for heroin addiction) predominantly methadone and buprenorphine are prescribed to addicts to substitute (to a lesser degree of intoxication) or block the physiological effects of intoxication (Hall and Carter, 2013 and 2017; Strang et al, 2004). It must be noted that substitution therapy preceded the BDMA by some 30 years, but the two are connected in their approach to addiction as a pathological disease that responds to medication, although substitution therapy is also often used as an ancillary to other forms of treatment (Hall and Carter, 2013; Hall et al, 2017; Luty, 2003). The maintenance often provided by substitution therapy has, over the last decade, received criticism for expecting too little of addicts, delivering too few returns for the government's investment (Ashton, 2008; Wardle 2009 and 2012). Substitution therapy has been argued to only achieve

harm reduction or stabilisation, rather than the various advancements and social contributions expected from the recovery desired by the state (Ashton, 2008; Fomiatti, 2020; Hunt and Stevens, 2004; McKeganey, 2006a, 2012, 2014; Thomas et al, 2019; Wardle, 2009 and 2012).

Critiques of the BDMA claim it to be empirically and conceptually flawed. For example, dopamine increase and reward responses are triggered by food, exercise and sex but these activities do not cause changes to the brain (Alexander, 2010; Courtwright, 2010; Henden et al, 2013). Lewis also critiques the model for pathologizing addiction whereas in reality, he asserts, the neurological changes upon which the theory partially hinges constitute *neuroplasticity*, a normal learning process whereby the brain adapts in response to rewards (in Pickard, 2017). Lewis also contends that this model emphasises addicts' dependence on professionals and medical assistance and provides a convenient 'sick role' to excuse their behaviour (Alexander, 2010; Bonnie, 2011; Davies, 2018; Lewis in Pickard, 2017). By concluding addiction is a disease, critics argue, the BDMA equates addiction to other illnesses such as Alzheimer's or cancer and yet these do not occur as a direct result of an individual's actions or decisions (Foddy and Savulescu, 2006 and 2010; Henden et al, 2013; Heyman, 2013). Secondly, as has been touched upon, while the medical model posits that addicts' behaviour is compulsive this is contradicted by recovered addicts' cited motivations to recover, such as parenthood. Certainly, recovery narratives often cite turning points where triggers occur and narratives are rewritten, indicating the role of agency (Pickard, 2017).

It is worth observing that many proponents of the behavioural model are not absolutist and do somewhat acknowledge the influence of environmental and individual variables such as unemployment (Nader and Czoty, 2005; Shetty, 2011; Solinas et al, 2008 and 2010; Volkow, 2005). However, this often translates as endorsements to promote employment of previous addicts as a recovery motivator, in isolation from the realities of the opportunities and conditions available in the job market. The relationship between unemployment and addiction has also been rather narrowly used to justify coercion of service users into underpaid precarious labour (Bauld et al, 2012; Walton and Hall, 2016). This is underpinned by the assumption that

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*any employment* encourages recovery and prevents relapse, rather than there being a more nuanced, multi-directional relationship between the two, contingent upon quality and security, among other factors (Bauld et al, 2012; Harris, 2010; Walton and Hall, 2016).

Gabor Maté (2008, 2012) proposes an alternative iteration of the Brain Disease Model which draws upon the correlation between childhood trauma and adult addiction (Herman, 2015; Masarik and Conger, 2017; Van Der Kolk, 2015). The result of childhood trauma, Maté argues, is that the dominant brain systems affected by addiction are ‘finetuned’ by their environment and so addicts’ brain-body systems are ‘not functioning properly’ (Maté, 2012, p.56). Survivors of childhood trauma are therefore more reactive as their physical stress mechanisms are disrupted by their trauma and so substance abuse becomes a self-soothing strategy. What Maté (2012) has not explored is the correlation between socioeconomic factors and traumatic experiences, nor the role of other potentially intersecting factors that may explain why some trauma survivors turn to addiction and others don’t. Maté’s (2012) theory also perpetuates the individualising, pathologising rhetoric of the dominant models in its failure to acknowledge the impact of sociological or systemic deprivation.

## 2.2 ‘The Official View’ and New Recovery

The theoretical interpretations of addiction and recovery underpinning UK policy and practice reflect Henden et al’s (2013) assertion that neither the moral nor medical view is dominant in the UK (HM Government 2010, 2017, 2021). Henden et al (2013) contend that an either/or stance is overly reductionist, and that addiction can be volitional *and* compulsive: addicts must not be relieved of responsibility for their actions but must also be recognised as having neurologically disrupted behavioural patterns and decision-making processes (Henden et al, 2013, p. 10).

Alternatively, Henden et al (2013) advocate a middle path which merges perspectives, advancing a theory with a range of iterations which have influenced the development

of New-Recovery.<sup>5</sup> However, this hybrid model has also not gone without criticism, nor its contradictions undetected. Sharpley (2012) notes that while the BDMA is used as an explanatory framework for addiction onset and treatment, it is not used in the diagnosis of addiction or the definition of addiction recovery, both of which draw upon behavioural and psychosocial indicators. The DSM-5 diagnosis tool<sup>6</sup> evaluates behaviour, for example criterion 6 wherein it is judged whether *‘Important social, occupational, or recreational activities are given up or reduced because of substance use’* (Saunders, 2017, p. 228). These contradictions raise questions about the coherence of addiction policy and practice that criminalises addicts for their choice to use drugs whilst framing them as the helpless sick. Conversely, these systems then expect addicts to rehabilitate in programs that demand the self-control they purportedly do not have (Karasaki et al, 2013).

The notion of choice in recovery is a prevailing force in the 2021 UK Drug Strategy which proposes levying increasingly punitive measures against ‘repeat offenders’, implying that sufficient deterrence can influence addicts’ choices and behaviours (HM Government, 2021). This again reflects tension between volition and pathology in the medical-moral fusion of models. Alexander (2010) terms this fusion the ‘Official View’ (OV), identifying six foundational elements consistent across all versions. Among these is the assertion That addiction is a chronic, relapsing disease that cannot be cured but can be managed, whether through professional treatment or peer support. Pertinent to this research, another foundation is that addiction is a behavioural/moral *and* medical abnormality of ‘deviant individuals within ‘otherwise well-functioning societies’ (Alexander, 2016, p. 1; my emphasis). While the moral angle is less present in the OV, moral judgements remain implicit in much of conventional treatment, for example Alcoholics/Narcotics/Cocaine etc. Anonymous, which locate the capacity and

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<sup>5</sup> As per Fomiatti et al (2018), ‘New Recovery’ refers to the definition and implementation of recovery which is currently dominant in UK treatment and that reflects neoliberal rhetoric. This model individualises and responsabilises recovery, calling upon individuals to realise and develop their ‘recovery capital’. This is devoid of recognition of structural and systematic considerations such as the impact of austerity (Discussed in 3.3).

<sup>6</sup> A diagnostic checklist used by clinicians and healthcare professionals to diagnose addiction and assess severity

responsibility for recovery within the addict (Alexander, 2016; Borkman et al, 2007; Orford, 2001). This observation appears in New Recovery discourse and practice too, whereby 'recovery capital' is accrued by individuals' realisation of existing assets, inspiring hope and transmitting recovery through communities (Cloud and Granfield, 2008; HM Government, 2010; 2017; Kretzmann and McKnight, 2005; White, 1998). However, key to this premise is the assumption that deficits can be corrected solely by the efforts of addicts, and, by extrapolation, the deficits are the result of their indolence and ambivalence, not the absence of assets in the first place.

Despite this implied responsabilisation, the inclusion of the BDMA within the OV introduces a degree of blamelessness to the moral components. This is premised by the assertion that drug use rewires or takes over brains, so addicts are neurologically incapable or were incapacitated to begin with because of improper social condition/learning (Alexander, 2016; Lewis, 2017). This is dominant in the current drug strategy's assumption that recovery and compliance with societal norms can be coerced through sufficiently stringent levels of retrenchment and punitivism (HM Government, 2021). The iteration of the OV that dominates in the UK has been termed 'New Recovery' and can be argued to embody the neoliberal principles critiqued by the alternative models discussed in Chapter 3 (Frank, 2018; McWade, 2016; Thomas et al, 2018). The specific rhetoric and manifestations of New- Recovery is discussed in detail in the next section.

### 2.2.1 New Recovery

New Recovery espouses an almost entirely individualising understanding of addiction and correlates recovery with self-attained improvements including in socioeconomic status and social compliance (Babor, 2010; Bull et al, 2019; Duke et al, 2013). This iteration of recovery is purportedly quantifiable and reproducible and promises outcomes without the acknowledgement of systemic and structural barriers (Bull et al, 2019; Fomiatti et al, 2018 and 2021). New Recovery concludes that as recovery is voluntary it can be attained through decision and action by individuals to realise 'recovery capital', a notion drawn from Bourdieu (2011) but referring to the human, physical, social and cultural (Cloud and Granfield, 2008). In New Recovery, the onus

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for the cultivation of recovery capital is placed primarily upon individuals, the professionals who support them and their communities (Duke et al, 2013; Fomiatti et al, 2019 and 2021; Roy and Buchanan, 2016) . The process of recovery itself is claimed to overhaul individuals' quality of life and satisfaction, inspiring active citizenship and 'meaningful lives'. Tools to define 'meaningful lives' measure economic contribution, cessation of crime (including acquisitive/survival), use of social and health care services and volunteering in the community (Fomiatti et al, 2019, Laudet, 2013).

New Recovery is distinct from other theories in that it has developed through particular political ideologies and has been shaped through partnerships between government, research and industry (Duke et al, 2013; Fomiatti et al, 2019 and 2021). This emerged from the Harm Reduction vs. Recovery wars that reached prominence following outcry that substitution therapy was failing, and the drug treatment system was suffering from lack of ambition, over-medicalisation and professionalisation (Ashton, 2008; McKeganey, 2012 and 2014; Wardle, 2009). Instead, New Recovery proposes that addiction and recovery are the responsibility of addicts and their communities; that people in recovery, their peers, self-discipline, and local asset realisation alone is sufficient (Bacon and Seddon, 2020; Berridge, 2012; Duke et al, 2013; Fomiatti et al, 2018; Kretzmann and McKnight, 2005; Roy and Buchanan, 2016). Frank (2018) argues that the unintended consequences of New Recovery are the obfuscation of political oppression and the criminalisation of poverty. This position has been echoed by others who identify the adoption of New Recovery by neoliberal states to justify demands that marginalised populations 'pull themselves up by the bootstraps' (Bacon and Seddon, 2020; Duke, 2013; Lancaster et al, 2015 and 2018; Monaghan, 2012) By declaring that recovery is *within the reach of every individual given their application and effort*, New Recovery consequently pardons the state of any potential role in motivations to use drugs and barriers to recovery (Roy and Buchanan, 2016). New Recovery also confers further stigma on drug users by ostracising those who are not interested, ready, or able to pursue abstinence (Smith and Riach, 2016). Indeed, Neale et al (2013) conclude that recovery-oriented treatment can, for example, push users into detox when they are not ready conversely having negative consequences in terms of service user wellbeing and engagement.

Furthermore, the conflation of abstinence-based drug treatment with ‘meaningful productive citizenship’ obscures the complexities of the transformations that may occur in people’s lives *alongside* cessation of drug use. This suggests a reductionist understanding of the life course and of change by assuming causation when recovery occurs in treatment (Duke, 2012; Duke et al, 2013; Lancaster et al, 2015 and 2018).

Similarly, Alexander (2008) argues that this assumption obscures the likelihood that people in recovery are not helped by treatment or any problem-focused support, as this doesn’t redress the deficits that correlate with recovery. Instead, lack of or access to social connection, secure and rewarded employment, self- realisation, and environmental security are the *inhibitors* and *creators* of recovery (Alexander, 2008; Depner, 2017). Therefore, Alexander (2008) argues, it is opportunities that address deficiencies in these areas which are truly responsible for recovery. As we will see in Chapter 3 neoliberal policies are argued to exacerbate environmental and socioeconomic deprivation, which only amplify these deficiencies.

## 2.3 Women and Addiction

We now discuss the implications of these dominant models for women and consider the ways in which they may neglect the female experience. Research over the last 25 years has placed more emphasis on discovering the differences in men and women’s addiction and recovery, and so this has become an increasingly developed field (Brady and Lydiard, 2021; Brady and Randall, 1998; Goetz et al, 2021; Greenfield et al, 2007 and 2010; Grella, 2008; Shand et al, 2011; Simpson and McNulty, 2008; Straussner and Brown, 2001; Tuchman, 2010). However, the models underpinning the treatment of men and women remain individualising and based on moralistic/behavioural and/or pathologising theories (Brady and Lydiard, 2021; Frišaufová, 2012; Najavits, 2015; Smith et al, 2021) .

A consequence of the dominance of individualised theories is the development of policy and practice concentrated solely on addiction as a symptom of individual dysfunction. This has been critiqued for neglecting the spectrum of experiences of men and women but also failing to acknowledge and respond to the roots of women’s



addiction and their particular recovery needs (Covington, 2008; Faber, 2001; Gatz et al, 2005; Martin and Aston, 2014; Swan and Wincup, 2016). PDU women's lives have often been blighted by violence and abuse and this motivates their use of drugs, as a physical and emotional coping strategy (Covington and Cohen, 1984; Hien et al, 2005; Mitra, 2021; Ouimette et al, 2000; Swan and Faber , 2001).

While the introduction of theories of labelling, deviance and desistance added the dimension of identity to behavioural/moral models, this expansion persisted in its neglect of women (Campbell and Ettorre, 2011; Liazos, 1972; Moore and Measham, 2014; Millman et al, 1972). Accordingly, Kalant remarked in 1980 that women's drug use research was a "non-field" (in Ettorre, 2004). When women were included, it was as *'sicker, more deviant and more psychologically disturbed than her male counterpart'*, suggesting women are subject to amplified pathologizing and moralistic judgements (Ettorre, 2007; Kulesza et al, 2016; Malloch, 2004; Moore and Measham, 2014, p.81; Schur, 1984). The greater punitivism and stigmatisation that accompanies these judgements are argued to be responses to non-conformity to expectations of femininity and motherhood (Ettorre, 2007; Malloch, 2004a and b; Moore and Measham, 2014; Mulia, 2000; Schur, 1984). These are often rooted in assumptions of deviance and sexual promiscuity which men are not subject to, and which reaches particular pique where mothers are concerned (Green, 2006; Hannah-Moffat, 2007; Mulia, 2000; Malloch, 2004a and b; Murphy and Rosenbaum, 1999; Noble et al, 2000; Taplin and Mattick, 2015).

As alluded to, feminist thought and action from the 1980s, which aimed to give voice to the experience of traditionally silenced populations, resulted in a shift in theorisation of women's PDU (Ettorre, 2004; Moore and Measham, 2014). Presumptions about women's inherent deviance and sickness were challenged and social, cultural and economic factors instead highlighted (Curran and Golombok, 1985; Ettorre, 2004 and 2007; Moore and Measham, 2014). For example, the disproportionate prescription drug use among women has been correlated with the historical prescription of tranquilisers by (predominantly male) doctors (Campbell and Ettorre, 2011). These dynamics are argued to embody expectations of female passivity and assumptions of psychological and physical inferiority (Campbell and

Ettorre, 2011; Curran and Golombok, 1985; Ettorre, 2004; Fraser and Valentine, 2008; Moore and Measham, 2014; Jeale et al, 2014 ; Tuchman, 2014).

By privileging the experience of women feminist theories of addiction provide a broader conceptualisation which incorporates factors such as trauma , power and performative needs , viewing these as symptoms of gender inequality (Campbell and Ettorre, 2011; Moore and Measham, 2014). Recognition of societal expectations and their impact, including the surveillance of motherhood and the subjugation of women in patriarchal society, is argued to advance a more nuanced and accurate understanding of the drivers of women's addiction and their barriers to recovery (Ashley, 2003; Covington, 2002; Covington and Surrey, 1997; Dawson et al, 2013; Ettorre, 2004 and 2016; Malloch, 2004a and b; Wechsberg et al, 2008)

Feminist addiction literature provides valuable insight into the correlation between female PDU and traumatic experiences, and the lack of support in the archetypally patriarchal criminal justice and drug treatment systems (Bloom et al, 2003; Covington, 2008; Ettorre, 2004; Gottfried, 1998; Kaschak, 1992; Malloch, 2004a and b). Correspondingly, drawing from Alexander's (2010) theory of social dislocation and addiction<sup>7</sup> and the evidence discussed in Chapter 3, it is cogent to explore the influence of inequality and poverty (and as an exacerbator of these, neoliberal policies) upon women's trauma, addiction and recovery experiences. (Covington, 2008; Gottfried, 1998).

Critical domains for women that have been long neglected in the recovery industry include safe and stable housing, childcare, employment, caregiving responsibilities and the experience of violence, control, and abuse (Brown et al, 2000; Bush and Kraft, 2001;Covington, 2002; Falkin and Strauss, 2003; Grella, 2008; Groesnick and Hatmaker, 2000; McLellan et al, 1998; Reed, 1985 and 1987; Straussner and Brown, 2001) Women are also discriminated against in services by professionals and service users alike, experiencing stereotyping, neglect, and harassment (Ashery et al, 1995; Bush and Kraft, 2001; Neale, 1998; Nelson-Zupklo et al, 1996). Mulia (2002) has

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<sup>7</sup> As discussed further in Chapter 3.

illustrated how the unsuitability of mainstream treatment can influence women's responses to treatment interventions. This can manifest as resistance, for example through concealment of information, which may then be misinterpreted by professionals who infer manipulation, an assumption which can lower the quality of care for all women (Mulia, 2002).

One of the main reasons behind women's reluctance to engage with services is the assumption of PDU and SSW<sup>8</sup> mothers' inherent risk (Brady and Lydiard, 2021; Clapton et al, 2013; Sharpen, 2018; Taplin and Mattick, 2015). Motherhood is arguably bound up with drug use, socioeconomic status, and deviance by a society preoccupied with regulating reproduction and prioritising the infant (Ettorre, 2007; Featherstone and Gupta, 2018; Davies and Krane, 2006; Moore and Measham, 2014). This is embodied in the condemnation of SSW and PDU mothers in policy, practice, media and society and, through internalisation, by women themselves (Ettore, 2007; Reeves and Campbell, 1994; Reinerman and Levine, 2004). A bleak illustration of this in the UK is in attempts to incentivise (financially or by withholding treatment) sterilisation or use of long-term contraception among women with multiple children in care (Logan, 2019; Olsen et al, 2014; Taylor, 2010).

While motherhood has been argued to amplify the surveillance and intervention of the state, women's class and status can serve as protective factors, as evident in media coverage. Young, white women from 'respectable' backgrounds indulging in recreational drugs, such as Gabrielle Price and Leah Betts are framed as 'tragedies', as victims, and their lives eulogised (Moore and Measham, 2014; Taylor, 2008). However, I.V drug user deaths and those of women from lower socioeconomic backgrounds are rarely covered and when they are, like the deaths of SSW, they are often devoid of pictures or family testimonials (Jiwani and Young, 2006; Moore and Measham, 2014; Strega et al, 2014; Taylor, 2008).

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<sup>8</sup> SSW and PDU women often occupy the same spaces, and it is impossible to discuss one without the other in these contexts. We will undertake a more focused consideration of SSW in 2.4.

The use of certain drugs is also subject to gendering with heroin especially perceived as a 'masculine' drug and so especially deviant for women (Ettorre, 1994). Consequently, female heroin users are excluded from *womanhood* '*representing femininity misplaced and defiled....she is characterised as an impure woman, an evil slut, or a loose female*' (Ettorre, 1994, p. 78; Colten, 1979). Furthermore, the embodiment of women's heroin addiction (for example track marks, emaciation) publicises their non-compliance with expectations of feminine physicality including cleanliness, fertility, and submission (Colten, 1979). Consequently, they are further demonised as their 'female visibility' becomes a challenge to societal norms (Ettorre, 2008, Moore and Measham, 2014). Accordingly, as these women do not 'fit' into the accepted modes of womanhood (*'good worker, wife, mother, and consumer'*), they are not afforded the few protections granted to women who do conform (Acker, 2002; Moore and Measham 2014, p. 7)

Women are also marginalised within drug using populations. Partly due to the policing of criminalised marketplaces and communities, women's opportunities are predominantly limited to that of drug mules and street sex workers (Anderson, 2005; Maher and Daly, 1996). This disbars women of low- income and status from the dialogues of gendered resistance and empowerment that accompany discussions of, for example, women's recreational drug use in the club scene (Erickson et al, 2000; Fleetwood, 2011; Jacobs and Miller, 1998; Maher and Daly, 1996; Moore and Measham, 2014). Maher and Daly (1996) observe how male monopoly and violence restrict the 'choices' of homeless female drug users, indicating the pervasive impact of the patriarchy at all levels (Anderson, 2005). Consequently, the risks of being a visible street-homeless woman are amplified due to women's fiscal survival being mostly dependent upon street sex working (Maher and Daly, 1996; Watson, 2011).

A further significant factor in women's addiction, as we have touched upon, is Trauma and C/PTSD<sup>9</sup> due to interpersonal experiences (Covington, 2008; Dass-Brailsford and

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<sup>9</sup> This thesis discusses PTSD and CPTSD and uses C/PTSD when referring to both or where a confident diagnosis cannot be made.

Myric, 2010). At the time of writing trauma is gaining presence, though has yet to be operationalised to any great effect on a broad scale, for example through nationwide localised networks. Complex Post- Traumatic Stress Disorder (CPTSD) refers to the natural responses of the brain and body to perceived or actual *repeated* threat of harm to body and life (Bressler et al, 2018; Herman, 2015; Van der Kolk, 2015). Symptoms include flashbacks, the inability to form and maintain close, safe relationships, dissociation and self-numbing (often with drugs and alcohol), hyper vigilance and emotional dysregulation (Covington, 2008; Herman, 2015; Van der Kolk, 2015). This can cause victims to oscillate between bouts of rage and total dissociation and numbness, and its effects permeate every aspect of their lives (Herman, 2015; Van der Kolk, 2015).

The collective evidence base certainly suggests a relationship between traumatic experiences and women's PDU (Anakwenze and Zuberi, 2013; Covington, 2008; Najavits et al, 1997; Thomas and Bull, 2018). Najavits et al (1997) demonstrate this correlation through an evidence review, concluding between 30% and 59% of PDU women have experienced trauma from childhood and from ongoing physical and sexual abuse. This is more than double the rates among male substance abusers and higher than among women in general (Najavits et al, 1997). There also appears to be an intergenerational element to PDU women's trauma, with developmental trauma (including Adverse Childhood Experiences (ACEs)) significantly more likely among women from families with histories of PDU, and psychological difficulties more prevalent among the children of parents who were exposed to ACEs (Haynes et al, 2020; Najavits et al, 1997) . Furthermore, the lifetimes of victimisation women disproportionately suffer often result in symptoms of PTSD which then intersect with each other, amplifying vulnerability *to* and experience *of* PTSD (Brown et al, 1995; Fullilove et al, 1992 and 1993; Keane and Wolf, 1990; Resnick et al, 1993). Trauma also influences the severity of women's addiction, with more addictive and destructive substances such as crack cocaine and opiates being used to pursue optimum oblivion and dissociation (Back et al, 2000; Brady et al, 1994; Fullilove et al, 1993; Goetz et al, 2021; Goldenberg et al, 1995; Tschoeke, et al, 2019). This dynamic can also be entrenching as PDU women often occupy other stigmatised roles such as

SSW, and this can amplify feelings of exclusion and vulnerability. This contributes to the trapping work-use cycle of PDU and SSW as increasing substance use is needed to respond to burgeoning trauma (Najavits et al, 1997; Najavits et al, 2004; Ullman et al, 2013). The prevalence of trauma among PDU women and the incapacity of the system to respond is also significant, with the paucity of trauma-informed practice in services resulting in many women's PTSD going unrecognised (Holly, 2017; Jeal et al, 2015, 2017 and 2018).

## 2.4 'Fallen Women' : Street Sex Work

One of the main roles of the state is to address (as per Bacchi (2012 and Foucault (2009)) and *define* 'social problems', of which, in the UK, one that primarily relates to women, is that of street/ survival sex work (SSW)<sup>10</sup>. How these problems are defined, historically and currently, influence how they are responded to in the architecture, components and the lived realities of women's experience in society. This has real consequences for the equality and equity of support and access to opportunity for SSW.

Although sex work isn't illegal, associated behaviours including soliciting, loitering and brothel keeping (which encompasses working indoors with one other person as support) are legislated against (Campbell and O'Neill, 2013) . The visibility of SSW workers, the cooccurrence of chronic addiction and other crimes including 'anti-social behaviour' mean these women are more exposed to the attentions and interventions of the criminal justice system.

SSW is distinct, although not entirely separate from its indoor counterpart, in that the majority of street sex workers have multiple complex needs including PDU, PTSD<sup>11</sup>, poor physical and psychological health and lower engagement with mainstream

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<sup>10</sup> 'SW' is used to refer to sex work more broadly, for example in discussions of decriminalisation and law which should not/ do not differentiate

<sup>11</sup> This thesis discusses PTSD (post-traumatic stress disorder) and CPTSD (chronic post-traumatic stress disorder). Where both are discussed, C/PTSD is used. In the data where evidence suggests chronic PTSD, CPTSD is used

services (Allen and Balfour, 2014; Alschech et al, 2020; Jeal et al, 2015, 2017 and 2018; Mellor and Lovell, 2012; Park et al, 2021; Patel et al, 2020; Roxburgh et al, 2006; Sanders, 2009b). It is also distinct from indoor street sex work in terms of the severity of multi-level stigma, criminal justice interventions, drug use, and most notably, risks and trauma, whether from clients, strangers or partners (Benoit et al, 2015; Church et al, 2001; Cusick et al, 2011; Deering et al, 2014; Jeal et al, 2015, 2017 and 2018 ; McKeganey and Barnard, 1996; Sanders, 2009b; Shdaimah and Leon, 2016; Tomura, 2009). A further differentiation is in the extent of choice ; while indoor sex workers cite a variety of motivations and may be guided by set financial and career goals, SSW are almost entirely compelled by addiction and poverty (Lucas, 2005; Murphy, 2010; Sanders, 2013; Spice, 2007; Weitzer, 2010). Furthermore, SSW are less able to negotiate the conditions of their work, including condom use, screening, refusing clients, negotiating fees and services and feeling able to report crimes to police (Campbell, 2010; Lucas, 2005; Spice, 2007; Sprankle et al, 2018; Weitzer, 2010). SSW is also conceptualised as a social problem conflated with crime, disease, moral corruption and the destruction of communities (Charcourt et al, 2005; Gibbs van Brunschot, 2003; Gurd and O'Brien, 2013; Sanders, 2009a). Although in some areas police action has directed street sex workers off-street and into 'brothel work,' the distinctions discussed above persist (Sexton 2003 and 2009). As the essence of this is the level of need and desperation, in this research 'street sex work' is used interchangeably with 'survival' sex work, reflecting the realities of participants who had been involved in sex work for survival in a range of settings.

The ways in which sex work and sex workers have been and continue to be treated in policy and practice is underpinned by ideologies and policies that, as with addiction, are not without tensions and contradictions (Lee, 2015; Shdaimah and Wiechelt, 2013). O'Neill and Seal (2012, p. 62) point out that although the act of selling sex is and always has been legal, sex workers are demonised as *'immoral, a danger, a threat to 'normal' femininity, and as a consequence suffer social exclusion, marginalisation and 'whore stigma'*.

It is then pertinent to preface further discussion with a note on the semantics of the field. Discourse and practice are fiercely divided over linguistic definitions that signify

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differing theoretical and legal positions, with opposing factions debating the suitability of 'sex work' over 'prostitution' and of decriminalisation or criminalisation of sex buyers (Krusi et al, 2014; Mathieson, 2015; McBride et al, 2021; Sanders, 2009a; Van Wesenbeeck, 2001). These stances consider sex work/prostitution either a liberal denial of the harms and violence intrinsic to the experience of prostitution or a denial of the feminist right to a legitimate career from transactional sex (Carlin, 2015; Moran and Farley, 2019; Scoular, 2010; Scoular and Jeffreys, 2010).

Theoretical explanations for SW tend to focus on survival/street sex work and be preoccupied with micro level explanations which, whilst acknowledging external factors, do not centre them (Scoular, 2015; Weitzer, 2005 and 2009). While some radical feminists do acknowledge structural factors, considering sex work a manifestation of gender inequality, a great proportion of the literature is preoccupied with the individual (Van Wesenbeeck, 2001; Weitzer, 2005 and 2009). The treatment of sex workers as victims in policy and practice is also conflictually paralleled in its simultaneous individualisation and responsabilisation (Scoular, 2015). Approaches from the criminal justice system especially draw upon historical narratives of sex work as a deviant behaviour or indication of lapsed or lost morals (Scoular, 2015; Weitzer, 2009). As deviance paradigms dominate much of the considerations of SSW, these are the focus of the following section (Armstrong, 1981; Bullough and Bullough, 1996; McCray et al, 2011).

#### 2.4.1 Sex Work as Deviance

One of the main conceptualisations of sex work is rooted in deviance theory. This does not *necessarily* connote pejoration or judgement but refers to a '*violation of societies or a group's norms that call forth censure, condemnation or a punishment for the violator*' (Goode, 2010, p. 110). Deviance then is concerned with the responses of societal audiences. Illustrated by social, political, and cultural attitudes, SW is one of the most dominant and frequently discussed forms of women's deviance (Gainford, 2017; Goode, 2010; Gurd and O'Brien, 2013; Lee, 2015; O'Neill and Seal, 2012; Stallybrass and White, 1986; Weitzer, 2005 and 2009).



The conceptualisation of sex work as deviance is not, however, a cohesive stance and operates subjectively and objectively for SSW and Indoor SW and is not without its own tensions. For example, the objective moral position embodied by criminal justice mechanisms considers punitivism a just response, for example where SSW face fines, community orders, or custodial sentences for actions indirectly or directly related to their sex work (Kantola and Squires, 2004; Klambauer, 2018; Monroe, 2005; Phoenix, 2008; Sanders, 2005b and 2017). Sex work is also viewed through a *subjective*<sup>12</sup> moral perspective, with particular censure reserved for SSW, demonstrating the intersection of audience and status with societal response, where the most vulnerable, visible and impoverished are subject to the greatest punishment (Goode and Ben-Yehuda, 2010; Hubbard and Scoular, 2009; O'Neill et al, 2008; Sanders, 2005b, 2009a; Williamson and Folaron, 2003).

The foundations of this application of deviancy can be traced historically in responses to sex work that emanate from patriarchal attitudes to women's behaviours and frame SW as a form of criminality and aberrant femininity (Lee, 2015; O'Neill and Seal, 2012.)

Previously, criminological treatise had remained somewhat silent about women. However, at the close of the late nineteenth-century, Lombroso's influential *La Donna Delinquente*, asserted that female criminality was solely due to biological, not social, factors (Bertrand, 1994; Gainford, 2017). Redolent of descriptions of those other notorious female deviants, witches, as wizened hags, Lombroso boldly claimed from his observations in prisons and asylums that the female criminal could be identified by her unappealing physical features. He claimed that 'degenerative abnormalities' such as moles, susceptibility to wrinkles and grey hair, excessive hairiness, extra teeth, and cleft palates were visual indicators of dangerous, abnormal women (Gainford, 2017, p. 10). This fixation on aesthetics belies the patriarchal, misogynistic notions of deviance that women are subject to, rooted in antiquated pseudo-scientific

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<sup>12</sup> Not supported by or endorsed in law but nonetheless an influential judgement  
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assumptions of women's innate inferiority (Bertrand, 1994; Gainford, 2017 ; Harrowitz, 1995; Horn, 2012).

Justified by this rhetoric, women were treated as chattel and physiological subordinates whose worth and moral propriety could be assessed according to visual and ultimately sexual appeal. The perpetuation of this is suggested in the discrepancy in treatment of indoor and survival sex workers, where greater protection is afforded to women who can work hidden from visibility and who are less likely to bear the aesthetic markers of poverty and addiction (Colten, 1979).

While Lombroso contradicted his own theory in his studies of sex workers in Moscow, finding them 'relatively, if not generally beautiful', he remarkably concluded that this was a criminological evolution in response to the 'requirements of sex work', granting these sub-species of women 'the beauty of the devil' (Bertrand, 1994; Gainford, 2017, p.10). Here, superstition and misogyny masquerade as science, depicting women's appearance as a supernatural device to lure otherwise good men into misdeeds.

Lombroso identified sexual maturity as another trait of the dangerous woman, claiming a correlation between early menstruation and criminality, especially sex work (Gainford, 2017). Thus, 'excessive sexuality' was noted to be a biological trait signifying deviance, even though in SW, female sexual behaviour is commodified by and reproduced in response to male demand (Sanders, 2005a and 2008).

The views of Lombroso and his successors persist today, especially for SSW who are subject to criminalisation and consequently punitivism which seems to echo archaic assumptions that criminal women are either '*masculine, mad and maladjusted to their roles in the family and labour market*' or else hopeless victims who are still subject to punishment (Gainford, 2017, p. 16; Horn, 2015) . Indeed, as Gainford (2017, p. 16) asserts, '*few crimes highlight the obvious misogyny quite like prostitution*', indicating that responses to SW are entrenched in historical gender discrimination, fears of unbridled female sexuality and women's commodification of it. The use of 'prostitution' as an umbrella term for any number of iterations of unacceptable femininity is evident in the seventeenth- century application of the term to encompass promiscuity, extra-marital sex, drinking and swearing (Bartley, 2000).

Visible female deviance as an affront to the sanctity, and propriety of 'respectable citizens' is paralleled today in anti-social behaviour orders, neighbourhood petitions and protests to councils about the noise, mess, infringement and risk perceived to necessarily accompany SSW (Hubbard, 1998 ; Hubbard and Sanders, 2003; O'Neill et al, 2008; Sanders, 2004; Scoular, 2015). These concerns tend to trump worries about SSW vulnerability. As Hubbard (1998, p.57) notes, the impact of this is the spatial exclusion of the 'disorderly, polluting prostitutes' who are relegated to the most deprived of environments where, ironically, they are at greater risk of victimisation. Through this intersection of social and legal ostracisation, SSW are branded deviant yet vulnerable and conversely their vulnerability is amplified as they are further relegated to the margins of society (Hubbard and Scoular, 2009).

#### 2.4.2 Victimhood and Feminism

A backlash to the moral condemnation of SW came from pioneering Victorian women including early suffragists and philanthropists who argued for pity and mercy for the 'common prostitute' (Lee, 2015; Scoular, 2015). This countering of the dominant patriarchal position can be argued to have paved the way for later feminist arguments presenting SW as victims in need of rescue (Scoular, 2015).

Feminist theories have since diversified and while united under the conceptual umbrella of feminism, some of the more popular perspectives are diametrically opposed. This division underpins the 'sex work is work' vs 'prostitution is paid rape' paradigm wars, concerned with whether transactional sex can ever be voluntary, a legitimate occupation or even anything other than abuse. These perspectives inform the treatment, support and services available to SW as commissioning patterns are often a reflection of dominant local and national political stances, as evidenced in mental health and sexual assault services (Simmonds, 2019).

Neo-abolitionists including Radical and Marxist feminists condemn SW entirely, whether or not the women themselves assert it to be a choice. This is couched in an understanding of SW as exploitation of and violence against women, (for Marxist proponents) by a capitalist and (for Radical Feminists) by a patriarchal society that

oppresses women, sexualises and commodifies their bodies and deems sexual access to them a male right (Monroe, 2005; Scoular, 2015; Wahab, 2004; Weitzer, 2000). Neo-abolitionists would hold that the capitalist patriarchy economically oppresses and exploits women, appropriating their sexuality and bodily capacity through commercialisation (Dobash and Dobash, 1979; Farley, 2005; Gerassi, 2015; Jean, 2015; Love, 2015; MacKinnon, 1982 and 1989; Weitzer, 2005 and 2012).

While this thesis agrees with radical feminist arguments that *survival* sex working is indicative of patriarchal socioeconomic oppression of women and exploitation of their vulnerability, the positions are not compatible. Radical abolitionist positions fail to acknowledge the complexity of the reality of sex work, imposing a reductionist framework that neglects to appreciate the spectrum of experience and degrees of volition across sex work. Abolitionist arguments also deny the agency of sex workers by insisting upon their inherent vulnerability and passivity rather than recognising the use of agency in sex workers' decisions, survival motivated or otherwise.

To the contrary, sex-positivists maintain that such arguments deny women's right to choose how they work and represent a reductionist understanding of SW by focussing overwhelmingly on trafficking and exploitation (Scoular, 2015; Weitzer, 2000). They contend that the reality of the spectrum of experience is of diversity, and that neglect of this replicates paternalistic viewpoints which conceive of criminalisation as the route to saving and freeing fallen women, whether they want 'saving' or have any other alternatives at all (O'Neill 2013 and 2017; Showden, 2016). Given the volume of SW<sup>13</sup> activist voices asserting that SW can be valid, voluntary, and empowering or that it may simply be the best of a not especially attractive range of options, neo-abolitionists can be accused of perhaps unintentionally, patronising and victimising SW by denying their ontological and epistemological validity; they simply don't know

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<sup>13</sup> Admittedly, most of these sex workers are not survival sex workers. For example, the English Collective of Prostitutes (ECP) are more focused on the eradication of poverty and inequitable government practice alongside arguing for the decriminalisation of sex work, perhaps indicative of their genesis as a cooperative for predominantly street based/survival workers (English Collective of Prostitutes, 2003).

what's good for them (Ferguson et al, 1984; Kesler, 2002; O'Neill, 2003, 2013 and 2017; Wolken, 2006).

This divergence in perspectives is also visible in systemic approaches, with greater funding directed to those who reflect the priorities of local commissioners (Simmonds, 2019). Services that operate from a harm reductionist standpoint focus on supporting women who choose to work to do so as safely as possible and advocating for their equal rights to police protection from abuse (Campbell and Sanders, 2021; Shah, 2004). Services whose focus is to rescue women from SW and ensure total 'desistance' may operate by insisting women's primary focus is exit and the provision of harm reduction support may be seen as encouraging continuation of sex work (Bowen, 2013; Campbell and O'Neill, 2013; Cusick et al, 2011). In the UK, the funding and commissioning of SW services, as with other voluntary sector organisations, is directed by the dominant politics and discourse of the locality. While all services necessarily work under the remit of the law, priority is accorded to those who pursue objectives which align with funders' stance and , depending on local government, the goals of the state (Crane and Dusenberry, 2004; Rekart, 2005). Sex positivism in turn receives its own condemnation, for purportedly encouraging sex work, despite empirical evidence indicating the influence of poverty and addiction on women's entry into SSW (Hughes, 2005; Potterat et al, 2001). Finally, the political economy perspective accords with Marxist Feminism in acknowledging socioeconomic deprivation and gender inequality in women's choices to sex work. Proponents are supported in their assertions by research demonstrating the prevalence of economic deprivation, poor housing conditions and lack of alternatives among SSW (Cusick, 2006; Farley et al, 2008; Miller et al, 2011; Valera et al, 2001; Van Leeuwen et al, 2004; Watson, 2011; Wilson and Butler, 2014). However, it is worth contextualising this against the overrepresentation in the literature of SSW or SW involving underage women (Weitzer, 2009). It is also harder to identify and access 'indoor' sex workers due to stigma and their greater ability to remain concealed, so figures on deprivation, while still significant, are not universally applicable. Therefore, policy and practice developed solely in response to this 'knowledge' can be critiqued as unscientific.

Marxist and political economy perspectives provide a valuable alternative lens through which to understand sex work in the context of political, socio-cultural and economic factors and thus counter individualising narratives. However, they do not capture the impact of epochs of neoliberalism in particular, nor do they provide a framework to assess the impact of contemporary political practices and capture the complexity of factors<sup>14</sup> at the heart of survival sex working.

### 2.4.3 Routes to The Street: Individual Journeys

Unlike with addiction, individual-level theorisations of sex work remain scant (Gerassi, 2015). Those theories that have been developed are predominantly concerned with processes of victimisation, entry, and exit, and have been critiqued for lacking in theoretical body and relying on descriptions of process (Gerassi, 2015). Reviewing four such studies, Gerassi (2015) describes their position as neo-abolitionist as they assert that SW is due to lack of agency and options. However, neo-abolitionism is not the only position that takes this perspective. Again, unlike with PDU, there is a greater recognition in sex work literature of deprivation and unmet need, lending support to the further development of a socioeconomic and environmental perspective.

Sanders (2007) has built on Mansson and Heddlin's (1999) exiting theory to provide a useful explanatory framework which places emphasis on structural, political and cultural factors in SW journeys. Sanders (2007) defines exiting reasons and typologies as follows: Reactionary (triggered by violence, ill health, life events); Gradual planning (via drug treatment therapy, welfare, rehoming, often supported by specialist services), and 'Natural' (also known as 'burning out' or reaching 'rock bottom', though this is contingent on alternative options). Finally, 'yo-yoing' refers to drifting in and out due to failed treatment/support and spells in prison. Baker et al (2010) expand upon this model to include structural and societal barriers and propose the use of their model to interrogate policy and practice, a useful suggestion that promotes the recognition of a range of factors.

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<sup>14</sup> Individual, social and systemic  
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My perspective is that rather than deny the agency of women, there is room for research that explores the choice of sex work as a valid position or a response to inequality in society, and that is likely to be influenced by a range of variables. I propose that the problem is not sex working but the variables themselves, and so this thesis considers the extent to which SSW can be viewed as a functional response to complex unmet need. An alternative interpretation of SSW and accordingly addiction is constructed throughout this thesis. The value of an alternative approach to add nuance and acknowledge the variety of experience within sex work is further illustrated by the tensions in the treatment of survival sex workers, to which we turn below.

This thesis forges a new direction theoretically, combining recognition of structural inequalities and the repressive state with understandings of a multifaceted conceptualisation of trauma and the validity of women's agency.

#### 2.4.4 Contrary Ideologies and Policy: Punishment and Pity

The political manifestation of victimhood/deviancy models can be detected in the shift in statutory responses to SSW from criminalisation to a purported welfare response (Scoular and O'Neill, 2007). The shift is, however, faithful to neither and continues to invoke contrary elements from both.

The similarity between the paradoxical helpless sick vs. wilful deviant treatment of (especially female) PDU is notable. One indicator of this conceptual inconsistency is the perpetuation of SSW's subjection to the conditionality and control inherent in previous more punitive approaches (Scoular and O'Neill, 2007). This is illustrated by the criminalisation of soliciting and use of anti-social behavioural orders, where police interventions force women into riskier situations in their attempts to avoid fines, arrest, and community orders (Hubbard and Scoular, 2009; Penfold et al, 2004). Campbell and Storr (2001) have illustrated how the use of fines to deter SSW merely traps women in work to pay fines, while Penfold et al (2004) argue that ASBOs marginalise SSW further by forcing them to work unsafe hours and spend less time screening and negotiating with clients. This means SSW are pushed into working in

more isolated areas and unable to collaborate with others to look out for one another's safety, placing them at greater risk (Barnard, 1993; Brewis and Linstead, 1998; Cusick and Martin, 2003; Hubbard and Scoular, 2009; Lynch, 2015; McKeganey and Barnard, 1996). Moreover, managed tolerance zones, as was previously in Holbeck, Leeds, have been illustrated to reduce stigma, increase SSW's ability to exercise safety precautions and to access support (Penfold, 2004; Roach et al, 2020; Sexton, 2003).

However, the current political narrative veers away from harm reduction, favouring more coercive measures such as conditional drug treatment orders through Engagement and Support Orders, or 'forced welfarism' (Cusick and Berney, 2005; Sanders, 2005b; Scoular and Carline, 2014, p. 104; Scoular and O'Neill, 2007). These approaches can be challenged for taking a binary view that treats addiction as the cause of survival sex work and neglects to explore the broader reasons behind addiction in the first place. Instead of adopting a broader lens, a symptom focused approach assumes that individual willpower and medical stabilisation can obviate the need for addiction and, by proxy, SSW.

This fixation of policy and practice bifurcates its treatment of SSW by offering social inclusion to those who responsibly exit and 'resume' normal lifestyles, and continued exclusion to those who remain involved in SSW, who become legally constructed and reproduced as anti-social (Scoular and Carline, 2014; Scoular and O'Neill, 2007, p. 765).

It is appropriate to remark that the *shift* to welfare responses is just that and elements of punitivism remain and resurface, reflecting the contradictions that simultaneously deem SSW victims and deviants<sup>15</sup>. Scoular and O'Neill (2007, p. 764) observe that *'closer examination reveals more expansive forms of control, which are often masked by the emphasis in government rhetoric upon 'inclusion', participation' and active*

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<sup>15</sup> For example, 2021 saw the closure of Leeds's Holbeck Managed Area in response to campaigns led by an organisation with personal connections to an architect in charge of the redevelopment of the land in the designated 'Safe Working Zone' for street workers (Hardy and Caradonna, 2021). These campaigns argued against a welfare-based response, despite depicting the women working in the area as victims



*citizenship*'. Despite a change in government from New Labour through a Coalition to Conservative rule, this persists contemporarily, reflecting the embeddedness of neoliberal individualisation and responsabilisation of 'social problems' (Ashbee, 2015; Scoular and Carline, 2014).

These approaches to SSW echo that of desistance theory, which places responsibility on the individual for their redemption and rehabilitation. Traditional desistance theory, popular in criminological circles, exemplifies this individualisation and the use of conflicting, co-occurring definitions of SSW as both a deviant choice and a form of victimisation (Barr, 2019; Matthews et al, 2014). This theory and its applicability to SSW is further discussed below.

## 2.5 Desistance

Akin to New Recovery yet with a criminological genesis, desistance theory proposes a strengths-based model to explain the processes by which people cease offending and reintegrate into 'conventional society' (Bevan, 2015; Maruna, 2001, 2010 and 2012; Paternoster and Bushway, 2009). It is a similarly value-laden construct too, encapsulated by Maruna's (2001, p.12) assertion that the role of the probation officer is to get an offender 'employable and marriageable'! Desistance is likewise focused on changes that benefit the state, such as the reduction of criminalised activity and increased economic contribution, a change presumed to be underpinned by a transition to a 'pro-social' identity (Barr, 2019; Bevan, 2015; Paternoster and Bushway, 2009).

Various explanations for desistance have been levied, incorporating ontological, sociogenic and maturational theories that give credit to biological and sociological processes (Bevan, 2015). These include 'growing out of it,' finding employment, marrying, having children and realising a 'prosocial identity' (often correlated with acting upon opportunities for 'redemption' or 'giving back' (Farrington, 2018; Giordano et al, 2002; Glueck and Glueck, 1974; Maruna, 2001, 2010 and 2012; Sampson and Laub, 1992). Similarly to New Recovery, it also focuses on the individual's realisation of assets to compensate for the deficits of criminality yet does

not confront the reality of the political landscape which as we discuss in Chapter 3, has actively undermined assets systemically, in communities, and individually.

As with recovery, desistance theory has also developed from a predominantly 'male and pale' origin, with most of the research concerned with the experiences of men (Barr, 2017 and 2019; Rodermond et al, 2016; Wincup, 2016). Nonetheless, Matthews et al (2014) have applied desistance theory to 'sex work exiting', claiming that processes of 'growing out of', 'getting fed up with' or finding alternative, more important occupation explains the routes by which sex workers move on. However, the authors conflate street and indoor sex workers, a position which, as discussed in 2.6, is untenable given the differences between the two (Sanders, 2009b). Matthews et al (2014) do remark that a core feature of desistance, identity shift, is not relevant as techniques of compartmentalisation and dissociation employed by sex workers mean they never consider themselves an 'ex', any more than 'sex worker' comprised a core component of their identity. This compartmentalisation is attested to by findings that suggest sex workers employ acting and other strategies to preserve their identity (Abel, 2011; Sanders, 2005a; Simpson et al, 2012).

Matthews et al (2014) can also be critiqued for their focus on the individual's motivation and efforts. As with desistance broadly, this doesn't acknowledge the importance of the availability of assets and opportunities. nor the increasing paucity of these in the aftermath of austerity and the ongoing marketisation of public services (Greer Murphy, 2017).

By echoing Fomiatti et al's (2019) critique of New Recovery and applying Law's (2013) simplification practices we can similarly deconstruct and critique desistance theory, especially its applicability to sex working.

Desistance is argued to practice *deletion* in its omission of the roots of trauma, systemic and structural factors from its considerations. Desistance guidance for practitioners attest that workers must help offenders 'go straight' by offering guidance and 'direction action' to address social problems (Farrall, 2002). This is premised on the assumption that motivation and existing resources are sufficient to empower offenders to change their lives and identity (Farrall, 2002; McCulloch, 2005; Page | 48

Graham and McNeill, 2017; Rex, 1999). The theory that desistance occurs in response to 'hooks to change' (assets and opportunities) that are 'reacted positively to,' much like New Recovery, appears to place complete onus on the individual. This discounts their socioeconomic and environmental circumstances and presumes the existence of assets (Giordano et al, 2002). As we will see in Chapter 3, political practices that have escalated under Thatcher and with renewed vehemence over the last decade have significantly undermined the availability of resources and opportunities, particularly for marginalised communities.

By ignoring the impact of deprivation, desistance also overlooks the reality that many women in the criminal justice system are there for survival 'crime' in response to poverty and grounded in histories of inequality (Clarke and Chadwick, 2017; Earle, 2018; Malloch, 2004a and b). By depicting SSW as a behaviour to be desisted from, desistance also opposes decriminalisation of SW overall. This arguably obstructs opportunities for harm reduction and the advancement of rights for sex workers which, it can be argued, would undermine their capital (Bourdieu, 2011). If the definition of rehabilitation or recovery is asset realisation, then surely interventions that limit the attainment of progress and opportunity, aka, capital, are illogical.

**Selection** processes operate in Desistance's focus on a single 'problem' rather than the realisation of a holistic understanding of causes and needs. Consequently, cessation of SSW is viewed as a triumph due to the adoption of 'pro social behaviour.' This assumed relationship between SSW and behavioural dysfunction neglects to acknowledge the improvements in, for example, economic stability that can afford street sex workers the freedom to move on (Sanders, 2007). It also presumes that the 'offending behaviour' is beneficial beyond serving as a survival strategy, and that the street sex worker views themselves as in opposition to the mainstream. Contradicting this, Reeve (2013) has found that SSW women identify themselves as mothers, friends, and partners regardless of how they financially support themselves.

By **framing** SSW as a deviant behaviour and as a crime, desistance operates a reductionist understanding that may succeed in producing monitoring tools and frameworks for the criminal justice system but reduces the complexities of human

needs and agency to quantifiable outcomes. Relatedly, while Desistance is a popular term in criminology, more has been done by way of promising how to achieve it than exploring the full narratives and subjectivities of people who do ‘desist.’ This framing is also flawed in its dichotomisation of ‘persisters and desisters’, ignoring the vacillation involved, especially in SSW’s ‘yo-yoing’ or working to meet a specific target or need (McNaughton and Sanders, 2007; Reeve, 2013; Sanders, 2007).

Desistance theory’s *ranking* prioritises outcomes that are of benefit to the state and services, such as reduction in ‘offending’, as opposed to supporting individuals to meet their self-defined goals.

Finally, *juxtaposition* is operational in arguments that ‘tertiary’ or complete desistance is contingent upon being perceived and treated by society as acceptable (Graham and McNeill, 2017). Tertiary desistance theory perpetuates normative expectations that increasingly stratify society’s most vulnerable into deserving and undeserving, hinging their worth upon social acceptance by the mainstream.

Therefore, much like the dichotomisation of harm reduction and recovery, desistance’s position as a positive psychological counterpart to models that observe risk factors can be critiqued for failing to acknowledge the complexity of people’s realities, especially those of marginalised women.

It appears that desistance and other individualising models continue to tell ‘the same old story’, where social control is exerted through individualising processes that responsabilises the individual for their adversity. Although policy documents pay discursive heed to poverty, abuse and other markers of deprivation, these factors remain subsidiary in the dominant ‘integrated exiting model’ (Cusick et al, 2013; Hester and Westmarland, 2015). Political exit strategies continue to be dominated by ‘*individualistic and responsabilising social interventions*’, redolent of desistance, mandating re- education, economic participation and drug treatment (Scoular and O’Neill, 2007, p. 769). Consequently, disadvantage and exclusion are no longer viewed as structural inequalities and social processes mostly beyond individuals’ control. Instead, they are reframed as ‘criminogenic needs,’ individualised crime risk factors

or merely 'private troubles', all of which are experienced, managed and controlled on an individual basis. (Kemshall, 2002, p. 48)

## 2.6 Conclusion

This chapter has explored the ways the dominant models underpinning responses to SSW and PDU can be critiqued. These models appear fraught by inconsistencies and areas of neglect, including the expectation of change through asset realisation that fails to recognise the varying availability of said assets. Both approaches also isolate the symptom rather than exploring the broader context and digging deeper to identify the cause.

Having explored these models and levied critiques regarding their suitability, in the chapters ahead we broaden our horizons. In the Analytical Framework, we adopt a wider lens through which to search for the cause, examining the role of political and socioeconomic factors. We proceed to turn our attention to alternative theories and examine whether these could offer a more suitable framework for understanding and responding to SSW and PDU.

## 3 Analytical Framework. Spiritual, Material, and Psychological Deprivation and Criminalised Responses

We have unearthed in Chapter 2 what appear to be significant areas of neglect and silence in the dominant models concerning SSW and PDU. Most notably, despite decades of investment in the industry, none has produced a solution to the burgeoning modern tide of problematic drug use (PDU) or survival sex working (SSW). Nonetheless, each model has its vehement faithful who champion their stance as 'evidence based'. This evidence is often a promising statistical implication or politically appealing correlation rather than an insight into the complex realities of people's lives and how these are affected by systemic and structural factors (Duke, 2013; Lancaster, 2016). Therefore, perhaps these bubbles of evidence omit to illustrate the lives of individuals and their choices *in the context of* their history, environment and unmet

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need: and in doing so neglect to develop appropriate policy and practice which recognises this *whole* .

A significant historical factor that the models detailed in Chapter 2 do not acknowledge is the pervasive impact of ongoing and mounting deprivation and inequality. This chapter explores the impact of forms of governance and policies that perpetuate these whilst diminishing the responsibility of the state. We will then explore the potential of models that are informed by these considerations and their applicability to women's PDU and SSW.

We have seen that individualising theories and their related tools may suit certain political purposes but appear inadequate in capturing the impact of inequality and promoting the democratisation of the genuine assets of change. This chapter focuses on Neoliberalism and, relatedly, austerity politics, an offshoot of Neoliberal governance that is argued to have inflicted enormous hardship on public services and marginalised communities over the past 12 years<sup>16</sup>. Individualising models such as 'New Recovery' appeal to current political rhetoric that, as we will see in Chapter 5.4, divorces the circumstances of the individual from the environment created by the state. Similarly, theories of moral and behavioural dysfunction such as desistance can be accused of failing to recognise the root cause and ultimate function of SSW, namely as a functional response to unmet need. Accordingly, we will begin this chapter with an exploration of the relationship between socioeconomic deprivation, SSW and PDU, demonstrating the ways SSW and PDU can be conceived of as coping strategies in the face of unmet need.

We will then turn further attention to the specifics of recent policies in the UK which have exacerbated deprivation and undermined public services' capacity to respond effectively to those most vulnerable. Throughout this chapter I construct an alternative perspective from which to interrogate the findings of this research; not

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<sup>16</sup> Austerity measures began in practice in 2010. The current government claims austerity is over and has invested in some measure in terms of COVID-19 and the cost-of-living crisis. However, this is a short-term fix and paltry contribution given the magnitude of inequality and the long term investment required to effect meaningful change (The Financial Times Editorial Board, 2022)

only are SSW and PDU correlates of deprivation, but both the criminalisation and responsabilisation of these by the state further contributes to that deprivation and need.

### Co-dependent Relationships: Poverty, Problematic Drug Use and Survival Sex Work

To redress the narrow focus critiqued in Chapter 2, it is first important to understand the enmeshed and multi-directional relationship between PDU and SSW in contemporary society. Sex work has always operated as a fiscal survival strategy, though this has gained a contemporary urgency and dimension with the modern ease of access to drugs and the increasing inequality and poverty since the election of Thatcher in 1979. Historically and broadly speaking, sex work has certainly helped women negotiate or lessen poverty and lack of opportunities.

However, it is argued that the seeming unebbing tide of addiction seen in Neoliberal (Post-Industrial, Western) societies currently is a consequence of exacerbated poverty and social dislocation (Alexander, 2008 and 2010). Alexander (2008 and 2010) and Wilkinson and Pickett (2010) argue that where poverty and inequality increase, so do stress-responses, which include PDU. This exacerbation is not solely related to poverty but the exacerbation of poverty *and* equality and the *visibility of this*<sup>17</sup> due to the ascent of Neoliberal policies, especially through the impact of austerity over the previous 12 years.

## 3.1 The Socioeconomic Lens: Neoliberalism, Social Dislocation, Deprivation and Poverty of the Spirit

Inspired by the Rat Park experiments which showed that living conditions and environment influenced the degree to which rats would use cocaine, Alexander

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<sup>17</sup> For example, the privileging of technological and material advancement has arguably contributed to a more widespread perception of understanding of 'how the other half live'. Certainly, the more and less privileged classes' understanding of the other is distorted through selective portrayal and the lens of capitalism, but the feeling of access to and therefore knowledge of others' lives can feel profound. Through television, the internet and social media, inequality has taken on a visual dimension and vividness that perhaps it did not have when cross-class experiences of one another were isolated to limited 'real life' encounters or anecdotes.

(2008, p. 12) developed a theory whereby addiction is a consequence of deprivation and social dislocation<sup>18</sup>. Alexander (2008) theorised that these factors are exacerbated by neoliberalism's prioritisation of economic success and individualism at the expense of the democratisation of wellbeing. The rats lived a traumatic existence; kept in isolation with no opportunities or even room to turn, they would use cocaine compulsively, indicating addictive behaviour. For the first time, drug use as a disease or dysfunction or even as *addiction at all*<sup>19</sup> was questioned, and instead proposed as a coping strategy in the face of pain and deprivation (Gage and Sumnall, 2019).

Inequality and social dislocation are demonstrated to be exacerbated by neoliberalism, a socio-political system which prioritises material wealth and over social rights and bonds, and responsabilises the individual for 'social problems' (Holmwood, 2000; MacGregor, 1999; Springer et al, 2016; Thorsen and Lie, 2006). Where Polanyi spoke of '*psychological and social separation from one's society*' when defining social dislocation, Alexander speaks of 'poverty of the spirit' (In Alexander, 2010, p.59). However, both describe a consequence of the dominance of individualising discourses and fracturing of traditional communities that are attendant to neoliberalism. Alexander argues that this dislocation arises as people are fundamentally unable to meet the expectations of the state while addressing those of their community and fulfilling their own desire for personal meaning and belonging (Alexander, 2010). Holmwood (2000) and Polanyi (1994) condemn the 'utopia' of the notion of self-regulating markets threatening as necessarily imperilling the security of social rights. These modes of governance view state provided services as overly bureaucratic and interventionist, insisting that self-regulating markets can cater to every human need and whim while promoting individual self-realisation and

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<sup>18</sup> Social Dislocation' is a term used by Polanyi (1944) and Alexander (2010) to describe the injury done by neoliberalism and free market politics to psychosocial integration (the ability of humans to live 'simultaneously in close cooperation and individual creativity')(Levine, 2009, p.7)

<sup>19</sup> I will continue to use the terms 'problematic drug use' and 'addiction' throughout as these are established in policy, practice and used by the women themselves. This does not indicate my agreement with medical or behavioural explanations of addiction as opposed to compulsive self-medication



resisting the coercion and homogenisation of state intervention (Barry, 1990; Holmwood, 2000). This is a form of 'laissez faire' capitalism where markets are given freedom by the state in order to encourage economic and productive excellence (Barry, 1990; Holmwood, 2000; Thorsen and Lie, 2006). The level of income generated and received in the commodification of land, labour and money arguably reflects the 'indispensability' of their services to those who control the markets (Furniss, 1912, p. 199). This means that a sector of the population must accept low wages and inequality due to their assumed lack of effort and the low value of their goods and labour. This accepts the impoverishment and oppression of a portion of society so that those who are able to participate can flourish and most importantly, so can the national economy. Applying this to what we have explored regarding the circumstances of PDU and SSW women and the expectations of the state, there appears to be a contradiction. The state may expect PDU / SSW women to recover and atone through self-propelled capital realisation. However, it inhibits the possibility of this by embracing a model that is stoic towards its inherent inequality and the consequent impoverishment of marginalised communities and the systems that erstwhile would have supported them.

To realise this vision of the optimisation of individual freedoms and entrepreneurialism, the 'small state' is the ideal; where government intervention occurs only to preserve the sanctity and scope of economic markets (Alexander, 2008; Holmwood, 2000; Thorsen and Lie, 2006).

Accordingly, legal systems are tasked with preserving privatisation and enforcing contracts rather than protecting democratic rights and supporting society's marginalised (McCluskey, 2003). As a result of this retrenchment, inequality burgeons whilst corporations thrive in an increasingly unregulated economic climate (Alexander, 2008; Holmwood, 2000; McCluskey, 2003; Polanyi, 1944). The pursuit of success in this climate requires total focus by the individual on the self at the expense of traditional loyalties such as those to family, religion or community which in some welfare regimes previously stood in lieu of state support (Esping-Andersen, 1990). Against this backdrop of ongoing social erosion and inequality, alternative models such as Alexander's 'Poverty of the Spirit' propose that PDU serves as a flimsy

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substitute; an adaptive behaviour designed to compensate for the lack of communities' and individuals' psychosocial integration (Alexander, 2010, 2008; McGarvey, 2019).

The costs of neoliberalism to marginalised communities described by Alexander (2010) and Polanyi (1944) are argued to be correlated with criminalised survival behaviours. It is inequality that is key here; while material poverty and social dislocation often co-occur, they are not synonymous and indeed the former can purportedly be borne without *spiritual* poverty (social dislocation) if communities are united and integrated, (Alexander, 2008 and 2010; Wilkinson and Pickett, 2010). However, when poverty, inequality and social dislocation occur in tandem, the consequences are, it is argued, unbearable; *'despair, shame, emotional anguish, boredom, and bewilderment'* (Alexander, 2008, p.59). Attempts to numb these unbearable symptoms are argued to include *'...suicide, and less direct forms of self-destruction'*, most germanely, problem drug use (Alexander, 2008, p. 59; Bourdieu, 2003; cf. Chandler and Lalonde, 1998; Chandler et al, 2003; Gosline, 2007). While these governmental practices continue to impact communities in this way, Alexander (2008, 2010) proclaims that theories of recovery and rehabilitation can do no more than pick up the pieces. Accordingly, discourse which places the responsibility for PDU and SSW on the individual can be considered to justify and contribute to even greater retrenchment of support for marginalised communities, who are in turn further blamed for their survival responses.

This politicised retrenchment of support and associated individualising narratives are embodied by austerity politics in the UK, as discussed in 3.3. Although austerity is accompanied by incitements for communities to band together in a 'Big Society' to restore the landscape, the proponents of the alternative models we have discussed would likely argue otherwise (Alexander, 2010; Polanyi, 1994). Instead, they argue, equality of assets, safety and opportunity comprise the salve through which communities may heal however, these are withheld by the ethos and policies of neoliberalism and austerity. (Alexander, 2008, p. 60; Polanyi, 1944).

As seen in 3.1, the evidence suggests a relationship between inequality, poverty, PDU and SSW that denotes correlation if not causation. If we are guided by the aforementioned theorisations of the impact of neoliberal governance, then no model can provide a solution to criminalised behaviours except one which mitigates the struggle and trauma of existence. An alternative perspective informed by this would suggest that PDU and SSW can better be understood through the lens of *need*, need exacerbated by a state that castigates marginalised populations for their responses to the deprivation amplified by that same state.

Accordingly, this research explores women's lives from their perspective, examining the motivations and histories behind their PDU and SSW, and the extent to which environmental and socioeconomic factors were influential. Drawing on Polanyi (1944) and Alexander (2010), the consequences of inequality and deprivation for marginalised women will also be explored in terms of the extent to which the responses and practices of the state can be argued to have helped or hindered them during their addiction and their pursuit of recovery.

We now turn to an exploration of austerity politics which embody a particularly stringent arm of the renewed neoliberal assault against marginalised populations over the last 12 years.

### 3.2 Austerity Politics and The Welfare State

Austerity measures were presented to the public as a crucial response to the 2008 recession but also underpinned by desires, inflamed under Margaret Thatcher's Conservative government<sup>20</sup> to continue the reduction of the responsibility of the state for supporting deprived populations (Jessop, 2015; Peck, 2010; Peck and Tickell, 2011). This aim and the associated policies have been pursued with ferocity in the contemporary iteration of Thatcher's economic and social upheaval, beginning in 2010 with the election of the Osbourne-Cameron coalition government (Loopstra et

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<sup>20</sup> In turn encouraged by Reagan's pursuit of national privatisation and economic deregulation in response to the 'stagflation' of the 1970s (Peck, 2010).

al, 2015; Macleavy, 2011; Mendoza, 2014). Austerity politics are discussed here in the context of their impact on unmet need and women's ability to redress these needs in socially acceptable, safe ways. As we will see, the effects of austerity are consequential for PDU/SSW women in several ways, through cuts to funding, the privatisation of public services, increasing conditionality of support and the overall amplification of deprivation. Austerity provides all the ingredients to further exacerbate the social dislocation described by Alexander (2008 and 2010) and Polanyi (1944) as a by-product of neoliberalism.

As we have seen, there is a well populated evidence base concerning the relationship between trauma and women's PDU (Brown and Wolfe, 1994; Covington, 2008; DassBrailsford and Myrick, 2010; Najavits et al, 2004; Ullman et al, 2013). We note in 3.3.2 and 3.3.3 that austerity measures have inflicted practical and psychological hardship and that resultantly there is a correlation between austerity and women's experiences of violence. Consequently, the evidence could underpin the development of an argument linking austerity, women's trauma and their PDU. Furthermore, austerity has also fractured the landscape of services that support women, leaving them more vulnerable; as we see in 3.4, austerity has also reduced women's economic power and opportunities, increasing the likelihood of SSW a survival strategy for PDU women especially (Monroe, 2005; McKeganey, 2006b; Reeve, 2013). Accordingly, in the remainder of this chapter I propose an alternative model to the pathologising, moralising mainstream. Rather than the preference of a maladjusted individual, SSW and PDU are examined by this thesis as responses to unmet need that is exacerbated by the rise of neoliberal policies and, further so by the impact of austerity and attendant continuation of individualising, responsibilising discourse.

Pertinently, Bramall et al (2016) define austerity as a political practice, noting that while conceptualisations of austerity, even from its opponents, vary, all essentially agree that austerity involves severe cuts to spending on public services (Bramall et al, 2016, p. 120). In this thesis, 'austerity' and 'austerity politics' denote the UK experience of 12 years of Conservative funding cuts, stringent benefit sanctions, the responsibilisation of social problems and increasingly explicit discourse on the deserving and undeserving poor.

### 3.2.1 The UK Austerity Measures

Conditionality and sanctions have been features of the British welfare state since 1911, and the individualising discourse of neoliberalism as we know it began its first epoch under Thatcher (Briggs, 1961). However, these took on greater centrality and severity following the 2010 Coalition Government's reforms, culminating in the 2012 Welfare Reform Act (Cerny, 2008; O'Hara, 2015; Reeve, 2017). The retrenchment of resources, conditionality and eligibility criteria guarding sources of support have had significant impact and it is important to consider these when contextualising the lived experiences of women today.

The practice of austerity has been accompanied by a justification of the assault on the democratisation of rights and basic resources; this has been presented as a vital response to the scroungers and shirkers caused by the 'soft' and 'irresponsible' ideals of preceding governments (Hart, 2010; Jessop, 2015; Mendoza, 2014; Stewart, 2016; Thomas, 2016). This narrative has also been employed to rationalise the DWP's use of 'psychology and the politics of fear' to dissuade claimants and evoke public support for the increasing retrenchment of welfare (Stewart, 2016, p. 6). 2012 heralded the introduction of the most stringent regime in the history of the UK 'welfare' state, subjecting claimants to hitherto unheard-of degrees of conditionality and unrelenting sanctions in a purported effort to 'make work pay' and embed a contractual element between citizen's rights and responsibilities (McCarthy et al, 2015; Reeve, 2017; Stewart, 2016).

It has been argued that this increasingly punitive welfare state, the marketisation of public services, and deregulation of labour markets, have culminated to entrench inequality in marginalised communities and debilitate the capacity of services to support those most in need (Ashton, 2008; Fox and Albertson, 2011; Gosling, 2018; Maynard et al, 2011; Wacquant, 2009). Consequently, these measures are argued to punish the poor and non-compliant, who are the most vulnerable, most in need and most problematised (Hodkinson and Robbins, 2012; Reeve, 2017; Wacquant, 2009). Consequently, the expectations of the state exceed the capacity of the most marginalised to adhere to the nebulous demands of the citizenship contract; the

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consequences of this are argued to be even greater exclusion and deprivation (Beatty et al, 2015; Chunn and Gavigan, 2004; Edmiston, 2017; Mendoza, 2014; Reeve, 2017).

This dynamic appears to disproportionately effect SSW and PDU women who often experience complex needs and are therefore less equipped and supported to meet expected standards (McDowell, 2005; McKay et al, 2003; Pearson, 2019; Reeve, 2017). It follows that SSW/PDU women, who are already attempting to cope with the impact of deprivation can only be further hindered, not helped, by state measures that aim to compel submission through punitive deterrents. This logic seems based on a supposition that 'undesirable' and 'disorderly' citizens are perfectly capable of compliance if subjected to a sufficient degree of motivation or coercion; that it is a lack of effort rather than a lack of resources that explains their deviance. This echoes the individualising models discussed in Chapter 2, and perhaps these models are a reflection of the cultural mores of the era of neoliberalism.

Therefore, in addition to disregarding the role of deprivation in 'social problems,' austerity can be argued to be implicated in amplifying exclusion by increasing poverty.

This dynamic comprises a deprive-blame-stigmatise cycle wherein marginalisation is exacerbated and entrenched through interactions with the state (Annesley and Himmelweit, 2010; Ginn, 2013; MacLeavy, 2011; McDowell, 2005; McKay et al, 2003; Pearson, 2019; Reeve, 2017; Stephenson, 2012). Therefore, the policies of neoliberalism in the UK, particularly austerity and so-called welfare reform appear to subject marginalised women to a punitive moralism which entrenches their disadvantage (Brown and Sanders, 2017; Ginn, 2013; MacLeavy, 2011; McKay et al, 2003; Reeve, 2017; Pearson, 2019; Stephenson et al, 2012).

### 3.2.2 Structural Violence and Austerity

'Structural violence' is a useful concept when exploring women's experiences of SSW and PDU. As we have seen, the evidence suggests that austerity practices exacerbate women's hardship and vulnerability (Ginn, 2013; MacLeay, 2011), adversities contribute to resort to PDU as a coping strategy (Durbin et al, 2017; Greer Murphy, 2017). Structural violence, as conceptualised by Galtung (1969), refers to policies or

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actions which directly or indirectly result in the avoidable impediment of personal growth. Structural violence can inflict bodily harm, but also psychological, and social injury, including stigmatisation, community dislocation and feelings of fear and threat (Bufacchi, 2005; Farmer, 2004; Galtung, 1969). Structural violence also has patriarchal elements as the male designed systems from which it operates often inherently disadvantage women (Rose, 2015). Wacquant (2009) can be argued to broaden the function of structural violence, applying the concept to mechanisms of neoliberalism (such as welfare reform) which purport to identify those who seek to leech off the state despite serving as the architects of their own deprivation (Fletcher et al, 2016; Garland, 2015; McKenzie, 2015; Patrick, 2017; Wacquant, 2009; Whittle et al, 2017).

Wacquant (2009) terms this 'punishing the poor' and describes it as part of an arsenal of tools employed by the 'Centaur State', which comprises a liberal head atop an authoritarian body. These methods are used to enact the retrenchment of state responsibility by replacing 'welfare' with 'workfare' and increasing penalism to identify and coerce so-called 'underclasses' into a precarious labour market. Fletcher and Flint (2018) argue that the UK exhibits the qualities of the Centaur State through both laissez faire market politics and stern paternalism depending upon the productivity and status of the recipients. As Fletcher (2013) points out, Wacquant's (2009) conceptualisation focuses on the United States and pays particular attention to the experiences of young black men. However, with regards to the retrenchment of the welfare state, the UK iteration overwhelmingly effects white working-class men (Fletcher, 2013 and 2015).

As problematised populations, PDU and SSW women may also experience the punitivism of the Centaur state and, consequently, further marginalisation. These groups of women may attract the attentions of the Centaur State for various transgressions including unemployment, anti-social behaviour, crime and as mothers under the eye of social services. They may experience feminised forms of structural violence through the Centaur state, for example having benefits rescinded for failing to engage with services and systems that are unsuitable.

Below, I explore some of the forms of structural violence that UK neoliberal policies including austerity, and perhaps the Centaur State, can be argued to inflict upon PDU and SSW women, beginning with an exploration of the impact of austerity upon psychological health.

### 3.2.3 Austerity and Psychological Structural Violence

The harm caused by austerity is multi-dimensional and its effects have been demonstrated to also impact psychological health and, by proxy, individuals' sense of self and safety. McGrath et al (2015) identify five 'Austerity Ailments':

#### 1. Humiliation and Shame

Shame is correlated with a range of mental health problems and emotional disorders. From the humiliation of media portrayals of 'shirkers' and 'scroungers' to the indirect shames of poverty, including depending on charity, austerity has many mechanisms through which it can be seen to cause humiliation (Chase and Walker, 2013; Griffiths and Patterson, 2014; Reeves, 2019; Zavaleta, 2015). Regular exposure to shame may have such an impact on women's mental health that they are more likely to turn to drugs to self-medicate, especially given the increasing incapacitation of services.

#### 2. Fear and Distrust

The enduring presence of fear has been connected with anxiety, poor health, depression, psychosis and suicide (Finlay-Jones and Brown, 1981; Sztompka, 1999). The conditionality of austerity-era support (reported to often hinge on the judgements of underqualified professionals) can seem arbitrary to claimants whose livelihood depends upon them (Dunn, 2010; Dwyer et al, 2020; Fletcher and Flint,



2018). Furthermore, poverty also exacerbates distrust of authority, and leads to poor mental health, factors which increase difficulties in navigating the complex and arguably deliberately forbidding benefits system

(Fujiwara and Kawachi, 2008; Reeve, 2017; Rogers and Pilgrim, 2002; Ross et al, 2001; Wilkinson and Pickett, 2010). Expecting engagement with and successful outcomes from interventions delivered by services that are perceived as threatening can surely only exacerbate exclusion and mental health difficulties. Similarly, suspicion and hostility may only be increased by punitive responses to a lack of engagement that is rooted in distrust.

### **3. Instability and Insecurity**

The experience of insecurity and instability has been shown to increase the aforementioned suspicion of and hostility to authority, exacerbating exclusion and psychological health problems even further (McDonough, 2000; Shinn and Weitzman, 1996; Sverke et al, 2002; Witte, 1999). Austerity is implicated in employment and housing insecurity which, in addition to the ferocity of sanctioning processes, amplifies disadvantage (MacInnes et al, 2014; Tinson et al, 2016).

### **4. Isolation and Loneliness**

Loneliness has a similar mortality rate to smoking and drinking alcohol and one greater than obesity, with the UK possessing one of the highest rates of loneliness in Europe (d'Hombres et al, 2021). Reduction in community resources such as Sure Start centres has furthered isolation in deprived areas which are also disproportionately affected by funding cuts (Hall et al, 2015; Hastings et al, 2013; Ross et al, 2001). As PDU and SSW women are already heavily stigmatised, it can be posited that isolation that

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results from systemic deprivation may only amplify this (Benoit et al, 2018; Goffman, 2009; Luoma et al, 2007; Room, 2005; Sallmann, 2010; Tomura, 2009).

## 5. Being Trapped and Powerless

The psychological impact of feeling vulnerability is significant and can contribute to depression, anxiety, and psychotic episodes (Cromby and Harper, 2009; Kendler et al, 2003). The decline of crucial support services including legal support and shelters for victims of domestic violence is argued to *'literally trap(s) women and children into violent and abusive situations'* (McGrath et al, 2015, p. 8; Sanders-McDonagh et al, 2016).

Where austerity measures only exacerbate women's mental health problems it can be expected that demand for services will increase, while capacity to respond is reduced by cuts, conditionality and inappropriate expectations and service design (Mendoza, 2014; Vacchelli et al, 2015). Further exploring the effects of austerity on the psyche, Reeves (2019) highlights dignity, an asset so crucial it is one of the four Code of Ethics and Conduct principles for the British Psychological Society.

We can identify several illustrations of austerity politics' assault on the dignity of marginalised populations (MacLeavy, 2011; McGrath et al, 2015; O'Hara, 2015; Reeves, 2019). One is in the relationship between the decimation of the welfare system and the mental health of those subject to it. Reassessment of disability benefit has been found to increase suicidality and self-reported mental health problems while neglecting to recognise the severity of these (Barr et al, 2016; O'Hara, 2015; Stewart, 2016). The process of assessment attached to welfare receipt is also argued to expose people to scrutiny that undermines their dignity and self-worth (Barr et al, 2016; Reeves, 2019; Shultziner and Rabinovici, 2012; Stewart, 2016). Although it remains a right for out of work or incapacitated citizens to seek state support, the processes by which to do so increasingly disbar vulnerable people, thus exacerbating their struggles

to survive while maintaining their dignity (Baumberg, 2016; Haslam and Loughnan, 2014; Marcovitz, 2016; Reeves, 2019; Shultziner and Rabinovic, 2012).

Finally, all the aforementioned psychological harms have been illustrated to contribute to male violence and abuse where men lack alternative coping strategies to handle assaults to their psyche (Ellis, 2019; Fahmy et al, 2016; Ishkanian, 2014; Jakupcak, 2003; Jewkes, 2002) Therefore, we can posit that there is a relationship between austerity and women's experience of violence.

These points suggest that austerity can indirectly and directly affect PDU and SSW women. Directly, as we have seen, in the denial of support and the psychological injury that accompanies that but also indirectly through the increase in violence connected with socioeconomic deprivation. It would appear that austerity has a significant role to play in reducing women's ability to achieve a 'minimally decent life', let alone the flourishing, productive lives promised by New Recovery (Miller, 2012, p.3).

#### 3.2.4 Poor Bedfellows? New Recovery and Austerity

The tools of New Recovery exemplify ways theories can perpetuate the responsabilisation of social problems. The appeal of New Recovery to neoliberal government can be proposed to lie in its location of fault within the individual, in isolation from their environmental and economic circumstances. The principles of New Recovery echo the concerns of neoliberalism identified by Alexander (2008, 2010), Polanyi (1944) and Wacquant (2009). These comprise the justification of devolved state responsibility and the explicit conflation of citizenship, values and worth with economic productivity (Duke et al, 2013; Frank, 2018). Drawing upon Kingdon's theory of 'policy windows', Duke et al (2013, p. 977) remark that in the rise of New Recovery a host of stakeholders and 'poster boys' saw opportunity for investment and influence and thus *'took the opportunity to insert themselves into policy making circles'*. The consequences of this political brokering have led to the prosperity of proponents of various theories and tools purporting to offer ways to foster, measure and capture recovery in politically appealing packages (Bull et al.,

2019; Duke et al, 2013; Fomiatti et al, 2021). Fomiatti et al (2019, p. 527) expand upon this, referencing New Recovery's promises of transformation, and empowerment if only people utilise their agency and overhaul their identity, locating and culling 'anti-social' 'negative elements' from their social networks. Fomiatti et al (2019) describe two such models, the ARC (Assessment of Recovery Capital) and Social Identity Model of Recovery (SIMOR), critiquing both for enacting '*a familiar divide between the individual subject and the social environment*' (Fomiatti et al, 2019, p. 527). Both models reflect neoliberal policies' individualism, are divorced from considerations of macro-level disadvantage and expect '*autonomous and self-determined action, participation and responsible conduct*' without any narrowing of the chasm of inequality (Fomiatti et al, 2019, p. 527).

As we did with the concept of desistance in 2.5, ARC and SIMOR can also be critiqued due to their simplification practices (Fomiatti et al, 2019; Law, 2013). The reductionist approach behind these models adopts a blinkered view by privileging indicators of change according to what can be measured most easily and are most politically appealing.

Nettleton (2020, p. 528) holds that New Recovery's currency has led some researchers to aim to '*improve the empirical robustness and utility of the recovery concept for public health purposes*'. Consequently, it may be argued that although these tools claim to be strengths-based and empowering, they in fact perpetuate and reflect normative expectations of citizenship while purporting that this sufficiently captures the complexity of subjects' lives. For example, the Life in Recovery survey, developed from the ARC and SIMOR, measures GP attendance, missed days of school, tax payment and planning for the future, such as family holidays (Laudet, 2013). This framework defines success in people in recovery according to expectations of health and social citizenship which assume drug use to be the barrier to a 'pro-social' life. This is despite the realities of ongoing austerity, which as we see in this chapter are theorised to exacerbate the deprivation and stresses that may drive women's addiction. These indicators also reflect neoliberalism policy's expectation of economic contribution and social compliance. For example, citizenship is conceptualised as a one-way tribute; what those in recovery do for others and how often they perform

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their responsibilities and obligations (Lancaster et al., 2015). This is further embodied by the SIMOR which appears to demonstrate a reductionist understanding of social life by juxtaposing nondrug users with drug users (Fomiatti et al, 2019; Duke et al, 2013). This binary simplification is suggestive of a stigmatising logic, suggesting that people who use drugs need to divest themselves of their existing social connections in order to develop a new 'recovery identity' (Fomiatti et al, 2018, p. 534). This assumes that groups share norms and that the core values of the group originate from its status as using or not using drugs, a stance which seems unable to capture and appreciate the diversity and fluidity of relationships.

In conclusion, it is perhaps no surprise that these tools and typologies have gained popularity in the age of neoliberal policies and austerity. Their inclusion may have a significant impact on the lives of PDU/SSW whose eligibility to social rights is measured by their success according to normative indicators which they are increasingly excluded from realising. Rather than being the progressive conceptions they purport, New Recovery and its tools appear to perpetuate neoliberal discourse that stigmatises and stratifies marginalised populations based on notions of socioeconomic worth.

Accordingly, New Recovery tools and policy may exacerbate the social 'problems' they purport to address by justifying inappropriate support, forcing abstinence, obfuscating the role of inequality and simultaneously divesting the state of responsibility (Bull et al, 2019; Fomiatti et al, 2019; Neale et al, 2013). If structural and social factors are as significant as Alexander (2008, 2010) and Polanyi (1944) posit, individualised models of change are not only insufficient but complicit in the perpetuation of the causes of the 'social problems' of PDU and SSW.

### 3.3 Neoliberal Governance, Austerity Politics, and the Female Experience

Neoliberalism (detailed in 3.2) and austerity politics have been argued to disproportionately affect women's lives (Annesley, 2012; Pearson, 2019; Reis, 2019; UK Women's Budget Group, 2012).

One iteration of this is through welfare reform which has especially harmful consequences for women, particularly those who are already marginalised and struggling to access support (Reis, 2019; UK Women's Budget Group, 2012). The argument built in this chapter asserts that the disproportionate impact of the feminisation of austerity subjects women to exacerbated poverty and exclusion whilst simultaneously responding punitively to the symptoms of this, for example in the criminalisation of coping strategies such as PDU.

The focus of the evidence discussed in this section discusses several areas of pertinence to SSW/PDU women, highlighting the role of neoliberal policies in decimating public services, increasing food insecurity and rising vulnerability to increasing levels of violence. These harms undermine the wellbeing of women and their families and increase their likelihood of experiencing interventions that feel punitive as services deem them risky and deviant due to their perceived refusal to conform with state expectations.

#### *The retrenchment of women's services*

Women's voluntary organisations are struggling with greatly reduced budgets due to central and local government cuts and a reduction in charitable donations (Barter et al, 2018; Stephenson, 2012; Vacchelli et al, 2015). The implications of this for SSW/PDU women include the lack of appropriate and accessible sex work services, women's centres, violence and abuse services and lower-level mental health support (Barter et al, 2018; Sexton, 2003; Sharpen, 2018). Cuts to drug treatment and the imposition of industry targets that incentivise the avoidance of complex populations also restrict SSW's opportunity to access appropriate treatment when they are ready (Christopher and Hood, 2006; Gilchrist et al, 2001; Sexton, 2003; Smith and Marshall, 2007; Vacchelli et al, 2015). For SSW, who it has been shown are best engaged through outreach or during certain open hours at sex worker only services, cuts can leave women devoid of support (Kurtz et al, 2005; Sagar, 2007 and 2010). For women in drug treatment overall, austerity reduces services' capacity to provide gender focused services such as childcare, separate premises, and compassionate, empathetic staff with whom to build trusting relationships (Gilchrist et al, 2001; Klee

et al, 2002; Malloch, 2004a and b; Neal and Salisbury; 2010; Sexton, 2003; UK Women's Budget Group, 2012; Wincup, 2010).

### *Food Insecurity*

One of the consequences of state cuts and sanctions (including removal or suspension of benefits for increasing durations) is the prevalence of 'food insecurity' (Loopstra et al, 2015; Stephenson, 2012). Women are often primary caregivers for children and the elderly or unwell in their family and held responsible for their wellbeing by social services. Consequently, food insecurity reduces women's capacity to provide for their families and thus increases the likelihood of service intervention (Povey, 2017; Stephenson, 2012). SSW and PDU may especially struggle to meet expectations of responsibility for the family's wellbeing as they often live in deprived areas which are lacking in resources (Bretherton and Pleace, 2015; Duff et al, 2011; Fitzpatrick and Jones, 2005; Fitzpatrick et al, 2013; Matto et al, 2016 McNaughton and Sanders, 2007; Monroe, 2005). They may also already be under scrutiny by social services due to their PDU and SSW, which are treated as indicators of risk, not of need or vulnerability, despite women's depiction as victims in other policy areas (Scoular, 2015).

This embodies the intersecting relationship between the conditionality of welfare, poverty and women's experience of state interventions when they are unable to meet the increasingly costly expectations of womanhood.

### *Violence*

The evidence base has also indicated the indirect ways austerity harms women by contributing to their experiences of violence (Fine and Weiss, 2000; Matto et al, 2016; Morrow et al, 2004; Vacchelli et al, 2015). One of the consequences of the erosion of psychological well-being by austerity measures and neoliberal policies is argued to be an increase in violence and abuse (Ellis, 2019; Khalifeh et al, 2003; Matto et al, 2016; Morrow et al, 2004; Sanders-McDonagh and Neville, 2016). As has been illustrated, historical and ongoing experiences of abuse punctuate the life course of many PDU and SSW women, and it is now understood that poverty exacerbates this (de Olarte and Llosa, 2003; Ellis, 2019; Khalifeh et al, 2003; Matto et al, 2016). The relationship

between poverty and women's experience of violence is demonstrated to work in two ways; firstly, economic solvency is a protective factor that empowers women to be able to leave situations of interpersonal violence (Sanders-McDonagh and Neville, 2016). Secondly, lack of economic solvency is a strong risk factor in women's experience of abuse (Gilroy et al, 2015b; Matto et al, 2016). Lyon (2000) has demonstrated how women in receipt of welfare (in the US) disproportionately experience domestic violence, and the impact of welfare retrenchment in the UK arguably also exacerbates this experience and reduces women's opportunities to escape (Ellis, 2019; Sanders-McDonagh et al, 2016; Sanders McDonagh and Neville, 2016). Women trapped in violent situations are less able to escape and to receive support due to the structural damage done to social and health care sectors and increasingly stringent eligibility criteria resulting from the dominance of business practices in public services (Sanders-McDonagh and Neville, 2016; Sanders McDonagh et al, 2016; Sokoloff and Dupont). Women living in low-income households are more likely to experience domestic violence and this risk is increased if they also live in deprived communities (Cunradi et al, 2000; Gilroy et al, 2015a; Jewkes, 2002; Khalifeh et al, 2013; Vest et al, 2002). Deprivation also means that women suffer the impact of violence more severely (Sutherland et al, 2001).

A further way women's vulnerability to domestic violence is increased is through the *structural* mechanisms of austerity. Firstly, the conditionality clauses and paucity of domestic violence and other related support services means women and their children are often trapped in violent households (Morrow et al, 2004; Sanders-McDonagh and Neville, 2016; Sanders- McDonagh et al, 2016; Sokoloff and Dupont, 2005; Vacchelli et al, 2015). In addition to the cuts to housing and specialist women's services discussed, cuts to Crown Prosecution Services and legal aid impinge on women's ability to safely leave violent partners and result in less thorough and fewer successful investigations (Sanders McDonagh and Neville, 2016). SSW and PDU are also often excluded from refuges due to their drug use and so this conditionality denies a significant proportion of vulnerable women the help they need to escape the violence that is statistically prevalent in their lives (Fox, 2020; Sharpen, 2018; Stephenson, 2012).



As illustrated, the evidence indicates that despite the demands of the state for transformation, the impact of Neoliberal policies may only exacerbate vulnerable women's survival behaviour. This appears to occur on multiple levels including increasing exclusion through criminalisation and various forms of retrenchment of support including the disproportionate impact of cuts and increasing conditionality (Durbin, 2017; Ginn, 2013; Greer Murphy, 2017; Mulia et al, 2008; O'Hara, 2015; Povey, 2017). Given the correlation between poverty and SSW and/or PDU, the amplification of this by neoliberal policies may be intrinsic to the entrenchment of women's deprivation and their criminalised and problematised survival responses. Individualising, responsibilising framing and treatment disregards the impact of an inflammatory and contradictory political and social system. We have observed the expectation of reform based on the individual realisation of assets while also noting the evidence base on the continuous erosion of these by the same system that wields these expectations. Below, I highlight several manifestations of this contradiction in services which are tasked with enacting transformation in marginalised women.

### 3.4 Monitoring Motherhood

Neoliberal strategies have been illustrated to include techniques of surveillance in interventions towards mothers deemed deviant or criminal (Peckover, 2014; Rogowski, 2015). These strategies focus on the conduct of the mother in appropriating blame for undesirable family circumstances (Peckover, 2014). The expectation of mothers' conformity appears to be levied without recognising or responding to the inequality and social and structural violence that impact upon women's capacity and experiences of motherhood (Bywaters et al, 2015 and 2018; Featherstone and Gupta, 2018; Gupta, 2017). The increased surveillance of poor mothers is indicated by social work interventions disproportionate focus on families living in poverty (Bywaters et al, 2015 and 2016; Cancian et al, 2013; Gupta, 2017; Pelton, 2015). Indeed, Morris et al (2018, p. 364) remark of data from UK local authorities that *'deprivation was the largest contributory factor in children's chances of being looked after and the most powerful factor in variations between LAs'*, with children in the 10% most deprived areas ten times more likely than those in the least

deprived areas to be removed from their parents' custody. As PDU and sex work in themselves are often treated as risk factors, when cooccurring these may intersect and result in especially stringent interventions by social services and family courts (Duff et al, 2015; Featherstone and Gupta, 2018; Munro and Scoular, 2012; Taplin and Mattick, 2015). This suggests that there is a feminised component to the exacerbation of poverty and responsibilising of mothers that emanates from Neoliberalism, where failure to conform can be experienced punitively. While social services understand their approach as child-centred and risk averse, women may interpret this as being penalised for their poverty, vulnerability and the coping strategies that result. Blaxland et al (2021) note how when women with histories of childhood neglect and abuse become mothers, they transition from being considered 'at risk' to 'a risk'. Certainly, mothers' histories of trauma and deprivation appear absent in discourse and practical approaches. Child neglect is isolated from environmental, socioeconomic, and even whole-family considerations and all fault is located with the mother, despite evidence illustrating correlations between neglect and poverty (Blaxland et al, 2021; Bywaters et al, 2018; Coulton et al, 2007; Courtin et al, 2019; Crossley, 2016; Featherstone et al, 2014; Featherstone and Gupta, 2018; Morris et al, 2018).

The individualisation and responsibilisation of risk is embodied in the UK Government's 2018 Working Together to Safeguard Children's focus on 'challenging family circumstances' (DfE and Hawkins, 2018). This indicates a shift from a focus on child *welfare* to child *safeguarding/protection*, and from families *in need* to *risky* families, with risk factors dominating decisions to place children on the at-risk register (Blaxland et al, 2021; Crossley, 2016 ; Fenton and Kelly, 2017; Rogowski, 2015; Saar-Heiman and Gupta, 2020). This justifies the focus on surveillance and evidence gathering to underpin reactive interventions rather than to develop traditional preventative, therapeutic strategies including longer term coordinated care plans (Fenton and Kelly, 2017; Parton, 1996; Rogoswki, 2015). Consequently, marginalised parents and sometimes children feel fear and hostility to social services, experiencing the sector as threatening, intrusive and judgement-laden (AVA and Agenda, 2019; Featherstone et al, 2014; Fong, 2019; Jones, 2019).

It has been argued that the occupational requisite for social workers to empirically predict harm emanates from a central organising principle of social control (Crossley, 2016; Fenton and Kelly, 2017; Rogowski, 2015). Social workers must be auditable in their practice in order to defend their actions due to the pressures of forensic case reviews and cultures of blame (Broadhurst et al, 2010; Jones, 2018; Kemshall, 2010; Scourfield and Welsh, 2003). PDU/SSW women, who often have their own ACEs and traumas are potentially more vulnerable to social services' interventions by virtue of their own disadvantage. This is both due to the lack of support discussed in 3.6 and their perceived multiple risk factors converging to reduce their capacity and increase the likelihood of punitive interventions (Edwards, 2016). These interventions also tend to place sole responsibility on the women, even for their own experience of violence such as at the hands of the child's father; as Davies and Krane (2006, p. 414) conclude, *'the protection of children from various forms of maltreatment more often than not falls on the shoulders of the mothers'*. As we have seen in Chapter 3, due to the impact of austerity policies, the shoulders of SSW and PDU women are often already overburdened and under-supported.

### 3.5 Complex Needs or Multiple Risk?

We have seen how SSW/PDU often women experience complex multiple disadvantage, which services are frequently unable to appropriately respond to due to lack of resources, inappropriate expectations and approaches. For mothers this disadvantage takes on a more punitive aspect as deprivation becomes viewed through the lens of risk (Saar-Heiman and Gupta, 2020). Clapton et al, (2013) illustrate how child protection social work is at the behest of a growing number of social panics. This is often in response to Serious Case Reviews leading to 'claims making' which amplifies panic (Broadhurst et al, 2010; Marinetto, 2011). Resultantly, parental wellbeing is side-lined and the problematisation takes centre stage (Clapton et al, 2013) . Sex work, problem drug use, domestic violence and mental health have all fallen under the alarm-laden umbrella of such 'claims making'. Consequently, due to their interpreted risk, women suffering multiple disadvantage, including SSW and PDU women, are especially vulnerable to the most punitive interventions from social

services (Clapton et al, 2013; Cree et al, 2016; Smith, 2000; Warner, 2013). Drug using mothers experience a constellation of disadvantage, with Powis et al's (2000) sample living almost entirely in poverty, to drink heavily alongside using multiple heavy substances, to experience a host of mental health problems, and 1/3rd to have experienced domestic abuse. Awareness of domestic abuse has entered the mainstream on the political agenda and within services and thus is included in social work's surveillance efforts. However, Peckover (2013) points out that there has not been a parallel development to support *women* who are victims, nor to correct the problematisation of domestic violence as a harm foremost to children, which blames the mother for 'allowing' her child to witness her abuse (Davies and Krane, 2006; Featherstone and Peckover, 2007; Humphreys and Absler, 2011; Mandel, 2010). The expectation of SSW/PDU mothers to change seems misplaced when core aspects of their lives- their safety and wellbeing- are undermined by systemic retrenchment and misinterpretation of their own victimisation.

### 3.6 The Consequences of Child Protection Interventions and Drawing Upon Motherhood as A Redemptive Identity

We have explored the ways in which the unintended consequences of child protection strategy can deter help-seeking due to fear of punitive responses; this fear also encompasses those socially and individually experienced including exacerbated stigma, rejection in the community and crises of identity and self-esteem (Bjönness, 2015; Kielty, 2008; Klee et al, 2002; Powis et al, 2000; Siporin, 2010; Smith and Marshall, 2007). These difficulties may all amplify drug use and street sex work by exacerbating trauma and stress (Belcher et al, 2001; Bjönness, 2015; Kenny et al, 2015) This suggest culpability on part of the state and its vassal services in the exacerbation of PDU/SSW women's difficulties, both to meet the needs of their children and to be able to contemplate recovery.

Fear of loss of child custody has been evidenced to present many barriers to multiple forms of help seeking, excluding women from a plethora of protections and support (Kurtz, 2005; Stengel, 2014; Stone, 2015). The impact of these barriers includes reduced reporting of domestic violence, seeking of prenatal and parenting support,

health care , housing and welfare assistance (Powis et al, 2000; Radcliffe, 2011a and b; Stengel, 2014). In short, women with complex needs often experience a paralysing fear of attracting the attentions of public authorities and this may impair their ability to seek and receive the assistance needed to keep themselves safe and healthy.

Although sex work narratives have shifted, from a focus on threat to public health and moral sanctity, to victimhood and vulnerability, this breadth of consideration does not extend to SSW as mothers. Whilst simultaneously drawing upon narratives of victimisation, policies punish SSW for being ‘incapable’ mothers and not meeting the criteria of social work orders, regardless of the impact of their own experiences of violence and neglect (Duff et al, 2015; Munro and Scoular, 2012; Sagar, 2007 and 2010).

In these discourses, the mother is presumed to be incapable of assuming the mantle of maternal responsibility and performing the necessary self-sacrifice (Bjönness, 2015; Sagar, 2007 and 2010). However, in exploring the experiences of SSW PDU mothers at drop-in services in Denmark, Bjönness (2015) found that women in fact frequently used strategy and agency to defend themselves and to counter institutional assumptions of their incapacity. This evidence of action also contradicts radical feminist narratives of SSW as helpless, passive victims. Bjönness (2015) found that women employed a range of strategies encompassing both resistance and compliance to navigate services. Nonetheless, it appears that both complying and resisting are ultimately futile strategies. Bjönness (2015) found that the women struggling the most and who narrated repeated clashes with social services seemed to experience further marginalization, ultimately leading to a sense of hopelessness and increased levels of drug use . Those who comply with what is seen as best for their children, such as voluntarily giving them away to foster care also endure a strong sense of injury, though are more easily contained by social services (Bjönness, 2015). Both strategies seem to result in women developing a strong ambivalence about themselves and feel a sense of ‘playing on away-ground’ (Bjönness, 2015, p785). They are also subjected to further exclusion and punishment due to their reduced opportunities for enacting resistance. In the end then, services and systems that operate on the assumption that women who use drugs and sell sexual services are

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fundamentally ‘improper mothers’ ‘may create conditions that prevent the same women from proving otherwise.’ (Bjønness, 2015, p.793). This raises questions that are addressed in the Findings as to whether the women in this research were able to maintain a positive sense of self and belonging in society when subject to social services intervention and how their compliance and/or resistance efforts were received.

Exploring the narratives of 20 UK women who lost custody, Kielty (2008) found that all had constructed narratives of compliance or resistance to protect themselves from being labelled a ‘bad mother’. The stigma of this was deeply felt in public, especially among other mothers and also deterred women from engaging with their children in the future, stymying any possibilities of families being reunited and potentially leading to children feeling further rejected by their mothers (Kielty, 2008). Compliant women often feared being judged for not 'trying hard enough', while those who resisted were conscious of being perceived as belligerent and incompetent (Kielty, 2008). This indicates a Catch 22 where women who have minimal options are punished for their attempts to keep their families together. It also poses the question of whether if given support to respond in the ‘right’ way, some women could be kept with their children.

Finally, the devastating impact of losing custody of a child, particularly where the child/ren are given up for adoption, cannot be understated. Women who have suffered this loss cite experiencing bereavement-like grief, obliteration of their sense of purpose and identity, overwhelming futility and chronic psychological difficulties including PTSD and suicidality (Broadhurst, 2013 ; Kenny et al, 2015; Wall-Wieler et al, 2018). Furthermore, for women already suffering from PTSD this loss can replicate traumatic developmental experiences , amplifying and entrenching low self-worth, causing re- traumatisation and potentially *complex*<sup>21</sup> PTSD (Schuster, 2015). These findings all indicate how the turmoil and grief that can accompany PDU/SSW mothers’

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<sup>21</sup> CPTSD is associated with repeated trauma and more severe symptoms

systemic experiences may in fact contribute to the trauma which compels them to pursue solace in drug use.

### 3.7 'Getting Better' in a Man's World: Expectations of Female Transformation in Male Spaces

The ways that services (which are primarily designed with men in mind) expect women to engage can also be retraumatizing and inappropriate, as attested to by a breadth of evidence (Covington, 2008; Holly, 2017; Sharpen, 2018; Yang and Kim, 2012). This includes expectations that women recount traumatising experiences (often at the hands of men) in mixed company, undergo monitored urine testing and strip searches in the presence of men and attend services where their abusers go. It is relevant to note that Neale et al (2018) found that when asked, women did not prefer women-only residential treatment, citing previous difficult relationships with women. However, when women were supported to enter single sex treatment and conflicts were managed, they reported feeling safe and understood (Neale et al, 2018). Mixed services frequently also lack childcare, parenting support, trauma recognition and relational and self-esteem work (Barr, 2018; Bloom et al, 2003; Covington, 2008; Grella, 2008; Holly, 2017; Malloch, 2004a and b; Saxena et al, 2014; Sharpen, 2018; Yang and Kim, 2012). This gender blindness affects the drug treatment and criminal justice sectors, even though interventions that do respond to women's needs are associated with improved treatment engagement and outcomes. Therefore, it can be advanced that although New Recovery and Desistance promise outcomes, the reality of their implementation lacks the gender awareness needed to achieve these.

The correlation between women's experience of multiple disadvantage and PTSD has been evidenced and yet even for services whose remit is to work with complex disadvantage, this is not taken into consideration in provision or staff training (Holly, 2017; McCarthy et al, 2020; Sharpen, 2018). Resultantly, women are often excluded from services due to a lack of capacity and confidence among staff to respond (Holly, 2017; Sharpen, 2018; Yang and Kim, 2012).

As demonstrated in 2.3 and 2.4, SSW and PDU commonly experience multiple traumatic incidents. Although at the time of writing trauma-awareness is gaining popularity this has yet to be universally implemented and lacks a cohesive approach (AVA and Agenda, 2019; Emsley et al, 2022; Reeves, 2015). Services including drug treatment and the criminal justice system often expect women to engage with potentially re-traumatising interventions while abandoning coping strategies such as drug use before safety and stabilisation are established (AVA and Agenda, 2019; Jeale et al, 2018). Such expectations are contrary to the principles of trauma recovery and can also exacerbate trauma symptoms (Covington and Bloom, 2008; Herman, 2015; Van der Kolk, 2015). A lack of trauma awareness can mean staff perceive lack of engagement as a sign of being uncooperative or unwilling, and respond punitively (AVA and Agenda, 2019; Sharpen, 2018). To avoid this, Sharpen (2018) asserts the importance of services recognising women's trauma symptoms including dissociation, burnout upon leaving a traumatic situation, defensiveness and chaotic behaviours as coping skills. Furthermore, the hyperarousal and hyper-vigilance to threat common among women with C/PTSD mean it is critical that professionals demonstrate their trustworthiness by being reliable, consistent, and responding to the expressed needs of the individual (Sharpen, 2018). This includes being aware of the quality of eye contact, body language and active listening which may be scrutinised to assess the trustworthiness or threat level of staff (Herman, 2015, Sharpen, 2018). However, services and professionals' abilities to meet these needs are increasingly undermined by struggles with funding, time, and the burden of administrative demands (Boyle, 2011; Ginn, 2013; Greer Murphy, 2017; Sharpen, 2018; Vacchelli et al, 2015; Whitehead, 2015).

Attesting to the importance of trauma-informed practice, women with complex needs prefer services that embrace 'resilience over pathology,' exploring their strengths rather than focussing on their risks (Messina et al, 2014; Saxena et al, 2014; Sharpen, 2018).

Resilience is a crucial asset in mitigating the impact of trauma; colloquially referred to as the ability to 'bounce back' (Connor, 2006; Fonagy et al, 2019). In woman-centred service delivery, resilience can be developed and strengthened through psychological



support, physical activity and spiritual and mental wellbeing strengthening exercises such as yoga and meditation (Dass-Brailsford and Myrick, 2010; Macedo et al, 2014). However, the broader societal circumstances of women's lives under austerity may be argued to simultaneously undermine their resilience on a greater scale than services can hope to counter. Furthermore, lack of truly trauma-informed practice<sup>22</sup> means services are unequipped to stabilise women, despite stability and safety operating as prerequisites of progress (Herman, 2015). Austerity, cuts and the marketisation of public services<sup>23</sup> mean services lack the temporal and fiscal resources needed to develop trauma and resilience focused provision (Emsley et al, 2022). In addition to trauma blindness, services have also been critiqued as unsuitable for PDU/SSW women in terms of location, design, delivery, staffing, scope and capacity (AVA and Agenda, 2019; Bloom et al, 2005; Covington 2008;

Holly, 2017; Sexton, 2003 and 2009; Simpson and McNulty, 2010; Thanki and Vicente, 2020; UNDOC, 2004 ; Yang and Kim, 2012). Without accessible, trauma fluent services it seems unrealistic and unfair to expect women to progress in ways that depend upon the provision of professional support.

### 3.8 Conclusion

Drawing upon the evidence base regarding the impact of neoliberal policies and the associated responsibilising, individualising discourse, this chapter argues that a consequence is the exacerbation of deprivation at individual, community and systemic levels. This amplification of disadvantage alongside increasingly punitive, responsibilising systemic responses, is argued to have effect on PDU and SSW women.

We can see how the discourse of neoliberalism justifies inequality ,reinforced by rhetoric and practice that responsibilises the most marginalised populations. It is

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<sup>22</sup> Definition of which includes practice according to the core principles of Trauma Informed Care and Trauma Informed Environments according to SAMHSA (2014) and Harris and Fallot, 2001 a and b)

<sup>23</sup> Where services undergo competitive tendering processes which are evaluated according to quantitative indicators of success, as embodied by New Recovery measurement tools

argued that the associated policies confer a pervasive and chronic form of deprivation that strips communities and individuals of their assets, identity, dignity and security. This comprises a form of structural violence towards marginalised women that may contribute to their entrenchment in PDU and SSW. The evidence suggests that these ‘social problems’ are in fact contributed to by society’s predication of the primacy of material wealth and power of a minority at the expense of others. This system shirks blame for the problems of these others, holding them responsible for their responses to deprivation while ignoring and refuting structural and systemic culpability. Instead, the state responds by meting out punitive responses and withholding appropriate support.

Supporting this theorisation is the evidence discussed indicating the influence of social and structural factors in SSW and PDU. Women’s PDU has been shown to relate to their experience of trauma and need to block out pain. SSW can be depicted as a predominantly functional strategy, albeit one forged of desperation, which interacts with addiction in an entrenching, trapping cycle. At the heart of both these social problems are not sickness, immorality, or behavioural dysfunction but structural and social processes that worsen inequality and deprivation. However, most policy and practice continue to be predominantly informed by models that responsibilise the individual and that neglect to acknowledge the role of inequality and the ways forms of neoliberal governance contributes to this.

This is exemplified by New Recovery which inappropriately situates the responsibility for recovery from structural problems in disempowered, deprived communities and individuals.

Accordingly, purportedly recovery-oriented policy and practice adopts too narrow a view, overlooking the impact of trauma and deprivation and failing to identify the root problem in the *environments* of the individual. This disregard then permits the perpetuation of women’s trauma and poverty and entrenches PDU and SSW.

In the forthcoming chapters (5, 6 and 7) I present my findings, exploring the suitability of the alternative models discussed in this chapter by exploring women’s histories. I do this with an awareness of the relevance of deprivation and of responsibilising

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Neoliberal rhetoric and practices, assessing the impact of these on women's PDU, SSW and recovery

I explore women's attempts to navigate adversity, the resources available to them to do so and the extent to which formal support systems are able to help them in this. Informed by an understanding of the impact of structural violence and the potential manifestation of this in neoliberal policies, the thesis also explores whether these hinder women's ability to meet their needs or present them with even greater challenges. This endeavour is structured according to the research aims and objectives described below.

### 3.9 Research Questions and Aims

- 1.) How suitable are dominant individualising models (such as New Recovery and desistance) when understanding and explaining street sex work (SSW) and women's problematic drug use (PDU)?
- 2.) What is the impact of neoliberal policies (including austerity) upon PDU and SSW women's experiences?
- 3.) How applicable are theories concerning the destructive impact of neoliberal policies when applied to PDU and SSW women's histories?

### 3.10 Objectives

- 1.) To explore the extent to which SSW and PDU can be viewed as responses to trauma and deprivation as opposed to pathological, moral, or behavioural deficiencies
- 2.) To give voice to the self-expressed needs of women who have experienced PDU/SSW
- 3.) To explore the suitability of treatment and responses to PDU and SSW
- 4.) To explore the relationship between PDU and SSW women and the expectation and approach of the state, including criminal justice, health care, drug treatment and social services

## 4 Methodology

### 4.1 Research Design and Methodology

One of the core aims of this research is to examine the suitability of individualising, responsibilising models when understanding and responding to addiction (PDU) and street/survival sex work (SSW). These models examine the ‘problem’ by focusing on the symptoms and trying to look for behavioural, moral, and physiological causes. The methodology and strategy of this thesis adopts a sort of reverse engineering approach, exploring PDU and SSW from a humanistic and feminist perspective that prioritises and respects the voice, agency, and validity of experience of the marginalised woman as individual. Namely, rather than focusing on the ‘undesirable behaviours,’ the heart of enquiry is in the experiences and history of the individual who lived them. This privileges the reality of subjective experience and interpretation and the influence of this upon women’s options and choices in life.

### 4.2 COVID-19: Impact on Methodology

Before describing my methodology, it is important to note the impact of the COVID-19 pandemic that began in 2019. Prior to data collection, we were placed under national lockdown. This halted any face-to-face research and was destabilising for services working with vulnerable people who found their work dominated by ‘firefighting’ and responding to crises (Nyashanu, 2020).

Accordingly, while I had intended to interview women with current *and* historical experience of addiction and sex working, this was no longer ethical or possible.

Consequently, I decided to focus on speaking to women who had attained recovery and were in a stable position so less likely to be severely disrupted by the pandemic. One impact of this on my findings was that I spoke to women who did eventually have access to the support and resources they needed to recover. However, this did preclude me from speaking to the arguably more deeply disadvantaged women who

are still in active addiction and who could give greater insight into the barriers they face.

One arguable ramification of this was that I couldn't hear the perspective of the most disadvantaged women, and so I was prevented from gaining an understanding of the *current* experiences of SSW and PDU women. It is likely that the women in recovery that they reflected more positively on the support they received and had some distance from their moments of greatest difficulty so felt unmet need less keenly than those on the frontline of deprivation today. It is also possible that this distance and their current position of relative stability altered their perception of the reasons for drug use and how they felt about it. It is reasonable to theorise that women who are actively using may have stronger feelings about the role played by substance abuse in blocking out pain or giving feelings of wellbeing and pleasure, and so these women could have provided a stronger illustration of the appeals of substance misuse to them. Alternatively, being in the midst of addiction could cause them to be especially despairing and condemning of drug use.

Distance and stability may also impact women's retrospective feelings about sex work. While women in recovery were adamant sex work was not work, several did emphasise that this was a preferable moral choice compared to , say, shoplifting, which was perceived as a crime with a victim. While actively survival sex working, women may be more likely to emphasise its validity as a choice and the aforementioned moral component. As a key part of recovery support appears to be the building of a positive sense of self-worth and purpose, perhaps women in active addiction may also view their addiction and sex working in a way more fitting dominant normative models: for example, as indication of immorality, incapacity, or sickness. As we see in 7.2., when in recovery, women in fact took great pleasure in their access of the normative elements of mainstream society, further contradicting moralising or identity-based narratives.

Instead of travelling to women's homes or local community centres and services, I also had to conduct my research from my home because of lockdown. This meant offering women a choice of a telephone or video interview. While traditionally, face

to face interviewing is seen as a 'gold standard' in qualitative interviewing, crucial to building rapport and for the observation of verbal and non-verbal cues, I didn't find this to limit the research. Firstly, the richness of the material that I gathered is testament to this, but there were also benefits to virtual interviewing that mean it can be argued to be more sensitive and trauma-informed than researcher-preferred methods.

Several women favoured remote interviews as this offered them greater flexibility and privacy, and they were able to take advantage of windows of opportunity to fit the interview around their other responsibilities (such as childcare). In a face-to-face interview they may have been restricted to a certain time and date and could have felt burdened by a sense of responsibility due to my travelling long distances to reach them. Other women did not like being 'seen,' confiding difficulties with their self-image and being uncomfortable with face to face or even visual contact. They preferred to stay entirely hidden by using the telephone only so this offered a way to respond to the unpredicted (by myself) but real issue that some women felt exposed and vulnerable when sharing their visual self. This raises interesting points around the potential value of offering qualitative interview respondents the choice to maintain distance and a sense of privacy and control. This may be especially so where trauma is likely to have had an impact and could mean women are uncomfortable with conditions, feelings of expectation and of being 'seen'. It seems that virtual interviewing added a layer of protection for the women, who felt able to speak more freely and perhaps more empowered to exit a situation, as pressing a button is less daunting than walking out of a room.

### 4.3 Justification of Method

My overarching aim was to holistically explore the subjective experiences and life stories of women with histories of PDU and SSW. Therefore, the most epistemologically and ontologically apt methodology was the qualitative paradigm, as this is most suited to capturing the nuances and complexity of subjective individual histories (Dickson-Swift et al, 2007; Etherington, 2007; Mason, 2017.) Semi structured interviewing is considered the most appropriate qualitative methodology to open

discussions with respondents about potentially sensitive and complicated topics (Brinkmann and Kvale, 2018; Shaver, 2005). This is because the interview can be structured to elicit the histories of the individual according to their perception, interpretation and experience, and in their comfort zone (Shaver, 2005). The semi-structured interview can capture the richness of individual's lives by opening discussion around the subject's past, present and future, of events, responses and feelings (Etherington, 2007; Mason, 2017; Newcomer et al, 2015).

Proponents of the method assert that knowledge is situational and contextual, and that semi-structured interviewing prioritises the experiences and perceptions of the individual in the understanding of their histories (Brinkmann and Kvale, 2018; Etherington, 2007; Mason, 2017). This methodology can also be used to construct research that reflects feminist principles by centring the voice of women who historically have not had the opportunity to tell their own histories and freely express their opinion of their experiences (Denscombe, 2010; Etherington, 2007; Wincup, 2017).

By considering the woman's experience the most valid form of knowledge this thesis adopts a humanistic approach which acknowledges the holistic nature of the human experience (Plummer, 2001; Wincup, 2017) This is reflected in the broad range of topics covered in the interviews which span life courses and individual, community and systemic experiences. Extrapolating upon this prioritisation of individual experience, as the data sought and its sources are individual and subjective, the most logical and feasible way to achieve this is through directly consulting with the individual. This entails eliciting *their* understanding of their life course, experiences, and needs, via '*conversations with a purpose.*' (Burgess, 1984, p.102 in Taylor, 2005). By using an informal structure and being explicit in inviting women to have a conversation rather than 'be interviewed' I acknowledged and attempted to address any interaction bias (Mason, 2017; Shaver, 2005; Taylor, 2005). This means the value of women's contribution to the knowledge, their autonomy and their agency in disclosing and depicting their truths are prioritised, whilst my own neutrality is emphasised. (Mason, 2017; Shaver, 2005).

My methodology then combines humanistic and feminist approaches which privilege women's experiential knowledge and the constructionist nature of reality. This approach also compliments the trauma-informed research methods I felt critical to the ethics, design and analysis of the research.

## 4.4 Research Design

Conversational yet purpose-driven interviewing avoided a formal question and answer format, as this may be redolent to women of previous negative experiences, for example, of services seeking disclosure with a punitive aim (Kvale, 1996; Shaver, 2005; Urada and Simmons, 2014). A conversational approach then enhances open disclosure and knowledge production in the interview and attends to ethical concerns when researching populations considered vulnerable (Shaver, 2005). I adhered to my trauma cognisant ethics by adopting an open-ended structure guided by the respondent, which avoided replicating potentially traumatising encounters where women may have been questioned in contexts they found distressing or unsafe.

The interview format draws upon Berends' (2011) Lifeline Interview Method, reflecting the thesis' concern with the life course, trajectories of exclusion and inclusion and a 'whole person' approach to problematised and criminalised behaviours. Accordingly, the women were encouraged to tell their stories of adversity, barriers and opportunities encompassing interpersonal, familial, environmental, and systemic experiences. However, I was also careful to observe the principles of Trauma-informed Care when interviewing and this created some tensions with Berends' (2011) lifeline method which advocates encouraging people to thoroughly tell their life stories (Day, 2018). I balanced this tension by ensuring that the power of disclosure remained with the respondent; where something was interesting and I wanted more detail, I would give verbal cues (e.g., 'oh really?', 'could you tell me more about that if you're comfortable?') but if I felt that something was particularly upsetting, for example I noticed the respondent's voice wavering, then I recognised that the topic was potentially triggering and would not probe any further. By being led by the respondent's disclosures and cues I felt able to gather women's stories without exposing them to a triggering or unsafe degree of questioning.



As will be seen in the Interview Questions section, an interview guide was developed to help structure conversations with this purpose in mind and to focus on the experiences and processes at the heart of the inquiry<sup>24</sup>. However, what transpired was that the conversations unfolded naturally and iteratively while still focused on the purpose. I credit this to the enthusiasm respondents had for telling their stories in full and for having their voices heard in a non-judgemental context. I felt this allowed the co-production of knowledge through flexible discussion and exchange, as opposed to an excavating approach. As Mason (2017) asserts, 'excavation' can diminish the scope and richness of material by inhibiting the natural discursive feel that leads a free flow of information and exchange.

A revision was made to the initial interview guide<sup>25</sup>, condensing it to three questions about women's lives leading up to their recovery and any positive and negative experiences with services. This revision proved redundant as once I had introduced myself, my interests and the general line of inquiry, women tended to speak freely and fully without my needing to ask any of the set questions. Instead prompts that expressed empathy such as 'that must have been so difficult,' 'of course', etc., or gentle encouragements to signify particular interest in certain points and experiences were used. This was the case for 21 of the respondents, with interviews lasting from 45 minutes to 2.5 hours. Two interviews lasted 20 minutes and I felt the women were somewhat reluctant to talk in much detail. Interestingly, in these instances I did try and revert to more formulaic questioning, but this still only gleaned one word/closed answers, so I respected that and ended the interviews, thanking the women for their time. I did use some excerpts from these and it was interesting and useful to note that what data was gained tended to support the experiences of the other women. It was also an informative experience with regards to trauma sensitive interviewing and knowing when to stop prompting or pursuing a line of questioning, however potentially germane to the topic it may have been.

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<sup>24</sup> See Appendices

<sup>25</sup> See Appendices  
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A note on compensation; I advised that interviews would take around 30 to 45 minutes. All respondents received a £30 Love to Shop gift voucher for their time although where women spent hours with me, I did send them more to compensate accordingly. I felt as I was thanking women for their time it was right to compensate as with any other job, reflecting their additional contribution. By the time I finished data collection and I felt the information I had was sufficiently broad and rich, I had vouchers left over and decided to divide these between all the respondents and send them out as an extra 'thank you' near to Christmas. This was done in a warm manner, but communication was deliberately closed, E.g., 'Thank you again for all your help. Merry Christmas,' so women would not feel this was an inducement to further sharing or expected to respond in any way.

Some of the passion women had for sharing their experiences I believe is due to the feminist principles informing the research. By giving priority to the voices of marginalised women, privileging their lived experiences and their construction of knowledge, I feel the women felt safe to express themselves openly (Bryman, 2016; Denscombe, 2010; Wincup, 2017).

## 4.5 Ethical Considerations and GDPR

Before recruitment and data collection commenced, ethical approval was received via the University Ethics Committee. I completed the University's GDPR and Information Security modules and made sure to adhere to these principles throughout the research process including password protecting data, anonymising content, and ensuring informed consent was given verbally both prior to arranging and on the day of the interview. The information sheet and consent forms are attached in the Appendices.

However, beyond these standard considerations, there were additional challenges that were pertinent given the nature of the research (qualitative, concerning sensitive topics with potentially vulnerable people). These include maintaining boundaries, reflexivity, emotional management and leaving the field (Day, 2018; Denscombe, 2010; Dickson-Swift et al, 2007). These were assessed regarding both the respondents

and me and the potential impact of the research. Consequently, I paid attention to building rapport while being clear about the remit of the relationship and the duration of contact. I was supported by my supervisory team who also provided links to university counselling if I needed it. I learned techniques for self-care and stabilisation through my work with the Rotherham Trauma and Resilience Service<sup>26</sup> and my private counsellor and was supported by an informal social network who I confided in regarding my emotional responses without revealing identifying details of respondents. These relationships allowed me to be reflective about the process and its impact throughout, which greatly assisted with my emotional management. I was also careful to leave space, usually a day, between interviews, both in terms of my own wellbeing and to be able to be present in and sufficiently immersed in each woman's story. As discussed with regards the extra compensation, I exited the field and ended relationships warmly but professionally, reminding respondents of their rights regarding withdrawal from the research process within a timeframe, wishing them well with their future and thanking them for their contribution. I asked the women if they would be interested in receiving copies of the research when it is published, which the 21 most forthcoming interviewees were enthusiastic about. This clarified the closure of the relationship and the next point of contact, while appreciating the trust and intimate knowledge that had been exchanged between us.

I also felt it important to be able to justify the purpose and benefit of my research as I was asking women for personal, possibly traumatic details of their lives. Especially in research with sex workers this can be done in a prurient, sensationalising way. My motivation was the lack of investment in appropriate support services for women and my belief that approaches to women's PDU, and SSW are unjust, fail to acknowledge the role of economics and politics and the purpose of SSW and PDU. I believe that this absence of recognition only serves to exacerbate and entrench deprivation and trauma. I am confident that the need to recognise the roots of trauma in criminalised

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<sup>26</sup> The Rotherham Trauma and Resilience Service works to provide training, consultation, and advocacy to an expanding network of voluntary and statutory services throughout the borough to support survivors of CSE, primarily those who are part of the Operation Stovewood grooming investigations. I have evaluated this service for the last three years.

survival behaviours and coping strategies is crucial enough to justify the research I undertook. I was further validated in this by the agreement, explicitly and indirectly through their stories, of the women I spoke to.

Furthermore, research undertaken according to trauma-informed principles and which exhibits 'caring behaviours' can in fact be empowering and beneficial to women who have experienced trauma and exclusion (Miralles et al, 2020; Reeves, 2015; Wincup, 2017). 'Caring behaviours' include providing empathetic responses to disclosures and demonstrating interest, , compassion, concern and sharing (Dickson-Swift et al, 2007; Reeves, 2015). These behaviours came naturally to me during the interview process and are discussed further in this chapter.

The benefit of participating in research that heeds these principles and practices is being able to provide women the opportunity to tell their stories without fear of reprisal or the pressure of expectation from the listener. Women presented their own histories, and the interviews were led by them, at their pace. Where women may previously have been asked questions, whether by services such as criminal justice or social services or by family members seeking answers, the burden of responsibility or self-preservation to present a certain account could shape their narrative. However, in speaking with me, which was an explicitly one-off encounter, women could present their stories without these pressures, knowing that I was only a passing, albeit hopefully beneficial and validating, presence in their lives (Dickson-Swift et al, 2007).

## 4.6 Trauma-informed Research

The evidence on conducting trauma-informed research is currently scarce, although the importance of it has been noted (Day, 2018) and Vickers (2019) commented on the utility of grounding techniques in response to unexpected disclosure in interviews. However, I used the familiarity with trauma- informed practice and experience I had gained in related research to develop my own approach. Great consideration was given to implementing the trauma-informed ethos underpinning this research and permeated the design and conduct, due to both the sensitivity of the topics explored and likelihood of PTSD/CPTSD past or present among respondents. I have previously

conducted three service evaluations of Rotherham's Trauma and Resilience Service and arranged and attended their 'Trauma Matters' training which was delivered to my research centre (CRESR). Resultantly, I was equipped with an understanding of the complexities of trauma and of trauma-informed ways to conduct research. This comprised as follows:

A critical element of trauma-informed practice is to establish safety and stability first and foremost (Crawford, 2010; Day, 2018; Herman, 2015). As per SAMSHA's<sup>27</sup> interpretation of trauma-informed practice, the definition of safety incorporates the practical and psychological (Elliott et al, 2005). While virtual interviewing raised some complications in ensuring the physical safety of respondents as they were in their own homes, I was attentive to the presence of others. Where there were phone calls, visits etc. that interrupted the process I was careful to check that women were able to continue speaking or whether they would rather end the interview. I also fostered physical safety by using grounding techniques, as detailed below. Corrigan et al (2011) describes how to observe the 'window of tolerance', referring to the understanding that trauma survivors inhabit an ideal arousal zone in which they can best receive, process and respond to information. This 'window of tolerance' can be breached if they are overwhelmed with sensory, cognitive, or verbal reminders of trauma and consequently, survivors can be triggered and 'shut down' or go into a state of hyper arousal (Corrigan et al, 2011 ; Ogden, 2009). To avoid this, I took care to be attentive to implicit and tacit cues from survivors, employing grounding techniques throughout and following disclosure of trauma with positive affirmations about their resilience, progress and current safety. In doing so, I took responsibility for helping the women to mitigate their biological and psychological stress responses by emphasising their safety, strength, and grounding them in the present day (Matheson and Weightman, 2021; Ogden, 2009).

I feel that methodologically speaking, my success in building rapport with women and their openness was partly due to my approaches countering messages and

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<sup>27</sup> The Substance Abuse and Mental Health Service's Administration  
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experiences that had traumatised them previously. Not being heard, not being believed, and being contradicted or silenced are common experiences for trauma survivors and can understandably result in them shutting down and withdrawing (Elliot et al, 2005; Ogden, 2009; Sweeney et al, 2019). When introducing myself and my research interests I was very clear about my position and my hypothesis; that in women, addiction is often related to trauma of various kinds, that addiction-connected sex working is a survival strategy in terms of trauma and drug use; that services often fail to appreciate this and in doing so, exclude women and worsen their disadvantage. I feel that this echoed the women's experiences so they knew they were in a place where they would be listened to and believed, which created a trauma-informed dynamic. I didn't feel that this was due to 'people pleasing' or women repeating what they felt I wanted to hear, as they were comfortable to correct me where I had misunderstood details, or to tell me if something wasn't relevant to them<sup>28</sup>.

By demonstrating that I shared an understanding of the roots of PDU/SSW in trauma I mitigated any likelihood of women obfuscating or minimising their trauma, of them being in defence or freeze mode and thus unable or unwilling to access certain memories (Herman, 2015; Ogden, 2009; Van der Kolk, 2015). My role as a trauma-informed listener also allowed them the freedom to speak of their experiences in the context of their traumas rather than their perceived 'failings.' This avoided replicating experiences women may have had where they were asked to recount their histories in circumstances where they may have felt interrogated or expected to present in a certain way certain to be eligible for support.

There are several other ways I was careful to ensure the research was trauma-informed that may be more broadly considered best practice in qualitative interviewing as they acknowledge power dynamics, researcher responsibility and compassionate practices. However, I prefer to include this under the umbrella of

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<sup>28</sup> For example, Jo had not engaged in any treatment services so stopped me when I was explaining my outlook to tell me this.

trauma-informed research as there is a history of qualitative research, especially with marginalised women, which has focused on the collection of trauma histories without the balancing and stabilising influence of trauma cognisance (Fontes, 2004; Mortimer et al, 2021).

I was explicit about the focus of the research but also that the topics discussed, and detail given was entirely up to the respondent. This was repeated in adverts, invitations, information sheets, consent forms and during and following the interviews, verbally and in writing. This ensured women could be prepared for the interviews (and indeed some had arranged to speak with a supportive friend after the interview for this purpose) and assured them that they were in control of the process.

I asked for no detail and gave no prompts in the discussion of traumatic or sensitive topics; all disclosure of abuse and other traumas were offered unprompted and my contribution during these disclosures was to show empathy and compassion. I was careful not to encourage or provoke further disclosure as this had to be volitional and at the women's pace.

Although I was somewhat limited in available cues as I was interviewing remotely, I was attendant to signs of distress and agitation including dissociation (e.g., zoning out), laboured or rushed breathing, hurried speech and difficulties regulating emotion. This was surprisingly infrequent but when it did occur, I would invite the woman to cease the interview or to take a break and do something soothing and grounding before continuing. No women discontinued the process and some shared that they had learned techniques to manage their emotions such as deep breathing that they could use.

Grounding is an important technique in communication with trauma survivors and involves assisting them to feel conscious in the present (Covington et al, 2017; Vickers, 2019). Survivors may become overwhelmed with memories and cues from the past, especially when anticipating discussing this. A helpful way to informally ground respondents before beginning the interviews was to have an informal chat first; to speak about their day, often our mutual experiences of/opinions on the pandemic. I also shared my background and how this motivated my interest in the research topic.

This aided in building rapport and mutuality which also contributes to safety and security where sensitive topics are concerned (Campbell et al, 2010; Dickson-Swift et al, 2007). I closed interviews with an informal chat, checking in with the women to see how they felt after the interview and asking about their plans for the rest of the day to help re-ground them in the present and focus their attentions on something positive and soothing. Several women seemed familiar with this strategy as they had already arranged self-care activities following the interview.

## 4.7 Data Collection and Transcription

As discussed, data collection was undertaken remotely and recorded either within the Zoom app (all calls were password protected) or on a password protected Dictaphone registered with the University. I was alone in my apartment during data collection for complete privacy and discretion. Following interviews, I was sure to copy the files onto my password protected laptop and delete the hard copies from all devices.

## 4.8 Sampling

I recruited 23 women through purposive sampling with the sole eligibility criteria that they have history of problematic drug use and/or sex working. I did not specify 'street' sex working as due to technological advances and in certain areas, policing, there has been a shift away from traditional 'beat based' street work to brothels and saunas due to the democratisation of internet access (Sexton, 2003 and 2009).

Regarding sex/gender I did not specify whether women were to be CIS or self-identifying , though all who did respond were assigned female at birth (AFB). In retrospect, the inclusion of trans women may have complicated the research as trans women have a distinct experience both in terms of their lives prior to reassignment and in terms of social and systemic treatment.

I had established relationships with various services for street sex workers and recruited two women through these. This was fewer than originally planned but services were unexpectedly in crisis mode and unable to collaborate any further. I recruited other women through online recovery groups.



This meant that at one stage I had fewer SSW involved than I hoped, unbalancing the sample. However, having interviewed a woman with lived experience and a professional role in providing specialist SSW services, she vouched for my safety and credibility to women she knew with SSW histories, and this significantly boosted the representation of sex workers to a small majority of the total sample (13 of 22).

Ideally, I would've spoken to women in all the different countries of the United Kingdom but due to capacity and time constraints, I sampled from England and Scotland. I chose these countries due to their differing policy discourse (with a greater focus on health over crime in Scotland) and the acuteness of the socioeconomic deprivation and drug problems in Scotland. While Scotland was instructive in demonstrating the impact of socioeconomic trauma, England is the largest country in the U.K and regarding policy, Whitehall is hugely influential; for example, regarding safer consumption rooms, it has the power of veto over Scotland (Christie, 2020 and 2021).

Five women now worked in services of various descriptions themselves and four others were involved in voluntary activism. The remaining women did not refer to any occupation and I felt it could come across as judgemental to ask.

The demographic profiles of the women are detailed below in Table 2.

**Table 2. Profile of participants.**

Pseudonym	Location	Survival Sex Worker?	Age
Katie	South of England	Yes	30s
Rosie	Southwest of England	Yes	40s

Brenda	Yorkshire	Yes	40s
Anna	Southwest of England	Yes	30s
Sonja	South of England	Yes	30s
Laura	Midlands	Yes	40s
Emma	South Lanarkshire	Yes	30s
Shelly	Southwest of England	Yes	30s
Paula	Northeast of England	No	40s
Megan	Glasgow	No	40s
Kylie	Glasgow	No	40s
Dina	Lanarkshire	Yes	40s
Lily	Southwest of England	Yes	30s
Gina	Aberdeenshire	No	40s
Keira	Glasgow	No	30s
Abi	Lanarkshire	No	60s
Cathy	Glasgow	Yes	40s
Eva	Highlands	No	40s

Jo	Glasgow	No	40s
Amy	Lanarkshire	No	30s
Jill	Glasgow	Yes	30s
Kim	South of England	Yes	40s

## 4.9 Conducting the Interviews

Interviews were conducted remotely between October 2019 and February 2021. I tended to do several per week, often daily, to have plenty of space to process the exchange and the data. I would then begin transcribing so I could make notes on my immediate reflections while they were fresh in my mind. I would then arrange another round of interviews.

As we can see in the Appendices (1.1) the interview guide began as quite a lengthy document based around three main questions but with several supplementary questions.

The first question sought a general overview of women's histories, 'Can you tell me a bit about your life leading up to your involvement in this project/recovery?'<sup>29</sup>. Supplementary questions explored women's environment, relationships, assets and unmet needs.

Secondly, I asked about negative experiences of services, with supplementary questions probing about the alignment between women's priorities and expectations and those of services, including the use of targets and goals by services and how conflict was managed.

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<sup>29</sup> 'This project' was used where women were recruited through services although due to COVID-19 this only related to two women and was later abandoned in favour of 'recovery'

The final question explored helpful experiences of services, again focused on women's needs and priorities and how these were met .

Every iteration was preceded by the same introductory paragraph explaining my interest in hearing women's experiences of their addiction and whether this could be understood by an inequality and trauma-informed lens. The introduction became the core of every interview as it often led many women to share their experiences and opinions in services in response to this paragraph alone.

For the second iteration I removed the supplementary questions as I felt they were getting in the way of a flowing conversation and weren't needed. However, I eventually found that the most successful way to approach the interview was through the introductory paragraph and question inviting women to tell their stories; this tended to provide answers to all the supplementary questions, requiring occasional prompting and causing far less interruption of flow.

To check the validity of my interpretations I would invite the respondent to refute or confirm this during the interview, by following their disclosures with, e.g. 'It sounds like.... Was this so or am I misunderstanding?.' I felt it was important to emphasise their role as expert in knowledge production in the research, and to initiate dialogue where they could correct me without feeling confrontational.

There were ways I responded to particular divulgements that, as well as embodying the essence of good practice in qualitative researching, also echo the principles of feminist interviewing. For example, I would affirm certain disclosures empathetically by normalising women's responses, therefore abiding by the feminist principles of validation through normalisation and sharing (Campbell et al, 2010; Dickson-Swift et al, 2007). E.g., 'That's awful, no wonder you responded like that... it's your brain and body reacting to a threat so it's totally natural you'd have done that... I've done similar in those situations before'. Sometimes this would cause the women to reflect and express relief or realisation, e.g., 'Yeah, I suppose it is all you can do at the time, isn't it?,' which I would again affirm, an exchange especially significant where traumatic experiences are concerned, wherein women often self-blame and feel alone. This reflection could also lead women to appraise the lack of resources available to them

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at the time, e.g. 'And I couldn't do anything else because the police had never helped me before ... anyone I told it was 'oh you must be exaggerating.' This provided, from the women herself, endorsement of my observations of systemic neglect and provided space for respondents to affirm their experience as a victim and apportion blame appropriately.

#### 4.9.1 Data Analysis

I chose to transcribe the interviews myself as I felt this was an effective way to really get to know the data out of the field and as part of the process of analysis. This was confirmed, and I found it an enormously valuable phase. It was emotionally trying as I found myself really engaging with the stories and their significance when truly 'hearing' and transcribing them. I realised that in the moment of the interview I was less able to realise the magnitude of the disclosures as I would often be overcome by one experience which would affect me. I was mindful of taking breaks when especially affected, for my own self-care but also to ensure I gave due consideration to, and reflected upon each moment during, the process. Transcription was intelligent, as it was the content of the interviews that were most important rather than, for example, the details of the discourse or language used (Bryman, 2016).

I transcribed, as with all phases of my research, informed by a set of hypotheses regarding the impact of inequality, neoliberal policies and correlated traumas. However, I also prioritised the validity of the participants' experience as knowledge, reflecting my feminist research principles. There could theoretically be tension in balancing the hypotheses with women's own accounts, but I found during transcribing that my theories were validated by the women's experiences. Individual trauma took on a greater role than predicted but this informed my conceptualisation of the feminised impact of neoliberal governance upon marginalised women. Through transcription I began to realise, then later flesh out, the relationship between neoliberal policies and deprivation, violence, child mistreatment and neglect, intergenerational and community trauma, and PDU and SSW.

I found that women's accounts fell naturally into life course phrases, namely prior to, during and after PDU/SSW , and so I allowed the life courses to structure the telling of their stories.

My second phase of analysis drew upon the Framework Method and was thematically informed by my analytical framework, as detailed in Chapter 3 (Ritchie et al, 2013). These underpinned my thematic analysis which was conducted according to the themes identified below.

- Trauma
- Centaur State- punitivism, retrenchment, exclusion/blacklisting\*
- Poverty of Spirit\*
- Neoliberal governance and austerity\*
- Presence and impact of individualising models\*
- Appropriate and inappropriate service responses\*
- Sense of self

\*All relating to the exploration of alternative social theories and their potential contribution

During coding and analysis, I began to realise that the traumas experienced by women went beyond the traditionally conceived of interpersonal moments such as child abuse or assault. Instead, trauma permeated their family histories, communities, and systemic experiences. Accordingly, I analysed again according to a three-dimensional conceptualisation, comprising the individual/interpersonal, community, and systemic. There was strong evidence of all three, interlaced with evidence of the impact of neoliberalism's individualising rhetoric, the practices of austerity and consequent exacerbated deprivation.

Having discussed the specifics of how I approached the challenges of ethically and effectively eliciting the experiences and perspectives of these 23 women, we now turn to the findings themselves, where the concept of multidimensional trauma will become more apparent.

## 5 Findings Chapter 1. The Antecedents of PDU and SSW. Developmental and Intergenerational Trauma: Inherited Consequences

This chapter describes the early lives of the women, the histories of the people and places that surrounded them, and how the associated experiences indicate the pervasiveness of multidimensional trauma. This conceptualisation of trauma incorporates the individual/interpersonal, community, and systemic and is theorized to permeate marginalised communities because of embedded cycles of inequality. Consequently, citizens are argued to exist perpetually on the cusp of survival, caught in states of fight, flight, fawn or freeze<sup>30</sup> (or ‘the four f’s’) and lacking the opportunity, assets and support to do otherwise.

### 5.1 Family Histories of Poverty and Trauma

Many women described a complex web of trauma and deprivation, often beginning at a very young age. These histories were bound up with those of their families and communities, suggesting the intergenerational accretion and transmission of marginalisation and its symptoms. Rosie attested;

*It's family history, poverty, whether exploitation was present, inequality. All those things need to be addressed more widely. There isn't therapeutic interventions in schools, the care system is fraught with problems. you're getting kids that are removed from situations at 3, 4, at birth already addicted whose needs aren't being met by their foster homes because their behaviour is all over the place Because it just doesn't get picked up early enough, we'll get a phone call like 'She's 17 and likely to be on your caseload soon' and it's like what the fuck have*

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<sup>30</sup> Described as the four threat responses or ‘four f’s,’ prevalent among survivors of trauma and those with PTSD/CPTSD (Owca, 2020)

*you been doing with her for 17 years?! She's been in children's services, in and out of foster homes!.'*

Rosie describes the early traumas and exclusion that typified many women's developmental years, and which were intrinsically connected to their addiction. Many women referred to their early drug use as a readily available coping strategy in an otherwise deprived environment. This embodies the essence of this chapter's findings; that women's traumas were not isolated events but bound up with their families' and communities' trauma and the erosion of wellbeing, safety, sense of purpose and value that accompanies austerity.

The retrenchment of public services can be conceived of as systemic neglect due to funding cuts and service limitations undermining the availability of appropriate support. This systemic neglect occurred in women's early years and contributed to women's drug use, for example, where untreated mental health problems resulted in self-medication.

As we will see in Chapter 6, women frequently only came to the attention of services in terms of an **active response** when their addiction had reached a chronic point, by which time they had been battling numerous traumas for decades. Furthermore, by the time women were noticed by systems and services, it was in terms of the risk they were judged to present. As a result, their experiences often felt punitive despite the origin of their difficulties in unaddressed trauma and deprivation from infancy.

Having been born amidst the socioeconomic upheaval of the mid-80s and, for most women, being in the midst of the austerity measures and climax of neoliberal discourse of the previous decade, correlated multi-dimensional traumas are posited to have blighted women's communities over decades. Trauma characterized women's developmental experiences and it can be asserted that this inheritance was due to their family members and communities bearing the wounds of the increasing neoliberal retrenchment and punitivism discussed in Chapter 3.



It is these early experiences and their contribution to women's traumas and coping responses in later life which we now explore in greater detail in the body of this chapter.

## 5.2 The Relationship Between Drug Use, Poverty, and Survival Sex Work

We begin with an overview of the relationship between unmet need, trauma, and SSW and PDU, before exploring this at individual, social and systemic levels.

As illustrated in Chapters 1 and 2.4, the need to finance drug use is one of the predominant drivers behind SSW, and this often results in a trapping cycle of work and use. Certainly, bar one, all the women started working to fund their drug use which provided dissociation from the distressing reality of their experiences and environment. As illustrated from 7.3.2 onwards, when the hardships and traumas that compelled them to PDU were addressed, all of the women also stopped sex working and spoke of it in nothing but the most negative terms.

The relationship between PDU and SSW is not isolated from other factors, and the findings of this research strongly suggest that the root of the cycle of addiction and sex work is within the experience of poverty and the higher incidence of traumatic events correlated with this. However, not all street/survival sex workers are funding an addiction.

Survival sex working by women who are not sustaining drug habits is likewise connected to inequality and poverty, as illustrated by Hubbard (1998) and McKeganey and Barnard (1996) who found increased rates of unemployment related to industrial decline correlated with women's SSW in Bradford and Glasgow.

The pervasiveness of poverty for many of the women in recovery is illustrated by Lilly who still had to sex work to pay her bills.

*I will admit, a few times I had regular punters, I did go and see them, not that it makes it better, but it was to get gas like, not drugs, because I was broke and I'd do it go get money if I didn't have gas and electric. But then*

*I couldn't do it no more because I didn't have the drugs to kind of... I just couldn't do it.*

Having sex worked previously numbed by intoxication, SSW without that protective layer was too much, and Lily was unable to resort to this last resort. This contradicts the assumption that addicts would otherwise be self-sufficient members of society, were it not for 'squandering' their finances on drugs. It also demonstrates how close to absolute poverty many (in deprived communities) are, without supporting themselves on the black and grey markets (Joseph Rowntree Foundation et al, 2014; McKeganey and Barnard, 1996).

Although this applied for the majority, as we see in 5.3 not all the women engaged in PDU and SSW in response to sexual trauma or exploitation.

Although Dina did experience polysubstance addiction and undertook SSW to fund this, her initial introduction into sex work accords with an entirely different narrative. She remarked;

*They think it's always the case where people get forced into it and they must do it and it's not always the case. I got introduced into it in a very glamorous way. When I started it was glamorous, the girl who introduced me, the one I was babysitting for, and the man who groomed me, they wasn't drug users. They did it for nice clothes and cars. So, at the start of my life, I never, ever worried about money. I've done from the low end going out there for a fix of heroin to making over a thousand pounds a day... I could buy anything I wanted; I could do anything I wanted.' She later explained that she 'wasn't just addicted to drugs, I was addicted to prostitution. Not the sex side of it. The power, the feelings of freedom.*

This suggests that sex working provided Dina with a sense of fiscal and personal power she felt was otherwise unattainable, perhaps a common feeling among women from deprived backgrounds. This may be especially so for women with histories of childhood abuse and abandonment. Dina commented that '*Kids who've been abused*

*and have escaped, prostitution's given the freedom to get out because at least they can feed themselves and rent a place.'* Therefore, sex work may be the only available opportunity for some populations to be able to meet expectations of self-sufficiency as the resources and support to access these are unobtainable or obscured.

Dina's story is complex; street sex working and indoor sex working, and the motivation of addiction and the lure of an extravagant lifestyle were not polarised nor without trauma. Although she described her introduction as 'glamorous,' she also identified her grooming and exploitation by an abusive man, though she credits this recognition to work she did in sex worker specific rehab and therapy. This illustrates how the experiences of sex workers are nuanced, and deprivation can have its impact in different ways across women's lives.

This chapter now moves into a more detailed discussion of the women's lives and how their experiences of interpersonal trauma contributed to their PDU and SSW.

### 5.3 Individual/Interpersonal Trauma

*A lot of women that I worked with in the criminal justice support service had untold trauma... I have never met a working woman who uses drugs and alcohol not to have the story from hell...So for lots of the women I worked with were at the extreme end, it was extreme. (Megan)*

The roots of addiction PDU and by proxy SSW were located almost universally in traumatic experiences, where drug use served to numb the psychological and physical impact of neglect and abuse. These traumatic experiences frequently began in childhood and often typified women's experiences of relationships throughout their lives, as we will see in 6.1.1., in the proliferation of abusive, violent partners.

This is attested to by Megan in this section's opening quote on the prevalence of trauma among women in the criminal justice system. This suggests a correlation between criminality/criminalisation, PDU and SSW and trauma. Megan explains the role of substance misuse in self-medication of trauma further, remarking that;

*I had complex mental health issues. I had a lot of anxiety that was probably there before I started drinking, based on a lot of traumatic events. I can't even explain it, you recede into yourself...it's almost like you need to run away but until you face things like this head on it doesn't start to get better, and you must start to heal from your trauma.*

The relationship (especially for women) between PDU, SSW and other forms of criminalised behaviour (such as shoplifting or benefit fraud) has been described in Chapter 1.1 , and Megan's experiences further testify this, suggesting correlation between trauma, poverty and criminalisation. Indeed, this emergent relationship establishes itself as a common theme throughout the Findings.

Discussed in the following sections are the multitude of individual, intergenerational and community traumas that intersected prior to PDU. By virtue of systemic responses (or lack of) to their traumas, women were often further marginalised and harmed.

### 5.3.1 Family Trauma: Deprivation and Distress in The Home, and The Systemic Neglect Of

Experiences of violence and neglect typified many women's upbringings, often occurring alongside a myriad of adversities, where appropriate recognition and support was absent.

This was illustrated by Kim's account of her early years:

*I grew up with an alcoholic father who was abusive, and I was sexually abused as a child and removed from the family home and then put into the care system. So, it was never really talked about. I was classed as a problem child even though I don't feel my behaviour was a result of me but a result of what happened to me. I was put into care at the age of 7 and I started drinking and taking drugs at age 10. I got put into this psychiatric hospital for kids, I was put there for a year. I'd go there in the week then go to a care home on the weekends. I did school there and*

*stuff then went to a boarding school for kids with behavioural problems.*

*But in all that time I never had no counselling, no therapy, no nothing.*

*R: That was gonna be my question, did anyone recognise you were a survivor of trauma and responding to that*

*K: Not at all. I struggled at school because I'm dyslexic as well. I did act out, I was bad. I couldn't do the schoolwork, I didn't have a home, and I got passed around. So, I was bad, and I was quite wild. When I hit my teens, we were all smoking weed and doing LSD and things like that and then when I left school at 16, I moved back as the school was quite far away and lived with my grandma for a while but she's an alcoholic too. There's lots of alcoholism in my family. And then I ended up living in a hostel for women because my nan couldn't manage, it wasn't really an appropriate place for me to live. I met a guy who was doing heroin.*

We see in Kim's account above that she was repeatedly exposed to traumatised (and traumatising) individuals throughout her developmental years (her father, partner and nan) which resulted in painful experiences in terms of attachment, sense of self and safety. This inheritance of trauma can be theorized to originate from her family's own experiences causing their trauma and coping strategies (alcoholism and violence). The experience of environmental and vicarious<sup>31</sup> trauma was one that persisted into women's addictions where, as we will see, they were again surrounded by other traumatised and traumatising individuals.

However, the symptoms of Kim's trauma were pathologized by services who conversely treated her and her parents as risks rather than in need, and who perceived Kim as 'bad' and incapable. The symptoms of this fractured start to life, including substance misuse, 'acting out' and struggles with school, contributed to a continuation of the patterns of neglect that had typified her early years. By her teens,

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<sup>31</sup> Through witnessing, hearing about and living among the symptoms of other's traumas (Atkinson et al, 2014)

Kim was placed in a risky environment for most, let alone a vulnerable young teenager, and was exposed to and inducted into heroin use.

It is also pertinent to note that the development of the recognition of PTSD as connected to women's trauma is a relatively recent occurrence and so during women's childhoods, as Brenda describes below, this often went unrecognized.

*I was abused from the ages of 6 to 11 but I didn't know how to deal with it. Back then there weren't no PTSD, you didn't talk to doctors, you just got on with it. So, when I was in my teenage years I rebelled, got angrier and angrier, got in with the wrong crowd and got into drugs... From younger to my teenage years, it weren't... I weren't being listened to; I weren't being heard. I was just a naughty child. It's like, the drugs became a way to numb the pain...oblivion. It gave me oblivion.*

It appears then that a consequence of the systemic lack of trauma response resulted in, for many, self-medication in response to feelings of isolation, shame, fear, and rage. This coping strategy embedded itself in many of the women's early lives and during their addiction had become almost a reflexive response to trauma, as indicated by relapses due to loss of child custody, bereavement, and violence.

Self-medication operated not just as an individual strategy but one with precedence in their communities and families, suggestive of the embedded operation of trauma as a driver for PDU generally. This is supported by research concerning the intergenerational transmission of trauma and criminalized behaviours within deprived and marginalised communities (Atkinson et al, 2014; Klest, 2012).

While Lily had been raised in an environment that normalised harmful relationships with intoxicants, it also served a very real purpose in her world schema, one that could be extrapolated to explain the attitudes of those surrounding her:

*My first thing of being drunk was my step nan and her weird bloke getting me drunk when I was about 11. I'd done drugs but now I know from young, I had so much crap in my head I just wanted anything that took away that feeling. I'd tried every drug, I'd tried LSD, cocaine,*

*mushrooms, Es, I'd tried everything. And I think when I found heroin, I found the thing that stopped my mind working, stopped them thoughts. It's hard to explain...*

Although drugs and alcohol consumption from childhood was normalised and even encouraged, Lily recognised its purpose was to numb pain. The ultimate way of doing this, as other women also recognised, was through using heroin, which has been described as the ultimate painkiller and dissociative (Horton et al, 2009). The argument that PDU operates as a functional strategy is strengthened by this evidence of the relationship between early experiences of trauma and subsequent use of dissociative and sedative substances.

Women were often seeking to numb various traumas. Prior to addiction women experienced a multitude of traumas encompassing sexual and physical abuse, homelessness and growing up in precarious and deprived families and environments.

For example, Lily divulged;

*Well, I suppose, I experienced physical and sexual abuse as a child. I grew up in quite a chaotic household, moved around a lot, ran away a lot. My parents divorced, then we moved to another city. My mum was with a heroin addict, so my stepdad was a heroin addict. I kept running away and met a, didn't know he was a pimp, at 14, so I was groomed and pimped.*

This constellation of traumas is also epitomised by Maria's story, which began with being raised in an emotionally restrictive and physically punitive environment. In Maria's family gendered expectations and inequality were ingrained and she was expected to assume a role of submission and servitude to the men in her family. She suffered multiple experiences of sexual abuse from a young age, leading to a series of abortions and ultimately expulsion from the family home. Her father was found having committed suicide, after which her mother died several months later, leaving Maria with the responsibility of parenting her brothers. This was despite her brothers being old enough to fend for themselves. Maria found herself having to do their

laundry and make their meals, abandoning any aspirations and still keenly feeling the dearth of validation and acceptance in her life. With these damaging series of events, and the lack of alternative sources to counter this, the consequences for Maria were devastating and further marginalising.

*That's when my life started spiralling out of control. I was so crushed and so heavy that at the age of 23 I started getting involved in illegal drugs, thinking I could make money out of it because I ain't got a job, it was just all on me.*

*When I was using illegal drugs, this is a glimpse of how small my life became: I was manipulating, I was selling drugs as well as using them, I was angry at everyone and God, and everything. I didn't have no dignity left, all my morals and values went out the window, I committed several crimes, I didn't care what happened to me, I was beaten, I was raped several times, I degraded myself just to get that drug of choice. I was smelly and I'd not shower for weeks or months, the neglect of self and hygiene and house I was living in went out the window. I was arrested several times; I didn't have no self-worth left in me. I became homeless, living in car parks, tents, under stairs, anywhere. I started working the red-light district and I never thought I'd be doing that, but I did, and I was just stuck in that small tunnel vision world. I went to jail several times, about thirteen times that I can remember. I just felt hopeless, I wanted to die. I was in dangerous situations, but I didn't care because when I was fixated on drugs, I don't see the consequences or what dangers are ahead. I'd just go ahead and do it. I was kidnapped. I never ate, I went down to a size 6, I had malnutrition, and basically through the whole process, if you look from young, I was sort of with myself but from then on never was there any thought for myself, nurturing that little inner child of mine. I gave up on myself, I didn't know who I was. So basically, I was physically, mentally, emotionally, and spiritually broken. I was just dead inside; I was a sad existence. That's how bleak my world became.*



Maria's experiences embody the trajectories of trauma and marginalisation that led to women seeking solace in drug use, and often in tandem to fund this (and for some, as an unconscious pursuit of acceptance), survival sex working).

There were two, often overlapping experiences in many women's histories that inflicted significant trauma upon them. These include sexual exploitation and sexual abuse by predatory men. These are discussed further below.

### 5.3.2 Exploitation and Abuse

Several women were targeted and exploited by abusive men from an early age and were inducted or manipulated into heroin use by them. Their manipulation frequently served either or both purposes of rendering them vulnerable to and reliant on the man while he abused her in multiple ways (including financial), and of involving them in sex work. These exploitative relationships seemed to set a precedence that repeated throughout women's adult lives, with several women referencing multiple abusive partners throughout their addiction.

Kylie had been sent to a children's home following the death of her gran who was her only caregiver, and several years later her father committed suicide. Following this, her vulnerability and need for validation was exploited by a man who instigated a sequence of events that retrospectively, Kylie recognises gave him enormous power over her.

*But I've always been a bit vulnerable, susceptible to anybody if they showed me a bit of attention. If you told me, all the lies that were under the sun, I'd believe them. So, I ended up getting into a relationship with him it was my early 20s... just a man, a guy that I'd met, and he'd interested me to try speed. Tried that. He was staying for a few nights, and he went out and he came back, and he said I cannae get any speed, but I've got heroin instead. And I wisnae that clued up with it at the time, I just knew I'd tried it at the time, and I didn't know how addictive it was. So, I tried that and enjoyed it, I really enjoyed it at the time, I only snorted it, but I really enjoyed it. He kept getting it over the weekend so*

*that 3 to 4 days I was on it and before I knew it, I was on it and that's what he was hoping for.*

Interpersonal trauma can cause a harmful junction of the desire for attention and validation and an inability to identify risk, as indicated above in Kylie's experiences (Van der Kolk, 2015). With these precursors, exploitation and induction into addiction may be employed by predatory men as a means to gain control and take advantage of vulnerable women. Although Kylie didn't sex work to fund her partner's habit, several other women mentioned doing this and being encouraged to relapse as to send them back to street working.

As we see below, Kylie experienced this to an extreme degree, being assaulted by her partner with a view to exacerbating her addiction before being deserted, having been taken advantage of as much as possible.

*He ended up moving in with me, and I was staying with him but what I didn't know was when I was snorting it and I was lying in my bed he was injecting me with it when I was sleeping, and I didn't know that (R: Jesus Christ) and he was breaking into houses about my local street and that, bringing stuff back to the house. When I'd say to him where'd you get all that stuff from it was 'oh I bought it' and before I knew it all the neighbours were up at the house. By that time, he'd fled, and I was hooked.*

This man's exploitation of Kylie and her home continued until he drew too much local attention to his burglaries in the neighbourhood, following which she was again abandoned but this time further burdened by chronic addiction and infamy in the community.

Almost all the women interviewed (and all of those with histories of sex work) experienced abuse in childhood that preceded their addiction, and professional and personal anecdotes demonstrate that most had also experienced child sexual exploitation. The impact of sexual exploitation during children's developmental years is powerful, frequently distorting their sense of self, sexuality and relationships. One

effect of this is the normalisation of abuse and conflation of manipulative and transactional sexual experiences with love (Firmin et al, 2016). This inflicted significant trauma upon the women which they proceeded to self-medicate to the point of addiction. It also served to make the notion of sex working not quite more palatable, but a miserable yet accepted, or 'natural'<sup>32</sup>eventuality that could at least remedy their poverty.

Maria's life was marked by multiple experiences of sexual abuse from a young age, and she correlated these with her vulnerability to further abuse and seeking affirmation in what turned out to be exploitative experiences:

*Little Maria's life unfolded. These are just some of the major traumas that happened to me, not all of them but some of them: I was sexually abused from 10 – 12 years old by one abuser, I was sexually abused by another abuser several times when I was 14. At school I was acting out, I was a rebel and I started going towards the bad boys and everything. I was being abused by those boys sexually. So, from a young age, being sexually abused from the age of 10, that's how I started seeking my validation.*

This intersection of painful and confusing experiences, exploitation by men, and the convergence of the search for acceptance with the reality of abuse was a commonality for many. Indeed, it was often recognised as a dominant factor in women's motivation for using drugs.

Of her professional experience, Rosie noted that;

*I don't know anybody I've worked with that hasn't got a trauma history of some description...the majority of women, I would say it's as high as 80% of the women I've worked with have had sexual exploitation pre- 18.*

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<sup>32</sup> As one woman described it  
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*It's massive... you don't start self-medication at 17 with heavy duty opiates unless there's a problem.*

Rosie's attestation to the direct relationship between histories of trauma and the use of drugs, in particular heroin, to soothe the impact of this, exposes the flaws of pathologising, moralising narratives of addiction.

*Of course, that's what you did because why wouldn't you have done that at that time, to take an opiate-based painkiller.... It's a pain killer isn't it ultimately? And it does a really good job!*

Echoing this, Anna described how 'every time I've been in treatment or meetings, almost everybody I speak to who has addiction problems has been sexually abused'. She also noted that the signs of abuse in her childhood had been overlooked and she felt that this was crucial to her life trajectory; 'Just recognising when, I think promiscuity in younger years, I would have sex with anyone, they didn't even have to ask. I think that was my first real sign'.

Most of the women who engaged in sex work connected it with normalisation of abuse and of self-protective/transactional sex in childhood, which fed into a harmful gendered narrative correlating self-worth and sex. Anna described her outlook as follows:

*I had a pretty normal childhood, normal to me. What I realise now is we were very unsupervised and there was a lot of 'messaging about' was what it was called then. So, my brother was sexually active, and he inflicted that on me and my sister. And a family friend as well. It started really young, so I feel like my idea of self was changed, and it developed into thinking sex was love also a kind of element of 'that's all women are for'.*

Similarly, by the time Cathy had been through a series of violent relationships and was in the throes of serious addiction and poverty, she found sex work an almost natural though unhappy next step.

*I got the Trade paper and found the back page and it wasn't even a problem, and I know that because of how I felt about me and what I'd been through I had this saying in my head, I know it sounds really crude, but this is what I felt, I felt like a punk vessel, and that's so sad.*

This demonstrates the tragic impact of early sexual victimisation in terms of harming self-esteem and normalizing exploitative sex. Sex work for Cathy was a survival strategy that was not made acceptable due to her lack of moral compass or disregard for the law. It was, however made essential by financial desperation and lack of options and made possible by her lowly position in her own schema of worth. These practical and emotional harms can be conceived of as the inheritance of childhood abuse and neglect.

Again, countering moralising assumptions, Brenda made a conscientious choice to street work to address her poverty, rather than take part in shoplifting;

*It were a vicious circle and that's how I got into prostitution. It were a choice between that and being a thief, and I can't do that. At least I can say everything I've spent I earnt*

*R: Ah so it was like a moral thing*

*B: Yeah, I earned it. Hated it because I don't like to be touched. Hated it but I couldn't... there were just no other option.*

Although Brenda's childhood abuse meant she found sex work hugely traumatic, her moral compass prevented her from stealing. This demonstrates a strong sense of morality alongside perhaps low self-worth in her decision to harm the self over harming others.

Brenda's reality directly contradicts depictions of SSW as immoral, 'fallen' women. Conversely to these moralistic assumptions, as we will see, when in recovery, women sought and even delighted in meeting the normative expectations of society.

SSW then was often cited as the only option to survive financially without causing harm to others, illustrating the irony of the criminalisation of SSW when it may be the sole alternative to committing acquisitive crimes.

Further attesting to the influence of women's moral compass when choosing how to afford their addiction, Cathy felt similarly to Brenda:

*I had low self-esteem anyway, I had depression and my way of thinking about it at the time was if I can sell my body then I'm not harming anybody. I'm not going out shoplifting, I'm not harming my family, I'm not harming anybody that's coming into contact with me.*

Like Cathy and Brenda, Lily identified her repeated childhood sexual abuse and grooming by a pimp (at 15) as influential in her acceptance of sex work, remarking that, *'To be honest, from my childhood experiences I always felt that was all I had to offer you know. The same old story, sex was all I had to offer and that was all I felt comfortable with.'*

The impact of these messages and experiences which denigrated women's sense of self, also contributed to their great emotional pain. When recalling what helped them in their recovery, many identified the importance of addressing poor self-esteem and histories of rejection and degradation through work that focused on establishing a strong sense of self-worth. Before recovery though, PDU was the only way the women felt able to numb their trauma and poor self-image.

Exemplifying this, Shelly had been using heroin since 12 to self-medicate the trauma and sexual abuse she had experienced throughout her life, *'It changed the way I felt. It stopped all the trauma hurting. What I know now to be trauma, I didn't know at the time'*.

Several women's traumas in their youth occurred at the hands of older men who posed as boyfriend figures to exploit them. Dina's story exemplified this intersection of adversity and the trapping trajectories of these 'relationships':

*At the time I couldn't see it for what it is, and I've had to have lots of therapy and rehab, and actually he was a pimp, and she was a prostitute, and I was a lot younger, and I was more valuable to him wasn't I...so I was groomed basically. And on my 16th birthday I did my first punter, and I moved in with him and had two children with him and there was domestic violence all the way through, 7 years I was with him, and it was severe domestic violence. It wasn't just hitting me; it was torturing me.*

Dina had been deliberately targeted for her vulnerability and youth, and her ability to leave was complicated by the pimp's depiction of himself as a protector, lover and provider, and later by her having children with him and the paralysing fear created by his abuse. As Dina testified, at the time she was impervious to outsiders raising concerns about her situation;

*I just couldn't see that because I really loved this man, I'd borne his two children and I really thought it was a proper relationship. Apart from the domestic violence I thought everything was fine.*

These abusive 'relationships' often segued into sex working in tandem with the (at the time) girls' use of alcohol and drugs to numb their pain. Shelly was;

*Introduced to a guy that used to pay me for photographs then quickly the photos got worse and worse and then I was 15 on a street corner, and that's how I funded my habit for twenty years.*

However, not all grooming experiences fitted the archetype of the male predator. Although Lily already had an extensive history of being abused and exploited by men, it was a woman who groomed her into sex working.

*Yeah so, I was running away and there was a group of women...weirdly it was a woman and she used to take in runaways, and she let me stay with her. But I didn't know she had links to all these pimps, and she was actually working with them. So, I moved in with her and the guy started coming round and showing me attention. And as sad as it sounds it was like 'yeah, I'll go out and have sex for money and give it to you, because*

*you're accepting me'. It's really weird. It's a really mentally weird thing, but as weird as that sounds... so yeah, I met him through a woman.*

Lily recognises how the combination of rootlessness and a desire for acceptance in a deprived environment culminated in her sexual exploitation, where it appears that a woman was trafficking runaway children.

The existence of group grooming was a harrowing revelation and indicates the operation of grooming gangs nationwide, beyond the infamy accorded Rotherham and Oldham.

Lily attested;

*Weirdly, now, all the voluntary work I do, there's a woman I met recently, and she's got a similar background to me and basically, we was with the same pimp but in different cities and we didn't know each other back then. It was such a big network across the Southeast and London and Wales... when all this Rotherham grooming stuff came out, I thought 'that's been going on for years!', and I'm 45 now, I was flipping 14/15 then. It was massive. My pimp, I think he's got 20 odd children across the South. And that's all the women, all the women who've got children for him were all prostitutes for him.*

Similarly to Rotherham, Lily recalled statutory services (including police and social workers) interpreting men's exploitation of girls/women as genuine relationships, and consequently failing to identify and respond to harm.

Regarding grooming and domestic violence perpetrators being described by services as 'boyfriends', Lily remarked;

*Yeah, are you crazy?! 'Boyfriend', don't! 'cos now I volunteer at a women's service for street working women and aww, I have to keep my mouth shut. Because they say, 'Oh my boyfriend!' but that's how they see it, because if that's all you've got at that time, as crazy and toxic and chaotic as it is, it's all you know and it's your everything. And that's what*



*I try and explain to the workers to try and take them away from that man, especially when drugs is involved as well, it takes time, and it takes patience. Because even though you'll be like 'Oh just get away from him', it's not that simple. I call it 'Bonnie and Clyde syndrome' and it's like, no it's not, you're being abused, and you're being exploited, you know?*

Often, the acceptance of abuse in the search for love was began from childhood experiences of grooming and perpetuated into women's relationship seeking patterns in adulthood. As Lily identifies, the impact of grooming on adult relationships requires empathetic response from services who may fail to recognise the footprint of childhood abuse and instead become frustrated by women's apparent predilection for abusive partners.

### 5.3.3 Intergenerational Incidence and Transmission of Trauma

One of the most striking themes that repeatedly emerged throughout the histories of women and their families was the persistence of traumatic experiences and related symptoms . This is indicative of intergenerational transmission of trauma and of the intersection and exchange between community and individual experiences. This has been implicit in some of the experiences discussed thus far, for example Kim in 5.3.1 but is explored here in greater detail.

For example, Anna felt unable to protect herself and her children, referring to being unable to 'safeguard,' which she connected to childhood sexual abuse in her family. Consequently, her son was exposed to traumatic experiences and began to exhibit symptoms of trauma and distress himself.

*At that time, I had a few people coming in and using my flat and this guy OD'd in my kitchen and my ten-year-old robbed him and it was like 'Oh my god what.' I don't even know how he thought to do that.*

Perhaps this was because of Anna's difficulties at this time to look after her child and herself and so his own struggles were expressed through criminalised behaviours. Rather than denoting familial deviance (Anna was certainly shocked), this could

demonstrate the intergenerational impact of trauma and how these experiences manifest as ‘inherited criminality.’ There was also a genuine need for protective intervention here, but Anna and her son were unsupported by this stage of her life.

Even though Laura felt unable to identify as having experienced childhood trauma on par with her peers in recovery, she did disclose physical punishment and emotional neglect. She also revealed that her brother had similarly shown symptoms of distress, using drugs as she did, and through his mental health.

*My brother, he did use heroin as well and he's had problems with alcohol and he's gone on to have really serious mental health problems, years and years of psychosis, delusions of persecution. I've had a really difficult time with my brother, trying to support him when he was thinking that everything you were doing was trying to not support him. It was really difficult, he ended up being detained for a few years and being medicated.*

This suggests that even less identifiable or normative forms of childhood trauma can have significant repercussions throughout families.

The proliferation of intergenerational trauma suggested by many women's childhoods may reflect the impact of periods of heightened neoliberal exacerbation of deprivation and the consequent cycles of community poverty. This parallels Atkinson et al's (2014) findings concerning deprived communities in Australia, where the pervasiveness of various intergenerationally transferred traumas triggered further exclusion through responses at systemic and societal levels.

Reflecting my own findings, Helen Milroy (in Atkinson et al, 2014) also refers to the impact of cycles of poverty and marginalisation upon Aboriginal communities in terms of multilevel trauma.

*The trans-generational effects of trauma occur via a variety of mechanisms including the impact on the attachment relationship with caregivers; the impact on parenting and family functioning; the*

*association with parental physical and mental illness; disconnection and alienation from extended family, culture, and society. These effects are exacerbated by exposure to continuing high levels of stress and trauma*

*... Even where children are protected from the traumatic stories of their ancestors, the effects of past traumas still impact on children in the form of ill health, family dysfunction, community violence, psychological morbidity, and early mortality. (Milroy, pxxi in Atkinson et al, 2014)*

We have seen illustrations of this in women's family histories, as detailed in the preceding chapters; for example, alcoholism, incest, childhood abandonment, untreated mental health problems and debilitating poverty. This endorses the utility of the concept of community trauma to describe the impact of poverty and its correlation with intergenerationally inherited trauma. Therefore, the consequences of poverty may be expanded to include intergenerational trauma as the symptoms of community deprivation and trauma intersect to inflict greater adversity and distress upon the individuals and families within it. As we will see, systemic responses to this are often experienced punitively and contribute to further marginalisation. The specifics of this relationship between deprivation, intergenerational trauma and the drivers of problematic drug use are discussed further below.

#### 5.3.4 The Consequences of Inequality. The Intergenerational Transmission of Trauma

Poverty, inequality and the intergenerational trauma discussed above appeared to be related to the attrition of parental capacity to emotionally provide for the women in their early years (Cancian et al, 2013 ; Casady et al, 2001). Extrapolating from the intergenerational trauma which the women experienced prior to addiction and its impact upon them, it can be advanced that their families and peers may have had similar experiences. The impact of bearing their own traumas, historical and ongoing can be hypothesized to have inhibited the women's parents from having the emotional, physical and fiscal security to be able to provide care to the best of their abilities.

A commonality in many women's childhoods was the lack of warmth and availability from their parents (particularly their mothers). As we saw in 2.53, detachment and dissociation are a protective strategy for trauma survivors, who close themselves off, engaging with others in the most perfunctory way possible, while hypervigilant to threat and prone to emotional dysregulation. If we combine the lack of alternative coping strategies and repeated retraumatisation (for example, by the stresses of their environment) that appears rife in deprived communities, we can understand emotional neglect in terms of inequality, trauma and its impact on the ability to connect, as such connection requires dropping vital defences.

Therefore, given the connection between poverty and traumatic experiences, the women's mothers may be understood as incapacitated by their environment and the correlated impact of their own traumas. This went on to have understandable repercussions for the women themselves.

In her recovery, Keira recognised that the lack of emotional warmth and validation in childhood resulted in distress which she discovered could be numbed by substance use.

*I had quite a rough childhood. Financially we were always supported, but emotional needs; we were never cuddled, for my parents we were never told 'Oh we're proud of you', or 'You're going the right way', nothing like that, it was kind of very much, you just pull your socks up and you get on with it. My mum's an alcoholic and my dad had a gambling addiction, so I've known from a young age I've had an addictive personality, kind of learned from my parents or passed on from my parents, that's the nature/nurture debate. So, there was always that issue, there was a bad relationship between me and my mum where I just hated her if I'm being quite honest. She was very nasty, very emotional abuse, it was very verbal, never physical but it was very much emotional abuse where I was told I was never wanted as a child, it was my fault for her drinking. So, I just took that on board... So, I tried it and I liked it because it helped blank out what I was feeling.*

While addictive personalities are not in the remit of this thesis, the presence of addiction and emotional dysregulation throughout Keira's family is suggestive of trauma and self-medication in response to unmet needs. As Keira indicates, this trauma and the strategies to cope with it were transmitted intergenerationally, although it is unknown whether this is genetic, sociological or a combination thereof. However, extrapolating from the women's own experiences and the evidenced correlation between poverty and adverse experiences, it is likely that trauma was prevalent among many women's families and communities (Blair et al, 2019; Steele et al, 2016).

Similarly, Emma retrospectively interpreted her childhood through the lens of developmental trauma, remarking on the lack of emotional stability and warmth from her mother.

*I realise now, I've actually gone on and worked in addiction and done a qualification in psychodynamic counselling and early attachment and I've very much realised that in my childhood... my mum doesn't have diagnosed mental health issues, but she has pretty severe mental health issues that she projects onto other people. So, I've realised that I had a very disorganised attachment in my childhood, but I had a diagnosis of BPD (borderline personality disorder) at one point. It no longer applies to me; it was queried, and it now doesn't meet the criteria, but I know it shares a lot of commonalities with complex PTSD and I think a lot of those symptoms were of trauma.*

Emma's experiences demonstrate the translation of disordered attachment experiences into trauma symptoms and suggest the accretion of traumatic experiences through unsafe attempts to self sooth adding complexity in adulthood. This is also often misdiagnosed among women as BPD (Bipolar Disorder) (Bailey and Brown, 2020). As other women mentioned, when trauma-informed clinicians became aware of their life histories, the actual diagnosis was the more environmentally aware and empathetic one of Complex PTSD .

The consequences of Emma's developmental traumas and lack of opportunities for acceptance meant she found the warmth she was seeking in substances:

*As a child I didn't even know who I was, I was completely groundless, unrooted. And when I used substances, they give you this false sense of confidence. You feel confident, and you feel connected, and you feel that sense of belonging. You're probably just being an arsehole. But it gives you that wellbeing, heroin in particular gives you that feeling of warmth and wellbeing, and the pain went away.*

The realisation that drugs and alcohol provided an escape from the pain of isolation and low self-worth in childhood was a driver in many women's initial drug use. Parental capacity to connect and provide validation is a complex issue, but as touched upon, several emergent factors include parent's own trauma histories of trauma, environments and opportunities for support and self-realisation.

Exemplifying this, Emma recalled of her parents;

*My dad's mum grew up in care, she had no family, she was abused in care. She had 11 children and my dad was one of the oldest, I think he hardly got parented, his dad died when he was young. My mum, her dad had a drink problem, and my gran is completely bonkers. She had traumatic things happen in her childhood too and I think I was able to think 'well they didn't do it on purpose, they were that wee girl at one point', but they've developed their own ...not all of us go through the stages I went through, they develop different strategies. So, I think that was a really valuable part of that (professional training) ... it was very authoritarian and punitive, there was never much love around. And I never felt valued.*

As demonstrated in 6.1, experiences of punitivism and rejection were often mirrored in adult experiences in both interpersonal relationships and systemic treatment. This can be argued to contribute to creating, entrenching and exacerbating cycles of trauma in marginalised communities.

Maria had grown up in a family where emotional fluency and expression was condemned and punished with violence; consequently, she felt overwhelming pressure to conform to normative expectations of femininity, although aware of the injustice of this compared to her brothers' freedoms. Her experiences prior to addiction were of inequality of a particularly gendered kind, of expectations of passivity and subordination, and of violence as an accepted form of discipline;

*My programming I received from a child was that I wasn't allowed to have friends, go to school events or friends' houses, my family were my friends, that was always drummed into me. And we weren't allowed to talk about feelings, we had to brush it under the carpet, and if we did talk about feelings I'd be shut down. And that was normal for me, I thought this is what happens. I wasn't allowed to disgrace the family name. I come from a large Catholic family so if I cry it was 'I'll give you something to cry about' and my father would hit me physically, if I bit my nails, he would hit me physically. And high expectations from a young age, I had to be with my mum in the kitchen and be a good girl because that's what the traditions are, you're not allowed to speak to boys, you have to be always with your mum doing women's stuff, whereas with my brother, he grew up doing whatever the hell he wanted to and I always had resentment over that*

It appears that Maria's home environment and incipient experiences of relationships were replete with the violent imposition of restrictive imperatives, and the emphasis of women's subservience to men.

The patriarchal structure of Maria's family may also have contributed to her response to the emotional neglect by her father, which overwhelmed any mitigation from her mother's emotional availability. Maria identified this neglect as contributing to her vulnerability to abuse from men and her search for warmth and connection. Devastatingly, it was this very behaviour that led to her being ultimately rejected by her family.

*I really thought it was normal to do sexual stuff with any bloke or boys that wanted to do it. So, I was kicked out of the family home, allowing myself to be abused by men. And I thought they liked me, that was my distorted thinking. And it was kind of to do with my dad wasn't really emotionally there for me, so I was craving his attention whereas my mum was emotionally there for me so it's just something I'm always searching for because my dad wasn't available for me.*

Not all the women understood their childhoods in the context of trauma so explicitly. Laura struggled to identify her upbringing as traumatic, despite disclosing symptoms such as hair pulling, anorexia and substance abuse from a young age. She also experienced a lack of warmth, validation, and connection from her mother and felt singled out in this respect, as what she needed, her sister received.

*So, the only thing that I can really think is, certainly my mum, was highly critical and I suppose I just didn't really feel that I had that real connection. I hear people say oh your mum's your best friend and I've never had that with my mum, ever. I've got an older sister who's just a bit older than me and she has got a very different relationship with my mum, she's much closer to my mum.*

Here, Laura identified the expectation of an incomparable bond between mother and daughter which conformed to her sisters' experiences, but the absence of which was so disruptive to Laura that it contributed to her use of drugs to substitute.

The impact of emotional trauma was also noted by Megan, who from her professional experience observed that histories of neglect often meant PDU from a young age to provide comfort, excitement and other positive affect. As a result of this was as adults, women were often unable to recognise and be comfortable with emotions without the influence of substances. This further attests to the relationship between PDU and trauma and the impact of this on the development of emotional literacy.

*People didn't even know what it was to feel happy or excited without a drug. And I was working with women that all we knew how to do was*



*give them more drugs This girl thought she was having withdrawals from diazepam, she says 'I need more Valium, where's the nurse?! Where's the nurse?!', I says 'What is it? You were fine this morning, what's going on?!' She says, 'I'll never get through to tonight, I'll not get to this (a themed night organised by Megan for the service). Everybody so much looked forward to this night, but it was 'Argh, I'll not get through it, I'll never get through it.' But she was excited. See, once I got to the bones of it, she'd never felt excited without drugs, she just didn't know what was wrong with her. It was just tragic.*

In communities ravaged by generations of trauma and poverty, problematic drug use may be an unrecognised natural response to managing the harms of this which also stifles emotional articulacy. Therefore, drug use can dually provide a form of emotional experience while rendering the 'natural' experience of emotions alien and frightening. This supports my theorisations in the previous section concerning parental capacity and trauma.

Speaking to the relationship between inherited trauma, developmental attachment difficulties and addiction, Rosie was cognisant of this in her own family:

*I've got two boys and they're not self-medicating because that chain of addiction in my family, that alcoholism that ran through my family, has been broken, thank God I had my boys in recovery, luckily, they've never had to experience me being an emotionally unavailable or abusive caregiver. Even though they've only had me, I've been a single mum for most of their life, they've had that secure attachment, that 0-5 attachment that is really, really significant and important.*

Rosie recognised that her difficulties began with her family's traumas and the transmission of them generationally, rather than her hailing from a 'risky family.' Rosie's ability to access the support to acknowledge her trauma, feel valued and empowered, allowed her to break the cycle of addiction and trauma in her own family.

Lily found acceptance and belonging in criminality, which served to counter the emotional neglect from her mother. It seems that her mother was also suffering from low self-worth and seeking external validation from unsuitable sources.

*My mum had a lot of different blokes round the house, she couldn't be without a bloke... and my stepdad, even though he was a heroin addict, he was the only one who wasn't dodgy in any other way, like trying nothing dodgy. He used to take me out shoplifting and I used to think it was great, I felt accepted in that kind of world I suppose so that's why I gravitated towards that. I think that's what I was looking for because I didn't feel it at home. I was looking for anyone that would show me that attention and kindness and I'd think 'Oh yeah, that's cool, I'll put up with this!', I don't know if that makes sense.*

Lily's account suggests that her mother's reliance on male validation, regardless of risk, fuelled her own pursuit of acceptance which she ironically found among the only of her mothers' partners who wasn't 'dodgy'. Extrapolating, while he was a heroin addict and a shoplifter, Lily does not identify him as 'dodgy', inferring that the other partners were suspect in other ways, likely in terms of being abusive. Therefore, conversely to normative expectations, criminality for Lily offered an early source of identity, warmth, and comparative safety.

## 5.4 Compound Community Trauma and the Ripple Effect

The following section broadens its focus, further illustrating the presence of trauma among the individual and collective lives of those who shared the women's environments prior to addiction. This broadening of focus further attests to the relationship between the intergenerational inheritance of trauma, community deprivation and their exacerbation by neoliberalism and inappropriate systemic responses. Accordingly, the environment within which the women were raised can be posed to have been incapacitated by the perils of existence in survival mode. As a consequence, the communities are argued to have been burdened not just by deprivation, but traumas, individual, community and systemic.

The aforementioned relationship can be argued to manifest in the proximity of 'bad crowds' in marginalised communities and in the solace sought in PDU and discontent expressed through violence, neglect, and dissociation.

Indicating this, the phrase 'fell in with a bad crowd' was used several times by women to explain their induction into PDU and reasons for their rejection by family.

Kylie had been sent to a children's home, which she attributed to her grandmother (who had custody of her although her parents were alive at the time) passing away and her associating with the wrong company.

*I think for me the first time that I ever tried heroin I was 15 and I was in a children's home because my gran had passed away and I fell in with the wrong crowd and I got sent to a children's home.*

Reflecting the pre-addiction experiences of most of the other women, Kylie had suffered significant trauma by the time she tried heroin. Her home life had been difficult enough that her grandmother was awarded full custody and her parents were not seen as viable alternatives upon her gran's passing. She then suffered the loss of her only caregiver and the amplification of her exclusion due to the marginalized position of her social circle.

Later in life Kylie was severely addicted to heroin, having been injected in her sleep by a partner who was notorious as a thief locally, and who vanished when staying in the neighbourhood became untenable. Kylie was abandoned, again, in a fractured and deprived environment.

*But the street I stayed in was quite a bad street and I'd already known people that were dealing it and I started hanging out with them and before I knew it, I was totally addicted. I didn't know how addictive it was but at the same time I knew I needed to make myself feel better as well. So, they would come up to my house every morning and I'd have the two wee ones, hiding in the bedroom, and my eldest would be kicking the door trying to get in and I'd be getting a hit at the same time. To try and make me feel better. This went on, for years, I just kept falling in with...I just seemed to keep*

*attracting the wrong crowd. When you're on heroin, everyone knows that you're using, and you start attracting the wrong ones.*

'The wrong crowd' then, is conceptualised here as a collective of individuals bearing the effects of community trauma (linked to pervasive inequality) and displaying the symptoms of this in their addiction, poor mental health, and criminality (Coade and de Wolf, 2008).

The prevalence of PDU as a coping strategy in communities was also mentioned by Jo. Jo came from a community where abuse of alcohol and drugs was considered normal so long as the dominant values concerning work and self-sufficiency were met. This contradicts narratives of 'scroungers' and the idle poor, indicating such a focus on employment that this could override or obscure vulnerabilities or struggle in other areas of life.

*I did start using really early, so I started drinking at 11. But one of the big things I think that held me in denial but also in good stead was that I always worked. So, I had got my first job when I was 12... you could do that back then... you were allowed to do that... I was working in a wee café. But I carried that on, I always worked, so I had this sort of working-class value that if you worked then there wisnae a problem, so long as you went to work there was never a problem, so I think my denial was pretty much steeped in that and also, I was surrounded by alcoholics who were functioning. When I first got clean and I spoke to my family about it most of their reaction was don't be ridiculous I drink more than you, I take more drugs than you.... It was just this complete normalisation.*

The status of employment in Jo's community does not imply that its members were without financial stresses and may in fact indicate the degree of economic pressure faced; if people could be self-sufficient and support their addictions this was acceptable as fiscal precarity was severe enough that it was imperative that everyone could support him/herself.

Furthermore, the widespread heavy use of alcohol and substances and the acceptance of this suggests an environment where citizens are self- medicating en masse and seeking communal oblivion from distress, whether spiritual, social, or economic.

Like several of the women, Jo had experienced childhood sexual abuse before turning to substances, and this had understandably disturbed her sense of self and safety.

*I had suffered emotional trauma as a child, so I had been sexually abused by my father as a child and physically very badly abused as a child and I think that was one of the catalysts for using drugs so early and it was a bit... I hear other addicts and alcoholics describe it as drugs or alcohol made them feel normal, it made them feel part of. It never did that for me but it made me not care that I didn't feel part of and so I felt very, very detached, and what alcohol and drugs gave me was a sense of not caring about being detached. It didn't give me a sense of being attached or connected, it gave me a sense of 'Oh its ok that I'm not connected'.*

Jo sought oblivion from substances to numb and dissociate from the trauma of her abuse, and of her lack of connection with those around her. Substance abuse and alcoholism was rife in her family as well as community, and by unlikely coincidence, so were histories of trauma.

Jo recalled her family's experiences of trauma, poverty, and rejection, recognising its contribution to her own experiences and its relationship with poverty and inequality;

*Both my parents had quite traumatic childhoods themselves. So, my mother, her mother had tuberculosis, so she was my mother felt abandoned, her mother went into a sanatorium, you know back in the 50s. my mother was a small child then and she was sent to an aunt and by the time my grandparents got out my mother didn't know who they were, they were in there a few years, they weren't allowed visitors. So, she grew up feeling abandoned, and rejected by her own mother. My father, who's still alive, my mother died two years ago of excessive*

*alcohol intake, her stomach burst, but she got to 70 though, you know, like me, she had a really strong work ethic, she was a manager in social work, she was clever, she was, had she been born now my mother, she would've had a totally different life. My father he's in my mind still incredibly unwell and he also had quite a severe traumatic childhood, so we grew up I mean his violence towards us was horrendous I mean we grew up with tales of how much worse the violence was that he suffered. I don't know anything about his mother's story other than she was a money lender in the Gorbals in the 40s so she was obviously criminal and a money lender, yeah... so I don't know anything much about their story, I know more about my mother's story because I asked but her mother, my grandmother, was born illegitimate, in Donegal in Ireland.*

These cycles of intergenerational trauma can be theorised to embed dissociation as a coping strategy; this can be detected among Jo's family and community's PDU as an attempt to mitigate the impact of their surroundings. This echoes Atkinson et al's (2014) assertions as detailed in 5.4, which suggest a relationship between inequality, compound intergenerational trauma and the coping-related consequences of these.

Relatedly, Jo identified a purpose of her substance misuse in soothing what Polanyi (1944) and Alexander (2008, 2010) refer to as social or spiritual poverty; her societal isolation and rootlessness.

*I was incredible emotionally isolated. I was emotionally isolated, but I wasn't physically isolated, do you know what I mean? And I think that's where addiction takes us...into that complete loneliness where you cannae speak to anyone, ye cannae share with anyone. It's not just a case of ye cannae do it... I didn't actually have the emotional articulation to do it... I found that much later. That was part of my recovery was learning the language of emotional intelligence. From a young age I had started to shut down my feelings so I couldnae describe what a feeling was. I didnae actually know how I was feeling and a lot of times I was just shutting my feelings down anyway so there was a lack of intimacy*

*because I was just not sharing with anybody, so I was incredibly emotionally isolated*

When considering Jo's history and those of her relatives, it is unsurprising that emotional detachment and the use of substances to achieve this was an accepted and common part of her community's life. In the absence of alternative sources of support or recognition at systemic levels of their need, PDU appears a natural response to the harms of the environment.

As we have seen, not all of the women interviewed were able to explicitly identify the roots of their trauma. They were however explicit about either feeling that something had happened or that although they didn't directly experience individual trauma, they grew up surrounded by community trauma.<sup>33</sup>

For example, Laura felt her childhood behaviour must have been indicative of some form of trauma, though she couldn't identify what;

*To this day don't know what those pills were. I mean my parents never took drugs. I would go in and take these pills and I did it quite a few times. And this one time I must've taken too many, I'd gone home from school at lunch time, and I'd taken pills and gone back to school and then I don't remember anything else. I just know I ended up in hospital that day so obviously it was quite a big deal. But when you look at something like that you think well that's not normal behaviour, something's not quite right, and I can remember doing things like pulling my hair out, you know, things like that, to the point I was leaving bald patches. So, I know there was something went on, and then I started sniffing solvents, sniffing gas canisters. I got caught doing that as well.*

While she did exhibit self-harming behaviour, Laura asserted that she didn't intend to commit suicide having 'taken too many' pills having previously taken them for

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<sup>33</sup> 'Community trauma' is that where experience of poverty, violence and other adversities are rife among others, which is witnessed or at least known, thus leading to vicarious traumatising (Atkinson et al, 2014; Duane et al, 2020)

recreational purposes. Similarly, her progression to solvents suggests the pursuit of oblivion from reality rather than destruction of self.

Despite having exhibited these behaviours, suggestive of trauma, Laura still struggles with identifying herself as having suffered adversity in comparison to others;

*As an adult in my recovery, I've spent lots of time thinking about it and it's actually been quite difficult for me because a lot of people who've been in addiction, they've had really terrible, traumatic incidents in their childhood, and I've not got anything like that. I wasn't sexually abused; I wasn't physically abused. We got smacked and things like that, but it was normal at that time, child development and what children need has really come a long way hasn't it, since then.*

However, being 'smacked and things like that' are not contextualised by young children against the mores of the time, so physical punishment from parents can be understood as a traumatic experience. Furthermore, Laura later identified that her mother was emotionally distant and highly critical, so it seems that attention and attachment were in fact lacking in her family. Nonetheless, it is important to acknowledge the validity of the women's perceptions of their lives, both as recognition of the epistemological validity of subjectivity and because the way experiences are received and perceived can affect how they are responded to.

## 5.5 Systemic neglect

A significant degree of the trauma experienced individually, and throughout communities, has its origin in systemic neglect. As discussed in the Analytical Framework (Chapter 3), a great deal of this is rooted in lineages of punitivism and retrenchment at systemic level, justified by socio-political discourses that reduce state responsibility for public services. Parallel to this, the expectations of the state for all citizens to be economically and socially productive and compliant have increased. This includes amplified state monitoring and intervention, despite the resources and input needed for marginalised populations to participate being in rapid decline.



Much of the systemic neglect experienced by the women prior to their addiction occurred through the professional disregard of trauma symptoms and of substandard care for marginalised children.

This frequently manifested as women appearing to have fewer protections and support in their childhood than more privileged children, something observed among children in deprived populations in New York, Canada and Australia with regards to mental health support, education and welfare (Giugliano, 2004; Miller et al, 2013; Slee, 2012).

Laura was abusing substances, self-harming and showing signs of an eating disorder from ten, yet despite authorities being aware of these behaviours, only an overdose was judged to warrant attention:

*I remember being sent to see someone who I think might have been a psychiatrist and I went for three sessions and that was it. Basically, I think they were querying was it a suicide attempt, taking those pills, I don't think it was. I don't know what I was doing to be honest with you. So, I think that's all I can really remember about that, they sort of said oh she's not suicidal and that was the end of it, that was that. So, there wasn't anything else, no. A few other things are coming back to me now, I remember I went through a period where I used to faint, I wasn't really eating properly, I suppose the indicators were there that something wasn't right. I don't know what wasn't right.*

Despite her behaviours suggesting trauma and the need for intervention, once authorities concluded Laura wasn't suicidal, she was given no further support despite, as she recollects, 'the indicators' being there. The impact of ongoing funding cuts and of COVID-19 narrows the parameters of eligibility further, with mental health services ever more unable to respond except to cases judged to threaten imminent risk, which is again defined by increasingly restrictive definitions (O'Hara, 2015; Sparasci et al, 2022).

Similarly, many of the experiences recounted by women of their childhood experiences of the social care and criminal justice sectors are suggestive of systemic neglect, including diminished rights and validity as victims. Shelly had been groomed by a man she met through the children's home she lived in, and despite her internalisation of blame for the lack of support in her life, she did identify systemic failures;

*I suppose I feel a bit let down by that part of the system. They didn't really care where we were. We'd be reported missing and that'd be it. We'd get taken back by the police and I'd just go again. It was that same cycle. They never tried to break through and get to the bottom of what was causing my behaviour...so at a young age I pretty much came to terms with the fact I was going to be an addict for the rest of my life.*

This lack of diligence, let alone professional curiosity and recognition of trauma, meant from a young age Shelly's identity was enmeshed with addiction and isolation. The responses Shelly received to her trauma-related behaviours resulted in her ejection from the children's home at 15, becoming street homeless and being pimped until her first custodial sentence at 16. Similar experiences of systemic neglect also affected Lily's childhood:

*I remember I got arrested and I was 15, with my pimp. I was such a runaway I think they'd had enough of me. But I was living in a hostel, and they had staff there, the staff were supposed to keep an eye on you, but I got arrested out on the street, I got cautioned, they knew my age. I didn't get no interventions. They cautioned me and then it was 'Yeah, get out', and I think it is that. Sadly, as well, because I did come from that kind of family where when I ran away it wasn't reported, it wasn't an issue, no one came looking...sadly it does then feed into that police view of 'Oh it's them kind of girls', they think it's a choice.*

Services were aware of Lily's being sexually exploited as a child and her vulnerable history, including being under the impression of being in a relationship with a known pimp. Despite this, her absconding and associating with criminals was seen as

symptomatic of her deviancy. Consequently, she was not accorded the diligence and care that is the duty of services tasked with safeguarding the vulnerable.

Lily and Shelly's experiences exemplify the systemic disregard of symptoms of women's traumas and of the correlation between childhood deprivation, trauma and exploitation and symptoms in adulthood. Keira recalled a woman she knows:

*This girl, the stuff she's been through herself... like when she was a child and in the care homes and in the foster homes, that's when you should've been protecting her and maybe all this knock-on effect might not have happened! It's heart-breaking. And that's just one person. The stories I hear off women, it's just being let down by the system. I don't know if it's they don't care, or... I don't even know what it could be because I think surely everyone is human and has a heart.*

While phrases like 'early intervention' are established in the discourse of criminal justice and health and social care, Lily highlights how in reality the disregard of early intervention is a critical flaw if government is serious about tackling addiction and other 'social problems.'

#### 5.5.1 Dual Diagnosis; Recognition, Yet Lacking Response

While the cooccurrence of mental health problems and addiction is sufficiently accepted that it's terminology, 'dual diagnosis', is established in discourse, systemic responses remain insufficient. Where addiction began as a reaction to inadequate support of mental health problems, this led to some women being further excluded due to their self-medication.

Eva struggled to find recognition of her mental health problems in the statutory sector, resulting in her being inappropriately medicated while otherwise unsupported, so she turned to drugs to redress this. This is indicative of the impact of retrenchment on services and the related inability of professionals to be able to respond appropriately.

*I had 32 years of addiction, mental health illness. It was basically mental health which then led on to addiction. It basically went onto alcohol and if that wasn't working it was going on to opiates, whatever I could get, and cannabis, whatever I could source. So that's what led me into addiction, my state of my mental health. My mental health was really poor and even though the NHS had put me into psychiatric, it wasn't working. I was coming out, the anti-depressants weren't working, I was just looking for something to make life a bit easier, if you know what I mean?*

Many of the women found PDU soothed the impact of trauma, but Eva was the only woman who had turned to drugs as an alternative to lack of support from the system for her mental health problems.

Nonetheless, this is likely no rarity; I heard a wealth of other attestations to the lack of accessible, suitable support for dual diagnosis and trauma, in addition to descriptions of the impact of funding cuts and outcome demands on services. It seems likely that there are doubtless many more women whose needs remain unmet and who self-medicate for want of a suitable alternative (Houghton et al, 2021).

A significant proportion of participants were either given substandard support or entirely neglected by services overall prior to addiction. This lack of support contributed to their PDU as substance use served in lieu of formal interventions, albeit perpetuating their vulnerability and exposure to trauma. As illustrated in 7.3.4, women were able to achieve recovery and transform their lives when listened to, believed in, and offered support that was holistic, compassionate and without exclusionary criteria. This is indicative of the role of systemic neglect in the development of addiction, as marginalised populations seek to medicate and mediate the impact of their deprived environments in the absence of alternative, suitable support.

## 5.5.2 Cumulative Life Course Disadvantage: Trajectories of Exclusion and

### Systemic Neglect

As we have seen in this chapter, SSW and PDU are often responses to lifelong experiences of deprivation and trauma. These myriad experiences often intersected, placing women on trajectories that only furthered their trauma and exclusion.

Sonja's life story demonstrates a sequence of adversities that increasingly marginalised and isolated her:

*So I was 15 and my mum remarried...He came in, no children of his own, and basically took over and I can remember him giving my mum an ultimatum and saying it's either me or your daughters...all I can remember is being handed the local newspaper and told to find somewhere to live...and I was the youngest girl in there (new house) with a lot of older men.*

From a very young and vulnerable age, Sonja was rejected by her mum who it could be inferred was also in a vulnerable position, controlled and manipulated by an abusive partner. Consequently, Sonja ended up living alone and unsupported, surrounded by predatory older men. She continued;

*So my first perpetrator was my elder son's father, he was years older...basically, he coerced me into a relationship, and I ended up getting pregnant. He eventually got done for domestic rape but that fell through the wire and that's how I ended up getting into prostitution, I think the thing was I'd lost so much self-respect from such a young age, going through so much abuse, totally rejected by my family, that I lost any sense of self-worth. My youngest son's father was basically my pimp... he broke bones in my body.*

Sonja had been neglected by her family and also by protective services including child services and the criminal justice system, where she was told by the judge 'there was

*no such thing as domestic rape*’. The violence she suffered went unquestioned by health professionals when she presented with broken bones, *‘with him standing there, having to lie to pretend I’d just had a fight randomly with some girl in the street, and having to lie because potentially he could beat me up even more.’* Sonja then became heavily involved in sex work and chronic drug use including crack cocaine and continued to be abused and exploited by a sequence of men posing as boyfriends. She explains;

*I was in the thick of it for so many years and from such a young age, all I’ve ever known is violence, violence, violence, to the point where ‘Is there something about me’, am I the one that’s making men do this to me.*

The convergence of her traumas with the systemic disregard of her victimhood can be argued to have undermined Sonja’s ability to recognise and advocate for herself as a victim. Instead, Sonja was left questioning whether she provoked or deserved the abuses done to her.

## 5.6 Conclusion

The testaments of the women vividly illuminate their lives prior to addiction set against a historical and ongoing backdrop of cycles of deprivation. These cycles manifest in the transmission and amplification of intergenerational traumas that are exacerbated by systemic and structural poverty and violence. Women experienced traumas at individual, community and systemic levels, reflecting the inheritance of the multidimensional consequences of systemic neglect of communities.

As vulnerable, developing children, many of the women experienced emotional and physical neglect from caregivers who were, as the women would themselves, medicating with substances and displaying other symptoms of trauma such as emotional detachment and dysregulation. Partly due to this neglect and vulnerability but also the absence of protective services and safeguarding, many of the women were sexually and physically abused and exploited. However, the messages from authority often reflected their experiences at home, indicating disinterest or incapacity to care and respond.

In response to these myriad traumas and the pervasive lack of recognition of and response, women sought solace and dissociation in drugs and alcohol, which were widely available and a commonly modelled coping strategy in their communities. These coping strategies were inherited through generational cycles , along with poverty, and exacerbated by the absence of suitable redress. This illustrates the convergence of the consequences of Neoliberal policies' retrenchment of resources and the individualization and responsabilisation of 'social problems' that are exacerbated by poverty.

Women's experiences prior to addiction left them living in a constant state of unpredictability, fear, and distress, with a dearth of recognition and support. Given this, it is unsurprising that to survive these feelings and this position in society, women turned to substances to numb their pain.

## 6 Findings Chapter 2. During Addiction: The Multiplication of Trauma and The Systemic Response

The previous chapter illustrated how, raised in environments and communities bearing the hallmarks of poverty and inequality, women's formative years were rife with individual, community, and systemic traumas. In response to these stressors, and in the absence of suitable recognition and response, substances and alcohol provided a source of comfort and escape.

In this chapter, we explore the women's accounts of their addiction, and observe how multidimensional traumas were further accrued and amplified as was their exclusion, due to their attempts to cope as active drug users and for many, street sex workers. During this time women suffered an absence of compassionate and appropriate support while experiencing disciplinary systemic responses to their coping strategies. Throughout their addiction, the women's accounts illustrate how criminalized attempts to deal with trauma and unmet need are responded to by neoliberal policy and discourse in ways that only exacerbate trauma and disadvantage. Furthermore, an increase in the experience of interpersonal violence and control parallels and intersects with this systemic trauma and women's historical traumas to amplify deprivation and vulnerability.

### 6.1 Individual Trauma

Having demonstrated the proliferation of individual trauma in families and communities, I continue to establish this element of multidimensional trauma in this chapter. By individual trauma I refer to that experienced on an interpersonal level, often of a relational type, between individuals.

As we have seen, before their addiction women had often left or been removed from abusive and neglectful family environments. However, during addiction they were now more vulnerable to and arguably, more reliant on in terms of seeking love and validation, men with violent and manipulative tendencies. These experiences are



more traditionally associated with PTSD among women, and as this section demonstrates, intensify their trauma by amplifying and expanding the scope of the messages they received in childhood of low worth (Herman, 2015). This lifetime of injurious missives inevitably affected women's beliefs : that they were somehow 'bad' or deserving of pain, that relationships were inherently risky and that they were unloved and unprotected.

### 6.1.1 The pervasiveness of interpersonal violence and abuse

We have seen that many women suffered abuse and neglect in childhood from caregivers and/or those purporting to offer safety and love (see Chapter 5). This left a vulnerability to abusive relationships; in PDU circles poverty, desperation and multidimensional trauma are often rife, and similarly it is be posited, so is exposure to exploitative men<sup>34</sup>(Anakwenze and Zuberi, 2013).

Several women suffered abusive relationships with men while in active addiction which inflicted even greater trauma upon them and thus greater reliance on substances to numb this. Kylie felt abandoned and rejected repeatedly throughout her life, describing herself as 'gullible' and susceptible to believing anyone who showed her affection;

*Everybody warned me against him, he's a bad one, he's done ten years for an assault on his ex-partner at the time and he was really notorious round about where I was staying but I thought he'll look after me, he'll take care of me as well.*

Despite the red flags, Kylie's need for emotional and physical security resulted in her entering a relationship with an extremely violent man. The horrific abuse and control Kylie experienced placed her in a constant state of hypervigilance and fear, and yet, as we will see later, her victimization and need for protection and support went

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<sup>34</sup> Anakwenze and Zuberi (2013) describe the relationship between urban poverty, poor mental health, substance abuse and male violence. Therefore, it follows that in PDU circles in the post-industrial UK, there is likely to be a prevalence of mental health and violence among men

neglected and, at times, punitively responded to by services. In culmination, her myriad experiences of violence and neglect only entrenched and intensified her trauma and the marginalisation that began in her childhood in residential homes.

Instead of being protected by her partner from a world she had already experienced as unpredictable and unsafe in her formative years, Kylie was entangled in a violent relationship. She felt trapped, unable to leave through fear of retribution, and increasing her dependence on heroin in her efforts to dissociate.

*So, I left and went back... But then he was constantly bringing up what I was doing when I was away, humiliating me, degrading me, beating me up. But what I didn't know was he was spiking me with drugs. So, he was putting more heroin, more cocaine whether it was drinks, in my food, to the point I'm going, I can't have taken that much to the point I was crawling on my hands and knees, he was making me beg, making me beg to get drugs off him. And by this time the social work were still coming out and they never even said to me can we speak to you yourself, and we'll speak to (husband) separate, he done all the talking, I just had to sit and go yeah that's right. He was saying to the social work see this is what I've got to put up with, she's being doing all this sleeping around and somebody needs to take care of her and all this and then if he'd beat me up and I had a black eye and a bust lip he'd put the social work off.*

The above account illustrates the reality of addiction for many women, where stigma imperils their identity and validity as respectable, deserving members of their sex. Consequently, experiences of interpersonal and systemic punitivism converge and public services unwittingly collaborate with abusers, exacerbating women's vulnerability. These experiences speak to the parallels between violence (albeit physical as opposed to structural), and control in interpersonal relationships and in experiences of services that occurred in several women's accounts. Had Kylie been supported by a professional network that prioritised her wellbeing and victimhood and showed the professional curiosity that is crucial when responding to abusive

relationships (where deceit is extended to professionals also), her suffering may not have reached such a horrific pinnacle.

When coupled with poverty, women's addiction and thus desperation to survive often led them to street sex work. This frequently rendered them vulnerable to calculated abuse by predatory men. Lily revealed how SSW were treated as 'targets' by men seeking to harm and exploit desperate women;

*I'd lost my teeth; I looked like a walking corpse. And as a woman I think how you can find that attractive or even get any sexual.... I don't know. Because it's obvious, I think the men who drive around them areas, that's where you get all the...a lot of the madness, because they know them girls are out there because they're desperate, not because they wanna do it, they're not enjoying it... and they know that. I remember when I used to be out there, there'd be people and they'd drive around and drive around because they know the later in the night it gets if you haven't done much, you're gonna get more and more desperate so they're just preying on vulnerable women.*

The evidence base (discussed in 2.5) and Lily's experiences indicate how SSW are often at high risk of repeated violence and abuse ; this is likely to accumulate across the life course, increasingly triggering and exacerbating their trauma responses. These assaults and the constant threat of harm while street working meant women repeatedly experienced violence from men yet were compelled to engage with them for survival.

This vulnerability and exposure to ongoing violence from men, known and unknown, contributed to women's' entrenchment in their addiction and consequently sex working, as they further sought dissociation and solace. It also intensified their association of relationships and the seeking of interpersonal validation with precarity and violence.

During addiction we can observe parallel processes to women's developmental experiences of systemic neglect , as we will see in 6.3, where vulnerability and trauma

continues to go undetected, and women begin to experience responses as more punitive.

## 6.2 Community Trauma

We saw in Chapter 5 that the majority of women described the environment they grew up in prior to their addiction and the individuals within it in ways that indicated entrenched deprivation. They described their peers and families as exhibiting symptoms of living in a state of imperilled survival mode, typified by the pervasion of the ‘four f’s’<sup>31</sup>. The consequences of this manifested variously in apathy, detachment and reactive, sometimes violent behaviours. In their addiction women found themselves situated in similar environments but experiencing a greater extremity of poverty, inequality and hopelessness. They and their peers were further ostracized, surrounded by greater destitution and any opportunities they may have had for inclusion were obscured due to their socioeconomic exile. Resultantly, during addiction their environments were particularly risky and damaging as well as *at risk* and *damaged*, a circumstance that often entrenched women in their disadvantage.

### 6.2.1 The Need for Safety, Support and Escape

Many of the women had grown up in environments that didn’t meet their needs, especially in terms of emotional wellbeing, and often experienced addiction from a very young age. A consequence of this was that they had never had the opportunity to learn common life skills. Addiction (especially alongside sex working) often brought its own physical and psychological traumas that were exacerbated by the destitution and threat of their environments. This section illustrates how growing up and then experiencing addiction in deprived and traumatized communities further removed women, psychologically and physically from opportunities for recovery, and instead further normalized and pushed greater recourse to substances and other criminalized survival behaviours.

The relationship between marginalised environments, community trauma and the indirect criminalisation of poverty is embodied in the neglect of spaces and places for

marginalised populations. Within these environments survival struggles, trauma, and the availability of illicit markets intersect to normalise and trigger PDU and SSW. For example,

Anna, found when placed in an environment close to the red-light district ;

*I left and was put in a hostel and for me that was like 'ok now I can do street work' and I'm only up the road...I used to get these guys approaching me, pimping me, and I was just, wise enough to know that this guy is seriously gonna be really bad but still...*

The risks posed by the places where purportedly deviant populations are exiled is exemplified by Kim's description of hostels and the vulnerability of street sex working women in these surroundings;

*I just lived in hostels. And being a woman in a hostel that sex worked you're very popular because you're making quite a lot of money, so I also had someone, I was feeding someone else's habit as well.*

*And along the way I picked up, I say, 'boyfriends', they weren't really boyfriends as such. I used to have one guy who used to say he'd watch me and look after me. So, he just used to sit while I was on the street, he didn't check what car I was getting into or nothing, but he used to get half of what I was earning because he said he was watching me.*

Kim describes an environment where desperation invokes a particularly gendered response; women who are able to engage in sex working, and men provide (or merely offer) the physical protection that women require in the face of the dangers they encounter.

Brenda was explicit with housing providers about the risks to her sobriety and safety posed by being housed in a particular area dominated by drug and sex markets. However, this was ignored;

*When I moved back to (city) from (area A) I went to the council, and I said look there's one area I can't move to and it's Area B. Area B is drug*

*central. You walk down the street and somehow, they can spot you a mile off. Even though I've been clean all these years we have flashing lights over our heads and the dealers can spot us.*

*R: Predators, aren't they?*

*B: Yep. Yeah. But I were in a place which is for the homeless until they get you a place to live and they offered me Area B and when I said I can't take it they said either you take it or you're intentionally making yourself homeless. It's like putting an alcoholic in a pub. It doesn't matter how long you've been clean. And within 6 months I've relapsed, and it was horrendous. And then I started working on the streets again.*

Intentional homelessness clauses placed Brenda and others in her situation in a Catch 22 bind wherein the choice being offered was between one traumatising environment and another, with substance misuse the likely response to both.

Nonetheless, when women weren't ready or sufficiently supported and resilient, a change of environment was insufficient. Lily recalled how, in the depths of her addiction, she was given the opportunity to escape her environment and improve her living conditions;

*I was there and got offered a council place. I got offered a really nice one and I went 'No I don't want that,' and then I got offered one in an area which is in the middle of all the drugs, and the red-light district and I was like 'Yes please! That's the house I want!'. The only reason I took that house was to be closer to all that, I'll be closer to all the dealers, I'll be right in it. As bad as it sounds, with a child, that's what my thought process was. So obviously moving there I went proper downhill then.*

It appears that at this stage Lily's addiction was so severe that her hierarchy of needs<sup>35</sup> had been subverted by this to the extent that she was consumed by the prioritisation of drugs. Rather than an indication that Lily's thinking was the sole consequence of a

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<sup>35</sup> See McLeod (2007)

cognitive-behavioural subversion, we can interpret that this way of coping was embedded by years of addiction, multidimensional trauma and lack of suitable support.

We have seen how both before and during addiction the environments and habitus of the women were typified by hardship and threat, increasing women's dependence on drugs as a form of self-medication. The response at a systemic level, as will be discussed, only exacerbated this by adding to these stresses and amassing messages and experiences of rejection.

## 6.3 Systemic Trauma

In women's childhoods we saw how systemic neglect was often implicated in their trajectories of disadvantage. In addiction the lack of, or negatively experienced, systemic responses are amplified. Systemic trauma then denotes the detrimental responses by the state and public services to criminalized survival and coping strategies, and the attendant additional multidimensional traumas. Despite the previously illustrated histories of trauma and the correlation with poverty, systemic approaches commonly neglected to identify the socioeconomic and environmental roots of problematised behaviour. Instead, these were viewed in isolation from the cause and as indication of individual deviance. This attitude was accompanied by a systemic expectation that individuals be able to 'pull themselves up by the bootstraps', a neoliberal ideal that conceives of everybody as equally capable of self-advancement and improvement, expunging the state of any responsibility to ensure the socioeconomic equity commensurate with doing so.

### 6.3.1 Self-preservation or Self-Destruction? : Systemic Neglect of Trauma Symptoms

A form of systemic trauma arises through the lack of recognition and response to symptoms of PTSD, including in the imposition of inappropriate expectations predicated support. Many women had experienced systemic neglect of their traumas in childhood and again, we see parallel processes in their addiction. Symptoms were

not recognized let alone responded to appropriately, and instead were, in the case of the impact of trauma upon the body, denied and underplayed, or behaviours misinterpreted and punitively responded to.

### 6.3.2 Trauma and the Impact on the Brain and Body

It is useful to preface this section with a brief discussion of the symptoms of C/PTSD, as much systemic neglect occurred through the misinterpretation or disregard of these symptoms. They were also spoken of and often retrospectively identified as trauma responses in the women's accounts of their childhoods, with multiple references to anger, 'naughtiness' and concentration difficulties all suggesting the physical and neurological impact of PTSD (Van der Kolk, 2015). Nonetheless, systemic neglect contributed to their labelling and exclusion then, and continued to do so in adulthood. In addition to the slew of traumas experienced during addiction, inappropriate systemic responses intensified and added to these. We see this amplification throughout women's lives, from rejection in childhood (such as exclusion from school, being sent away or to children's homes) to a more punitive approach during addiction, including removal of children and the application of criminal justice sentences.

Often women's symptoms of distress went unnoticed and even punished. When Gina confronted professionals in the rehabs she was sent to about their apathetic approach and demanded more, she reports being branded a troublemaker and ejected from the service through dubious means. From there, her systemic experiences continued to feel punitive and neglectful, confining her to a series of environments that only served to entrench and amplify her exclusion.

*So, they put me into a hostel with 45 under 24s and I started drinking again but I started taking to fits, and I attacked somebody in a fit, so I got flung out onto the streets again. Then it was 6 months and then I ended up back in hospital and they put me in another hostel. I was in hostels all over really rough bits of the city. Then I ended up back in the psychiatric hospital with depression at 18. None of that helped either. They flung me out for drinking as well. I met a guy in there, ended up going to a party*



*with him, he persuaded me to overdose so we had this big suicide party. This is when I was 18, really not well, so the hostel threw me out for overdosing and that was me homeless again. Then I moved to another shithole, don't go there! The courts placed me in rehab again at 19. I did six months, then I got a house and then, at least I wasn't homeless.*

Instead of recognising a cry for help, the hostel responded to Gina's suicide attempt by making her homeless. The stream of mandated rehabs she was then sent to, punctuated by stays in hostels, only increased her exclusion and risk, paradoxically responding to her need punitively and exacerbating it.

Certain physical health problems have also been recognised as bodily manifestations of trauma including chronic pain, fatigue, and stress (Ciccone et al, 2005; Lopez-Martinez et al, 2018; Van der Kolk, 2015; White et al, 2000). Due to diagnosis often relying on self-reporting of symptoms these conditions are especially vulnerable to stringent and medically dubious conditionality tests by the DWP, where doubt tends to be cast on claimant reports (Gardner, 2000; Henriksson and Liedberg, 2005). Although by law fibromyalgia sufferers are entitled to Incapacity Benefit, assessments ignore patient's accounts of their health and focus on the examiner's assessments (Gulland, 2019). DWP examiner's approaches have been glibly described by Gulland (2019, p.1) as ruling in favour of 'Only the Unconscious or Asleep' and indeed, there have been reports of assessors using attendance at assessment as proof of ability to work! (Gulland, 2019; Shweiger et al, 2017).

After a lifetime of traumatic incidents, Dina found her body could no longer cope;

*I've got fibromyalgia. It's a really weird experience. I'll just have to explain it. I used to be so fit and healthy after I'd got me kids back, I could do anything. Then when my partner died, and I got depressed my body started shutting down where I was full of pain. I struggled to get out of bed.*

The intersection between health and life experiences was a potent one for Dina, who was could only endure so much before she was physically and psychologically unable

to perform daily tasks. Fibromyalgia has been found to predominantly affect women and commonly co-occurs with psychological problems, trauma histories and PTSD symptoms (Ciccone et al. 2004; White et al. 2000). However, it is also under-recognised or dismissed by the DWP as ‘aches and pains’ or over exaggeration, a systemic neglect that resulted in a 2019 petition to recognise Fibromyalgia as a disability (House of Commons, 2019).

Abi described the physical and psychological effects of a life course of trauma and of absorbing the traumas of those around her;

*I think what I'd actually done, I'd taken on everybody else's problems, and I hadn't realised that I was actually carrying everybody else's dysfunction. And I carried that, I carried my parent's dysfunction right through my own marriage. I'd carried my husband's problems through the whole marriage, and I carried all this drug, anorexic, bulimic aches and pains and crap right through my whole marriage. And 40 I took violently ill and discovered I had lupus.*

Abi's absorption of what can be termed 'community trauma' translated into psychological and physical ailments, which she medicated with substances until this was no longer a tenable option.

The reality of the toll trauma takes upon physical health went ignored by the welfare state who refused to recognize Abi's ill health;

*Because of my lived experience of not feeling safe or supported, and I think that's why I've got sick as well because my adrenal glands at 40 just collapsed.... I took not well, I lost my teeth, because my body's been through so much. I've been through about ten health assessments. They took my benefits off me and then they stuck me on jobseekers. I've got Lupus and was in ASA and been through about ten health assessments with ATOS, then at 60 with the same condition they took my ASA off me, and I ended up so ill with the process, I lost all my back teeth, I just lost*

*another front tooth, it just fell out. And it's the constant stress. I live on £73 a week and I live on food banks.*

Evidently, the impact of trauma, a perpetual sense of precarity and systemic neglect upon physical health is significant. However, Abi's trauma and ill health was not recognised and she was denied support, further, confining her to the exhausting hardship of poverty.

### 6.3.3 Dissociation: 'What a woman presents as is not everything she is'

A further symptom of PTSD, especially complex PTSD, is dissociation, which is a protective strategy in which the trauma survivor will 'zone out' and detach from reality, a state easily attained through drug use (Horton et al, 2009).

Lily had used this strategy to survive her childhood sexual abuse and also drew upon it when street sex working, so dissociation was familiar;

*I already had these views and this kind of experience, that to be abused sexually is nothing, it's what happens and when it does happen, if it's a pimp or whatever, it's not that bad, it's just another thing. And you can disassociate from it. And now, when I tell my story, I used to tell it and I'd be in tears, but I think I've told it so much, it's like I can see things, it's me, but it's like I'm disassociated from it.*

Sexual assault is unarguably a traumatic ordeal, and to protect herself from repeated assaults over the years Lily's brain learned to dissociate from her experiences and recall them with a sense of detachment. The requirement of Lily to recount her experiences despite the distress this caused her demonstrates the ways service's expectations can be retraumatizing and counterproductive in terms of engagement and women's wellbeing.

In her recovery, Lily was working to raise awareness of trauma presentation among other services and to lessen the likelihood of other women being retraumatised. Because of her experiential and professional knowledge, Lily was able to identify

trauma symptoms and understand the importance of a more compassionate approach:

*We're training GPs now in trauma awareness and that's what I say to them, when a woman turns up you might see a woman turn up that's angry or aggressive, or quiet! I know some women that won't say boo to a goose they're so traumatised, they're so into themselves. And that's what I say, what a woman presents as is not everything she is. There's so much more behind that if you take the time to look behind that.*

Her abuse as a child and the lack of recognition of it contributed to Anna feeling unable to recognise and respond to risk:

*I was never able to safeguard myself and I feel like I underestimated the effect it would have on my life. I met up with a woman and ended up going to someone's house and injecting, and it was speed, it just happened, just like that. Because I entertained it, instead of being like, 'Oh I'm not going in that house, it's really dodgy', as I say, I was unable to safeguard myself or my child.*

Childhood trauma and abuse has been correlated with this inability to protect against threat and harm and even the subconscious seeking out of dangerous situations, all symptoms identified by Anna (Laird et al, 2020). This suggests that what may be perceived as lack of care or concern, and thus responded to negatively by services, is instead a vulnerability inherited from childhood trauma that requires empathetic recognition.

#### 6.3.4 Emotional Dysregulation and The Four Fs

As described in the evidence, one of the symptoms of PTSD/CPTSD is emotional dysregulation (Greenberg et al, 2019; Herman, 2015): when women had received trauma specific support, they were able to understand this and identify how its misinterpretation in the past had led to them being perceived by professionals as 'crazy' or 'dangerous'.

Anna had attended a trauma-informed rehab and remarked that;

*If I'm triggered and if someone has a go, I'll go 100 times harder and faster and go psycho and scare the crap out of them and myself. And now I understand it and I think that's OK because there is a reason, you're not just a psycho, you're a traumatised fucking woman!*

Behavioural conditionality clauses also often failed to recognise trauma symptoms and so excluded women based on assumed deviance rather than recognising the root of their behaviours in trauma histories . For example, Kim was left without support or housing in response to her symptoms;

*I moved back into a dry house and tried to get clean around my 30th birthday. And I managed it for quite a long time, but I was really angry, so angry. I was rude and I was aggressive to everybody, so I ended up getting kicked out because of my behaviour. But I had this one worker who kind of believed in me. She'd seen the violence, when I'd be with her, he would be ringing me like 'Who are you with?', 'Let me talk to the worker', and I'd have to put her on the phone. It was really controlling. And then she fought my case basically, she went back to the dry house and said I'd managed it for this long and if she got me some funding to work around my anger and came up with a program, I could go to every day would they accept me back?*

Once a worker recognised the relationship between her anger and her traumatic experiences and advocated for appropriate support to help stabilise Kim and reassess her relationship with the world, her ability to engage blossomed. This illustrates the power of a narrative and pragmatic systemic shift from exclusion and punitivism towards trauma fluency. This shift facilitates the acknowledgement of righteous anger, recognition of the impact of exploitation and abuse, and the crucial need to provide safe ways for women who have had these experiences to engage.

Trauma accrued across lifetimes of deprivation also seemed to colour women's self-esteem and identity. . Shelly had suffered terrible sexual abuse and exploitation as a

child and began using heroin at 12. However, despite the culpability of others in failing to safeguard her and in her abuse, her recollection almost solely located blame within herself;

*Looking back on it now, I don't feel truly let down by any part of the system because I believe I was so unmanageable it was probably more my doing than theirs... I didn't give any other service (aside from the women's service Shelly credits with supporting her into recovery) the time, I couldn't stick to a methadone script, I couldn't keep housing, all due to my unmanageability.*

This internalisation of blame has been identified as a gendered response to abuse and injustice; whereas men tend display maladaptive behaviours associated with hegemonic masculinity, such as aggression, women direct their pain inwards and tend towards self-blame (Baugher et al, 2015; Chouliara and Karatzias, 2014; Ferguson and Crowley, 1997; Olff et al, 2007; Street and Dardis, 2018; Türkoğlu, 2013) . Shelly blamed herself for being unmanageable, despite her history of abuse and the onus of responsibility for engaging and managing her being upon the services whose remit this is.

Many women also experienced a profoundly relational form of 'social dislocation' in their loneliness and desire for acceptance and love. Their trauma histories intersected with this desire which meant some women sought these connections even in risky and abusive situations. Megan recalled a woman she worked with;

*Oh god love her; she was a prostitute. She was working, she went up, she thought she was going to have sex with one guy and there was a whole queue of them, and nobody would use condoms and she's saying this to me, and I'm saying, 'How does this make you feel... why would you go back to this But it was all she knew, she was lonely, she was actually lonely, and this gave her a 'being a part of' because somebody wanted her.*

### 6.3.5 Traumatized Communities, Traumatized Responses and Systemic Assumptions

As illustrated in 6.2, marginalised communities were often replete with criminality, trauma and exploitation, inflicting a stifling sense of futility upon the women. Relief from destitution and the maintenance of substance use to sustain oblivion from the environment was often attained through survival sex working. As has been illustrated in 6.1, the consequences of these environments led to many of the women exhibiting symptoms of PTSD and CPTSD. However, a lack of systemic trauma awareness intersected with their stigmatized position in society to exacerbate and increase their disadvantage. This occurred through punitive responses, assumptions of deviance and a focus on the identification and management of criminalised women as opposed to the recognition of, and response to, unmet need.

Simply inhabiting marginalised environments appeared to mean women experienced the indirect consequences of this habitat. Many women experienced a designation of 'guilt by association', whether that be due to their partners or their status as criminalised women which was accompanied by assumptions about their validity as victims, worthiness as recipients of support and capacity as mothers. Consequently, as discussed below, many of the women found services responses punitive and inadequate and focused on identifying individual deviance and incapacity, rather than recognising need and providing appropriate support. This also meant services inadvertently reflecting and replicating the controlling behaviours women experienced in their interpersonal relationships. Instead of interpreting their behaviours through the lens of trauma and unmet need, women felt viewed with suspicion, derision and the assumption of defiance rather than incapacitation. Resultantly, their systemic experiences during addiction were felt to centre around on preventing them *causing* rather than *experiencing* or *continuing to experience* further harm.

In Kylie's case, where her violent partner had been sent to jail (for other offences) this provided a window of opportunity for services to engage with Kylie and provide her with the support and protection necessary for her to be able to contemplate change.

The consequences of the failure of services to realise this opportunity are horrific, as we will see;

*So, when I'd moved back with him the police found out and came and arrested him and he got a year in the jail which I thought that'll be really good, it'll give me a chance to get better. But I was still in contact with him because he was phoning, he was writing letters, he was missing his two young boys and (eldest) was 4 at the time, really playing up, missing his dad, 'I want to see my daddy' so I took the two younger ones up to the jail and then ended up getting into a scuffle with one of the guards. Because the two wee ones were there, they reported it to the social work so when I got home the social work came out and they took me out for a coffee. And they didn't even mention it, they just said 'So how's everything been, have you been in contact with (husband)', so I goes 'Aye well I have been writing and phone calls because he is the father of the kids, and he is worried about his kids'. They kept this going for two days then they turned around and said, 'We know what happened at the visit' and I was like 'Oh right'. I goes 'Well I didnae want to mention that to you because of what happened'.*

The hold that Kylie's ex still had was multiple. Firstly, in the context of his control and abuse of her he continued to exert significant pressure upon Kylie. The children's desire to see their father and his exploitation of that also put her under pressure to maintain contact. However, the coercive dynamic of the relationship and the history of violence was not recognised by social services. Instead, their response unwittingly replicated her ex's controlling behaviour, covertly monitoring Kylie before confronting her;

*I went home that night. The next day they came out with an order saying that they were removing the kids, putting them in foster care because they were saying that I'm putting him first before the kids. And even then, I tried to say to them look you had that chance to intervene with me and say, 'Look he's away for a year let's get you away'. I didn't know the options because I was closed off from everybody, I didn't know that you could have all these options, do you know what I mean? So once*



*the kids went away things got a lot worse, I just used all the time.*

*Husband was still sending out letters, being quite violent... things like that. I went to a lawyer to try and get access to them.*

While it was Kylie, not her children, who was the recipient of violence, social services accorded no recognition of her victimhood or her lack of support. Consequently, Kylie's children were removed due to, she felt, assumptions of her lack of concern, regardless of the continued influence of her ex, her entreaties for intervention and her appointment of a lawyer. Kylie's suffering, historically and at the hands of her ex, was completely overlooked while her victimhood was inverted and used to depict her as a liability.

*I was going up to see them once a week, but I'd felt really no well. I'd had a hernia in my stomach, a bad hernia and I wasn't keeping too well. And I remember going up to a visit and I'd been sick, my stomach was quite swollen, and I remember the social work asking if I was pregnant and I goes 'I'm sterilised I'm not pregnant' and they go 'Well you're not looking too well'. And I go 'I'm on medication from the doctor, I've got a hernia, I'm not keeping well at the moment'. So obviously my son in foster care picked up, 'My mum doesn't look right is my mum ok?'. Next things I know, the visits were stopped, and it went to a children's panel, and they were like Kylie is out of her face on drugs. I had to go to the Dr to then get a letter to explain why I was feeling the way I was feeling, the medication I was on, it was a strong course of antibiotics, that's why it was making me no well.*

Despite the established correlation between trauma and ill health, especially in women, social service's risk averse approach imposed a stigmatising narrative upon Kylie that ignored the reality of her medical diagnoses and assumed first a pregnancy, then a relapse (Lopez-Martinez et al, 2018; Van der Kolk, 2015).

Even when Kylie explained her traumas and own traumatic childhood, she felt social services failed to hear and respond to this;

*I was trapped, really. Know what I mean? So, when that had happened it was like... you're at a panel, you've got three strangers and the social work, no matter what you say to them, you try and explain to them, 'Look I've been going through all this trauma, my partner beat me I've lost my family, my self-confidence is away, I've only known what to do since I was 14/15 because I was in children's homes, you're hooking up with guys because you're looking for certain things'. Nobody's ever just that way. But they always believe what the social worker says, the social worker will have a written report, they just believe everything that they say. You don't really stand a chance, so.*

Emma also felt stigmatised by professional assumptions. Having been assaulted and presenting at the hospital for care for her injuries, she was served damning ultimatums about her addiction;

*It took until four years ago, I got involved in an incident where I was then thrown down the stairs. I was under the influence of alcohol, I was unconscious for about 45 minutes. So, it took the medics to get me to the hospital and it was waking up the following day to be told by a doctor 'You need to get your addiction under control' yeah, saying 'You need to get your addiction under control, I'm not releasing you until you will commit yourself to a program'. So that's what I did. I had to do that. He was saying 'Oh this costs an ambulance and blah blah blah' and yeah, I was under the influence of drink, but somebody had pushed me down the stairs. It wasn't my alcohol addiction.*

Such approaches from healthcare professionals suggest discriminatory attitudes to PDU women, blaming them for their own victimisation and treating addiction as an explanatory lens through which to inform judgements about the validity of women's victimhood and entitlement to care.

Despite the testimony of Kylie's GP that she was suffering a hernia and the side effects of strong antibiotics, a different professional's word was taken at face value, despite

Kylie's attempts to advocate for herself. Following this loss, she felt completely isolated and her (then) husband was able to re-enter her life and continue his exploitation of her;

*But anyway, when the husband got out the jail, stupidly I ended up getting back to him because I had nobody, I just thought well I'll just be with him but...*

*R: Oh don't call yourself stupid, lots of people... you're looking for intimacy, familiarity...*

*K: I was looking for that at the time, I just felt trapped. I was with him for nearly 13 years and he totally brain washed me like nobody else would want me, I'd be nothing to anybody else, and 'I'm the only one that's every looked out for you'. And he did make it feel like oh I'm lucky to be...when that wasn't really the case. But I went, we ended up moving he got a wee one-bedroom flat when he got out the jail and I gave up my house because it was a private let and I was going into rent arrears. I moved in with him and that's when it really, really went downhill.*

Having been failed by police, and her attempts at help seeking having been effectively ignored and arguably responded to punitively by social services, Kylie felt utterly abandoned. Her isolation and lack of protection from public services would have terrible consequences;

*'This is my house, you'll live by my rules, you'll keep your voice down', things like that. It got really bad one night, he threatened, he got a big samurai sword, held me hostage for two days and threatened to cut my head off, smear the blood all over the walls, cut me up, slit his own wrists, he goes 'The place will be such a mess the police wouldnae know what had happened'. That gave me that lightbulb moment of I need to try and get myself out of here. And it took me a few days to plan it but on (date) I made a beeline for the front door with a backpack with just a few things in it and that's when I turned my life about.*

Kylie's experiences are a damning indictment of the consequences of cautious police responses to domestic violence and the lack of professional alliances to support vulnerable women;

*It was that day in the house when I thought he was really gonna kill me. And he was still using. I'd actually stopped, I'd actually stopped for a couple of days, and he did loads of drugs in front of me and he was using in front of me kinda taunting me with it and then when that incident happened that was a lightbulb for me and I go I need to get out of here, I need to go. And I managed to pack up some belongings over a couple of days, hid a rucksack up the road, planned the exit, made sure I knew when the door was gonna be unlocked, it was careful planning.*

Fearing for her life, Kylie was mobilized into temporary abstinence, although she was understandably still reliant on drugs to manage her significant trauma;

*I think maybe for the first 6 months I was still using just to try and block everything out. But once I moved to (town) and got into the Women's Aid I started to get a bit of structure 'cos the Women's Aid they were really good at doing group work and things like that. And I started having relationships with my mum and my brother and I was going up to see them and I could talk to them. Then obviously I met my partner, and I could talk to him, and I could start talking to people and I was building up the support network that I needed years ago.*

Kylie was taken seriously as a survivor and supported by Women's Aid to achieve physical safety in terms of changing her environment but also rebuilding her self-esteem, identity and beginning the therapeutic process of working through her past and forging positive relationships.

### 6.3.6 The Self You Deserve: The Individualisation and Isolation of Symptoms

In addition to occupying similar habitats, the women's accounts of the drug treatment and criminal justice sectors suggest they also shared experiences of the individualisation of their survival responses. While many women were offending solely to fund their substance addiction which medicated otherwise unbearable histories and environments, interventions failed to acknowledge this. Instead, women felt responses focused on problematized symptoms, perceiving these as indications of their deviance or immorality rather than recognised in context, as coping and functional strategies.

For example, the below exchange with Kim illustrates how conditional community treatment orders fail to recognize the frequent role of and intersection between trauma and deprivation in women's criminality;

*We lived together; it was really violent, not healthy, and we both had a habit. So, I used to go out shoplifting, doing check books, whatever I needed to do to support both of our habits.*

*R: For the both of you?*

*K: Yeah, and he used to stay at home and look after my son. Then I met somebody that was a sex worker, I couldn't really go into shops because I was known, I'd been arrested many times.*

*R: Ah, so had you been on community orders?*

*K: Yeah, I think when I was 17 and pregnant with my son was the first time, I'd had engagement with a service because I had a heroin habit and I got arrested for a shoplifting charge and they said they would give me a caution if I spoke to a drugs worker. That was the first time I'd had contact with a drugs worker, and I have to say, they were quite good because I was pregnant. They got me on a methadone script quite quickly. And my son was born addicted to methadone, so we stayed in*

*hospital for a while. And we lived with my partner who was really violent. And before I started sex working, I'd been to prison, I went to prison for a charge with shoplifting and I'd been there for a while.*

Kim's offending behaviour was entirely driven by her addiction. However, community orders that mandate treatment don't recognise the complexity of women's lives and explore the reasons behind their PDU. In Kim's case this involved a lifelong history of sexual abuse, rejection, systemic neglect, violence and pregnancy at a young age. Merely agreeing to contact with a worker and getting on a script was not enough to begin to address the multiplicity of trauma and unmet needs in Kim's life, offering at best a medical 'solution', essentially leaving her vulnerable to her traumas, reliant on PDU and SSW.

In her professional life, Kim recognised how inappropriate professional responses to trauma was excluding the women most in need of support;

*And I always get given the sex working women as my clients because I understand them and I think that some other workers would be like 'Oh they're just being aggressive' and that's it, we're gonna ban them. And I can see through it because I was exactly the same.*

Kim's experience suggests a lack of recognition of trauma symptoms in services; it can be posited that this is partly due to the impact of funding cuts and Local Authority payment by-results governing service's remit. Vacchelli et al (2015, p. 181) describe how the impact of austerity and competitive tendering practices stifles women's services especially, as their provision is seen as 'too niche.'

Trauma-informed practice is, however, gaining in popularity, and while empirical evidence is scarce, the anecdotal body in its favour is strong (Purtle, 2020). Many of the women identified specific needs connected to trauma, and when they experienced trauma fluent services who were able to support them to achieve a sense of safety, stability and the capacity to cope before addressing other basic needs, the impact was significant. Women's experiences of trauma-informed services stand in

stark contrast to the symptom focus we have seen many experienced from mainstream services.

### 6.3.7 What's Happened To You? vs. What's Wrong with You? The Importance of a Trauma-Informed Lens

Several women recognised how neglect and misinterpretation of their trauma ended up furthering their exclusion and entrenching addiction. Brenda noted the role of trauma in her reluctance and inability to engage with services, raising questions about the utility of treatment that relies upon coercion or conversely, self-mobilisation, when women are still persecuted by their traumas.

I could've gone to AA and things like that, I had their numbers. I could've used them if I needed to, I don't know why, I maybe wasn't ready. But all along, through all these things, nobody offered me any support with trauma or anything. So, I think I was still using on that.

The importance of trauma support for women's recovery is attested to by Brenda, who relapsed after years clean because of unaddressed trauma;

*So, I relapsed because, although I'd got clean, I'd not dealt with the issues as to why I took drugs in the first place. I just didn't deal with it. So, I relapsed for 8 months, and it was 8 months of hell, and if it hadn't been for SWOP, I'd probably be dead. They gave me the support I needed to get out. Nobody else were hearing me, do you get what I mean?*

The support provided by the local SWOP (Sex Worker Outreach Project) team also helped Brenda address her multiple unmet in a range of domains; fiscal, physical, psychological, and social;

*Housing, benefits. I hadn't been on benefits for months, that's why I'd been evicted. They helped me with that. All my health problems, they come to the hospital with me because I've got chronic fatigue and heart problems so they go to the doctors with me because I can get uncomfortable talking to strangers. And now you don't have one doctors*

*you have different doctors. When I was a kid, you only had one doctor, and now it's different... and just, talking to her, just that support network. Me council tax, we got that sorted.... I spoke to the doctor about my mental health, about panic attacks and things like that, SWOP was there for that, getting that initial thing done, and talking to them. Because I had trouble trusting people, doctors, anybody, so it took me years to be able to open up about it, but SWOP had known all along.*

Without a cohesive, holistic approach to women's needs, including the tangible (such as safe and stable housing and an income stream) and psychological (including managing trauma symptoms), it seems unreasonable to expect women to gain anything long term and meaningful from recovery interventions. This is attested to by the data, where several women in addition to Brenda mentioned 'fingernail' sobriety, that which is unsustainable because of unaddressed traumas and unmet needs.

## 6.4 But Not for Me: Inequality and The Retrenchment of Resources and Rights

The culmination of women's branding as risky, non-compliant and aggressive with their trauma histories and ongoing experiences meant that they often found themselves excluded from services, resources, and protections. For example, women cited being denied equitable and equal access to public services including fiscal support, legal protection and healthcare. Many connected this retrenchment to their marginalization and inability to meet increasingly stringent eligibility criteria, feeling unjustly punished for their nonconformity.

Below, the rights that women were denied or only partially accorded, and the ways that these were withheld, are defined, and discussed.

### 6.4.1 Performing Eligibility: Conditionality, Siloed Working and Other Inappropriate Responses

The conditionality of support and rights permeated women's lives in many ways, resulting in them being unable to access and receive appropriate responses from



public services. Consequently, their needs were neglected, and traumas further amplified. This exclusion operated in several ways including through behavioural expectations, eligibility criteria, the fractured understanding and paralysis of ownership of siloed working, and a focus on service's needs over service users'.

#### 6.4.2 Conditionality and Expectations

Women were unable to access the support that was available, sufficient or not, if they couldn't meet the expectations of services in terms of conduct and set targets prior to engagement. Vacchelli et al (2015) suggest that the restrictions of eligibility criteria effect both statutory and third sector services as payment-by-results and austerity cuts converge to put particular pressure on women's services (Rubery, 2015; Vacchelli et al, 2015).

Despite being in severely unwell due to her addiction, Cathy was still denied help through the imposition of contradictory criteria that demanded a level of self-sustained abstinence that she felt was impossible to achieve;

*I remember waking up, I didn't know how long I'd been there for needles sticking out of me and coke wrappers everywhere, and I thought, do you know what, I can't go on anymore. I literally can't do this anymore. But I knew I could go to rehab but what they wanted me to do was three piss tests. Now this was the problem, they were saying I had to jump through hoops for 2 years to get to rehab. Now if I could do three clean piss tests, I potentially might not need rehab in the first place. I can't even get half a day clean, can't even get an hour clean, let alone the amount of time to go in and do three clean tests.*

By imposing unrealistic expectations of abstinence and interpreting suitability, need of, and motivation for treatment through capacity to provide clean tests, services are excluding those who need intensive support (such as residential rehab). The demands made that to Cathy to meet outcomes were only possible for someone already in a position of significant stability, disbaring her from dearly needed support.

Katie described the debilitating and trapping impact of struggling to meet eligibility expectations in both drug treatment and mental health services;

*A lot of people won't help you with the mental health side of it unless you're stable for however long. And I think if there was more recognition of a dual diagnosis approach that would help. Because otherwise you're always just looking at the symptoms and you're not addressing what's going on, why are you addicted, where did it come from. And because you don't get to the root of the problem it's like a revolving door then, you get trapped in services and they don't really address what's going on.*

Kim also identified the exclusionary impact of untenable expectations upon street sex working women and the need for more flexible and intensive support to respond to lifestyles that may be unable to be fitted around regular working hours;

*Because when women, some of the women are so chaotic, I'm not going to just close you because you've probably been out working all night, I'm ringing you and you might not pick up and that's fine. Every now and then my manager might look at my case load, 'Why are they still on there', if I can justify it, it's fine. But not everybody's like that so it's hard. And what we're offering is not good either, it's a phone call once a week. How're you gonna get clean doing that?*

This rigidity was exemplified in community treatment orders, which occupied a precarious and tense position on a nexus between health and criminal justice approaches. Megan attested to the unworkability of the order's rigidity and expectations:

*The whole purpose of that order was an alternative to custody. However, they were getting referred to me after completing the order and were absolutely mad with it. And why is that? I had a client on community payback orders, and they all had to get their methadone script. But they've got to meet the van to go and do their order at 8 in the morning.*

*And so, nobody can get their methadone and so the last two weeks if you're lucky they start using again because they can't get through their day without their script...it just seems to me we make people totally powerless and so they don't have a choice.*

Megan describes a certain irony in community orders that impose expectations that are beyond the capacity of service users and so make recovery and stability an even more distant prospect.

In addition to the practical impediments of treatment conditionality, services were described as suffering from a lack of resources and excess of demand, and so unable to provide people in need with the support required to 'level up' to meet the criteria.

Rosie explained:

*There's just under 2000 registered addicts here and the drug service has a team of maximum 30 workers. So you look at it, the prescribing service and the drugs service cannot do what they need to do because of the amount of demand and the lack of workers.*

This convergence of lack of time and resources and the demand for service users to meet criteria to 'qualify' for treatment operated as a bureaucratic barrier. Rosie remarked that for sex working women the strain on services and limitations on engagement attempts was particularly unsuitable:

*This is what they're like, 'We tried to get them on the phone twice.' I spend hours arguing with these people, Rebecca! Are you kidding me? 'She's been out all night, she's not gonna answer at 9 in the morning! Try her at 4, I always get her at 4.' No flexibility at all.*

In Megan's work in community drug treatment, she noted the bureaucratic paralysis caused by conditionality, lack of resources and low engagement due to inappropriate delivery:

*When I was working frontline, the problems I saw, was that most people, you go into services, there's no clients there, everybody's stressed out, all*

*the workers are stressed, they work long hours, they don't get their lunch, they eat their roll at their desk. But what we're typing up, always, is people that didn't engage, that's what we record, how many people that didn't come to appointments!*

Speaking to the debilitating impact of the prioritisation of business practices over frontline initiative, staff were consumed by documenting nonattendance, unable to engage with clients and begin meaningful work.

Relatedly, Katie noted that the conditions and expectations of services seemed designed completely at odds with the priorities and capacity of people in active addiction:

*I think (what's needed is) a bit more flexibility, because a lot of service providers, and court ordered treatment as well, is very, like, if you miss two appointments that's it, you get kicked off. If you're late, that's it you're recalled, and it doesn't really take into account the nature of that person's life and the chaos of addiction, they might not be awake during the day, especially if they're working at night. It's not always easy if you're not living in your own house, you might forget the appointments. I find things can be quite regimented and regimented doesn't fit if you're addicted because your priority is getting your drugs, getting your drink, and having the money to do it. And if something clashes with an appointment, if you're not at the stage where you're stable, that's gonna come second and then that gets you into more trouble. Then you get kicked off your treatment plan and you miss your probation and that's that.*

Conditionality also manifested in the rigid delineation of service remit and a distrust between services of the other's ability to verify eligibility. Rosie described how, *'they have to be verified as street homeless, actually bedded down outdoors in order to get somewhere'*. Notably, women are more likely to be 'hidden homeless', sofa surfing, exchanging sex for somewhere to stay or sleeping on the streets out of sight due to

safety concerns (Duff et al, 2011; McNaughton and Sanders, 2007; Reeve and Batty, 2011; Reeve, 2018).

Despite this, women were required to demonstrate themselves as homeless overtly and visibly. Furthermore, conditionality and restrictions on services also limit workers' abilities to meet vulnerable women's needs. Rosie disclosed:

*We have to say to those women 'Be at MacDonalds at 7 o'clock in the morning, get a duvet from somewhere and just sit there and we'll send out St Mungo's to come and find you'...We're currently arguing with the council, can we not verify, we're on outreach, we can see she's street homeless, can we not verify? And it's 'no, St Mungo's have to verify' and it's unbelievable.*

*We were working with a young couple recently who were living in a Wendy House in a squat and the squat was all boarded up. And St Mungo's wouldn't go in the squat because it would've meant climbing over and they would've been trespassing...She was 24 years old and pregnant, sleeping in a Wendy House with her boyfriend and we could not get them into a B and B because they HAD to be seen by St Mungo's.*

Where services were tasked with a specific remit, conditionality was often used alongside punitivism in treatment to try and compel women to produce outcomes. Having attended a rehab in prison in order to receive visits from her children (while not 'wanting the rehab') Dina suffered a relapse for a year due to a string of traumatic events in her life. The stint in prison rehab that she felt coerced into had neither equipped her with skills to manage these stresses nor linked her to ongoing community support to do this. This was in spite of her facing the added pressure of being reunited with her children and bearing full responsibility for their care upon release. This is indicative of the futility of providing brief sessions of intervention where women are not ready and are not equipped with the assets and skills to manage ongoing moments of adversity that create vulnerability to relapse.

*I did 9 or 10 prison sentences, all to do with drug related crime and on my last sentence I wanted to move back home so I could get visits off my children but the only way I could do that was to agree to being signed up to a rehab in a prison. But I didn't want the rehab, I wanted the transfer so I could get visits off my kids and family.*

Separation from family members and children has been highlighted as a significant source of grief and trauma for women in prison (Annison and Brayford, 2015; Goldhill, 2009), so it is understandable that Dina would be desperate to receive visits and could be pressured into treatment to achieve outcomes. Perhaps due to the element of compulsion but also the lack of aftercare and holistic support, upon release a series of traumatic events triggered Dina's relapse:

*It was a 12-month relapse. I think it was just coming out of jail, my dad no longer being there. Because of the death of my father my youngest son had started playing up and self-harming, trying to hang himself with belts.*

Despite this relapse and Dina's recent experiences of grief and instability, she was again offered custody of her children in exchange for entry into treatment due to, it seems, lack of alternative options for social services. (This parallels with Paula's experience of being offered custody of a child when her mother couldn't cope, despite the huge amount of pressure this put on her in a precarious situation).

*My mum found she was unable to cope, and social services asked me if they got me an in-house detox at our local mental health hospital would I be able to take on full responsibility of my son and they'd help me get rehoused.*

This offered Dina the return of one of her children and the opportunity to move on from hostel living but was conditional upon completing a detox, despite the recent failure of a more intensive rehabilitative program which at least aimed to do more than a solely medical detoxification. Dina was also under huge pressure, yet not provided with wraparound support to help her to manage the sudden responsibility

of new sobriety and the return of a child. Consequently, while she agreed to do the detox, *'It wasn't successful, I run off to use drugs within the first two weeks.'*

Attesting to the need for a holistic approach which recognises the need for socioeconomic, systemic, and individual level support and change, Dina relapsed again following the death of her partner who overdosed, and she again lost her children. Dina's life had been marked by abandonment from a young age and a series of losses and lack of support had undermined her ability to be resilient to further experiences of grief that for others may be rarer and somewhat anticipated: for example, death of relatives from old age, the transition from supported from living with parents to independence. Many of the adversities women experienced (suicides, overdoses, premature death) are arguably avoidable and correlate with deprivation (McLean, 2016; Van Draanen et al, 2020; Wilkinson and Pickett, 2010). This indicates another way in which policies that increase inequality may be culpable in exacerbating problems they respond to aggressively. Furthermore, if sufficient support was available, woman may have been more resilient when confronted with traumatic events as opposed to being retraumatised and relapsing to cope. For example, the ability to withstand repeated trauma has been illustrated to be mediated by the presence of social and practical sources of support including trusted workers and social networks (Connor, 2006; Macedo et al, 2014; Tsui, 2016).

Relapse is also related to the volitional nature of recovery and whether this is coercive and punitive or positive and supported. Brenda's cousin received an ultimatum by social services to get clean or lose her children. While this was successful in terms of an outcome for social services and in the short term as her cousin was motivated predominantly by an especially punitive iteration of conditionality, her recovery was not sustainable:

*People get clean for their children. My cousin got clean for her son; she were clean for 5 years. But she relapsed, because she didn't do it by choice, she did it because she'd got no choice. You've gotta come to your own.*

Conditionality of **conduct** within treatment also presented barriers for women, resulting in them being rejected by services due to the severity of their symptoms. Shelly had endured a lifetime of violence and neglect and consequently suffered PTSD. Nonetheless, symptoms of these experiences, particularly of uncontained PTSD, were often treated as grounds for exclusion from services. Shelly recalls:

*I came into recovery with lots of anger about everything, about life, people that had been in my life, I was just angry about anything and everything... I ended up getting chucked out [of rehab] three months early for my anger.*

Again, Shelly was blamed for (and seemed to blame herself for) her anger and her rejection, when it is the responsibility of services to engage with people with complex needs which must involve acknowledging their histories and the impact of this inheritance.

In community treatment she was also expected to meet obligations regarding attendance and contribution to receive support, despite her drug using and sex working meaning this was simply not possible:

*There's too much expectation, like before you can go to a treatment centre you have to do a load of day groups. I truly believe you need to act in the gift of desperation, and it doesn't stay like that because as an addict you can get the gift of desperation when it gets too hard. But it doesn't stay too hard and then you use it.*

Shelly demonstrates how the expectation that people jump through hoops to be eligible for support acts as a deterrent, especially where windows of opportunity can be brief and must be acted upon quickly and appropriately, without conditionality.

### 6.4.3 Siloed Responses

The ownership of particular 'problems', or lack of, added another dimension to treatment conditionality, an issue especially pertinent in the siloing of mental health and substance misuse. This often meant women were unable to receive support from



either as they were stuck being passed back and forth and excluded by eligibility criteria, they were unable to meet without support recognising the often-symbiotic relationship between mental health and addiction.

Cathy, for example, experienced the frustrations of the conditionality of recognition by PDU and mental health services, having been repeatedly deemed ineligible and so caught in a trap of referrals:

*Services would chuck me from one service to the next. The drugs services would say I need to look at my mental health, the mental health would say 'No we can't look at you until you've quit the drugs', and this still today is an ongoing problem, you know, you'll get passed to and from mental health to drug treatment, mental health to drug treatment and nobody would help... Mental health won't deal with you unless you come off the drugs and then when you do, the waiting, it's a massive, long list and by that time you've relapsed again*

This indicates the need for a dual diagnosis approach that recognizes the role substance misuse plays in self-medication of mental health problems but that also vows to address the root causes of both, recognising the role of trauma and deprivation in often pathologised reactions.

#### 6.4.4 The Absence of Suitable Support and Appropriate Responses

In addition to exclusion through eligibility criteria and conditionality clauses, women also referenced service responses that failed to recognize their complexity of need and the intersection between trauma, mental health and substance abuse.

Where mental health **was** recognized as an issue, Eva's experiences denote reliance on pathologisation at the expense of the recognition of environmental and socioeconomic needs. In addition to her psychiatric illness, she was in a violent and abusive relationship, but in receipt of no support beyond medication:

*I couldn't cope with it physically or mentally, it was like no just the mental abuse it was like the physical abuse. But the physical abuse was*

*nothing compared to the mental abuse... Six times I was leaving the marital home, Rebecca, because I just thought what do I do? I'm gonna come out of here in a coffin. Until I eventually had the guts to say rights that's it, I'm leaving. But by that time, I was riddled with amitriptyline and Prozac and all the antidepressants they could give me, but they weren't doing anything!*

*R: And nobody was asking you what's happening with you and how can we help you with what's causing...*

*E: I think they were listening to me at the beginning, but they were switching off. They weren't actually there; they were just there to say right we'll give you amitriptyline or we'll give you fluoxetine. And in the meantime, I was going well this isn't working, and so I was getting heroin and I was getting codeine, and so I was getting fixed by opiates. I had this addiction because it was taking the medics longer to try and remedy it if you know what I mean.*

The lack of suitable support and a professional dependence on medical solutions meant Eva's addiction became further exacerbated as she attempted to compensate for the shortcomings of her treatment.

Eva experienced further treatment barriers where health professionals refused to support her with her mental health until she became abstinent, failing to recognize the relationship between mental health problems, self-medication and addiction:

*I went to the doctor, and I said I need something to help me with my mental health because I was going off the path, and he goes well you need to get your alcohol addiction under control first before I can help you. And I thought 'woah!' well thank you very much! That's what shocked me, he wouldn't give me antidepressants until I got my alcoholism under control.*

Consequently, Eva felt and feels she was abandoned by healthcare services who neglected their duty of care to her, and so left her even more vulnerable to addiction and its harms:

*He wasn't gonna prescribe anti-depressants, so I thought what do I do? Do I go down the path of drinking and using opiates or do I try and solve it myself? Because I was going further and further down the path of addiction, and I thought what's my next step. Do I go further down another addiction, am I gonna go down a sexual addiction to pay for my habit? And it was like, what do I do? But he wasn't understanding, he wasn't understanding at all.*

Eva then felt she had to try and find alternative support or resign herself to an endlessly spiralling life of addictions, abandoned to a landscape incapable of or unwilling to respond to dual diagnosis, due to lack of understanding, increasingly scarce due to funding cuts and rigid outcome expectations (Yang and Kim, 2012).

Gina also experienced concurrent addiction and mental health problems and spoke of having been repeatedly labelled a 'troublemaker', being seen as impossible to treat by services for questioning the quality of her care. Consequently, Gina felt excluded from both sectors for behaviour that is symptomatic of mental health problems and PDU and, for which services ought to be prepared:

*They used to have this big hospital, this big alcohol place. And so, they tried to ban me when I was 20 because they said I was a chronic alcoholic and wasn't entitled to anything as they didn't think I'd ever overcome it. They had men in in their 70s for the 48th time detoxing. Yet they were willing to just write off somebody at 21.*

*R: That's shocking. What do you think that was about?*

*G: No idea, they totally banned me. I wasn't allowed in; I wasn't even allowed on the premises to visit anybody. They just kept putting me to the psychiatric bit. That got shut down as well. But they diagnosed me*

*with BPD in '98, what the struggle was that you'll notice it now if you're doing much on addiction and mental health, they'll not join the two up.*

This connotes a lack of recognition of the presentation of mental health symptoms alongside addiction. Instead, dual diagnosis symptoms seem to be treated as indicators of unsuitability for treatment in either service or used to justify the exclusion of people with more complex needs.

Siloing of mental health and problem drug use was evidenced to operate on all levels, from practice to policy. Keira attested that in politics too, mental health and substance misuse are considered separate issues, illustrating the permeation of remit conditionality system-wide:

*So, I met with the mental health minister, and I brought it up about the addiction and she turned around and says to me 'oh that's another minister'. And I'm like wait, addiction is mental health, you're the mental health minister and you're telling me... and even coming from her I felt the stigma. I just felt the stigma needs broke from the top down.*

Keira indicates that siloed attitudes to mental health and problem drug use are rooted in and strengthened by division, both ideological and practical, from the very top, attesting to the importance of system-wide change in approaches and understandings.

#### 6.4.5 Unconditional Support

Conversely, services who were able to offer unconditional support, regardless of complexity, and the powerful impact of this (further discussed in Chapter 7, Findings 3) is encapsulated by Maria's experiences:

*But even when I couldn't show up to life, the charity would take me to everything. They gave me community support, they never gave up on me, they showed me hope and they believed in me still. They were sort of like those defibrillators, those bring me back to life moments would happen every time they started engaging with me. It was second to*

*none. And because of them being consistent and keeping engaging with me, something happened and changed. I did ask them for help, I needed treatment. I was resistant but I believe as a result of them not giving up on me the penny dropped after so many times. Through all the appointments I was funded to go back to treatment, and I can't thank them enough.*

Maria evocatively attests to the importance of persistence, of a constant open door and the demonstration of faith. However, neoliberal policies and the implications for practice including responsibilising rhetoric, the retrenchment of resource and restrictive outcome demands all impinge on services' ability to offer such transformative connections.

Women's experiences of community drug treatment were largely negative, as services often expected them to meet engagement criteria that were incongruent with the reality of women's lives and were felt to prioritise ticking boxes over meeting needs.

Shelly's story exemplifies this, illustrating how the rigidity of conditional community sentences which offer a choice between complying with community drug treatment (including appointment times that primarily suit the service and submitting regular clean tests with very little support), or incarceration. As we see in 6.7.2, the latter can involve loss of housing, benefits, custody of children and inflict further isolation. Here, Shelly describes how community treatment orders privilege the requirements of the service and do not acknowledge the subversion of the hierarchy of needs that occurs in addiction:

*My first sentence was at 16, my last was 31. My first sentence was for shoplifting. They gave me a community order and I couldn't abide by it; I was an addict with a habit and that became priority.... Your priority ain't to get yourself to community service or probation, if you wake up sick your priority is to sort yourself out. And they don't take account of that.*

When entrenched in the cycle of addiction and sex work women are especially unable to meet the demands of community orders or conditional sentences as they are incompatible with the realities of street working. Rosie described the hoops people had to jump through in order to receive even community treatment, a rigmarole that was especially inappropriate for sex working women who dearly needed a flexible approach:

*And it's three weeks for the first appointment, and that's a telephone appointment then it's another ten days, mouth swab, test. Then you get phoned by the prescribing service, if you don't pick up your phone you have to wait another three weeks and be referred in again. It is shambolic.*

Even where conditional treatment orders could be complied with, Katie attested to the ineffectiveness of treatment that is non-volitional and that fails to address the causes of behaviour, instead focusing on achieving reduction or cessation of the behaviour itself:

*I did have some alcohol counselling with a drug treatment service about 8 years ago, but I wasn't honest, so it didn't really work, because I had to do it, the court made me do it, I had a court alcohol treatment requirement, so I had to do this alcohol counselling for six months. But because I had to do it, I wasn't in a situation where I was taking it seriously. Even though I attended, and I ticked all the boxes. Then, I did go into another treatment provider just before I got sober, and I went a few times then didn't go back. I just stopped drinking after that, off my own volition really.*

Katie was aware of the focus of the conditional order and that consequently it could be manipulated easily due to its 'tick box' nature, and so she went through the necessary motions, unaffected and disengaged:

*I was still drinking while I was going there. It wasn't as bad. Sometimes I'd have a drink before I'd go to the counselling session. I'd get there a bit*

*early, hop off the bus and get some mini vodka bottles to drink before I went in there. So, my drinking never really stopped during that time I was on probation and the alcohol treatment requirement. I said it did, but it didn't!*

Katie identified the counselling's inappropriate focus as one of the main reasons for her disengagement:

*Yeah, it was counselling, but it was specific counselling for alcohol, so it was 'ok this week you've had x units of alcohol, next week let's aim for', you know, reduction or 5 units a week. So, it was very specific, very directional. Which I guess would be alright for people wanting just to reduce their drinking a little bit, if you just want to cut back, it's not got to the stage where alcohol is having a massive effect on your life and it has done for 10/15 years, where it's more of a chronic issue. That sort of stuff might be ok where it's just an acute issue, you know, your temporary short-term thing. So that's what I would say to that.*

As Katie remarks, the mandated counselling focused on the desires of the court rather than her needs and exploring the root of her addiction. Where women have decades of substance misuse and decades of correlated trauma, brief interventions do not begin to address this and seem doomed to failure.

Katie later added:

*If you get given a treatment plan and it's like well you get ten sessions or twenty sessions, for me, it's like well I've had 20 or 30 years of this, and when I was in my childhood it was from birth so sixteen years of trauma that you're expecting me to just turn up in ten sessions and come out of it all, and I don't know you! And there's a fear that, if I go into it and I've only got ten sessions and I open all this up, that's not enough, so I'd rather not come out with it and I'd rather just go and have a drink because I know that's safe and I know I can come back to that. A session*

*a week is fine, but I know that there's an off license or a drug dealer that I can always go to!*

Katie here captures the inappropriateness of providing rigid interventions when needing to ameliorate the impact of a lifetime of trauma. Where services may have limited availability or close the door, substances are always readily available and (overall) are unendingly attainable.

Lily illustrates how perpetual open doors and open arms, regardless of engagement, can instigate transformation in women who have otherwise been deterred from seeking help by services they feel are untrustworthy:

*I met her when I was on the street, and she was a support worker at the specialist women's sex working service, and that's how I knew her, she wasn't my official support worker, because I was so hard-headed, I wouldn't talk to no one. I didn't trust services at all. But she just kept on bothering me for years (laughs!) And that's what I said to her, she was one of them people that went above and beyond; if she didn't see me out and about, she'd come to my house and shout through the letterbox like 'Lily! You don't have to come and see me, just let me know you're OK, just shout that you're ok' and even though I stayed on drugs for long after that, that little.... I knew that she actually cared. She's awesome. And the number of women she's helped that'll say the same thing about her.*

Lily had adopted a policy of avoiding services as a form of self-protection, associating them with punitive experiences. However, through sheer persistence and the demonstration of care, Lily's suspicion was eroded and eventually she was able to engage with professionals who in turn could identify and respond to her needs.

The neoliberal championing of producing set outcomes places services under pressure to evidence these, despite a lack of resources overall, in order to be awarded increasingly scarce funding (Jones et al, 2018; Vachelli et al, 2015). The consequences of this are attested to by Anna's experience, which demonstrate the need for care



that provides ongoing and appropriate support. While on paper Anna's service may have produced important outcomes including her having completed rehab, regained custody of her child and being housed, the reality was that she was still unsupported and vulnerable:

*I went to rehab when I was 25 and got him [eldest son] back. I moved out of treatment and was put in a flat in the back of beyond. I had no transport. I had a support worker for about three weeks. But I knew when I was out, I just wanted to use because I was so damaged. And I couldn't admit that I had another child, and she wasn't with me. I felt people looked at me like I was the devil's spawn.*

Upon completing rehab and being considered a 'successful recovery', Anna's underlying trauma and the injury done to her self-esteem remained untreated and unacknowledged. She was isolated and disempowered by being placed into housing that removed her from sources of support and was grieving the loss of her daughter while battling the stigmatisation of this. As a result of this lack of support and constellation of traumas and vulnerabilities it is unsurprising that Anna's response was to numb her pain with substances.

Laura remarked upon the absence of suitable counselling to help her explore the childhood trauma she felt must be at the root of her problems. Again, this is suggestive of an industry that is centred around demonstrating rigid 'hard' outcomes and is unable to provide the intensive, holistic and person-centred support that women feel they need:

*So, I suppose I've always felt that I struggled to really understand what happened to me or why I ended up so messed up. I would've really liked therapy; I would've loved to have gone to therapy, but I didn't want to tell my doctor and I've never been able to afford it. I think that's another service that would be really great if it was more accessible to people.*

Without eligibility or resources, Laura had come to unhappy terms with her inability to afford or meet the thresholds required to receive the therapeutic intervention she felt could provide her with understanding and peace.

#### 6.4.6 Retrenchment of Rights<sup>36</sup> to Public Services and Protection

In 2009 the European Committee of Social Rights expressed concerns that the financial crisis that began the year before was having severe consequences in terms of social rights relating to ‘health, social security and protection’. It seems that due to the impact of burgeoning austerity measures and thriving individualising discourse, these concerns continue to be valid.

Several women experienced retrenchment or denial of support from public services, especially the police. The police in particular failed to exercise due diligence and to respond without discrimination to women’s experiences as victims of crime. Therefore, according to the UK Human Rights Act (HM Government, 1998) and WHO (1946) specifications, can be argued to have been denied their human rights. This occurred prior to women’s addiction, for example where abuses in childhood were universally not picked up by services.

Some women’s childhood abuse continued to be disregarded during their addiction, even when they summoned the courage to seek help. Katie attempted to disclose her abuse to police officers at a vulnerable moment during arrest but was dismissed:

*I remember when I got arrested for the common assault, I was explaining to them how I’d been abused by this person who I had the fight with,*

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<sup>36</sup> I use the term ‘rights’ to refer to the 1998 Human Rights Act (HM Government) which sets out the civil rights that are held by everyone UK and these cannot be rescinded due to gender, race or any other discriminatory criteria. One such right is for staff in public service to respect and protect other’s human rights, and this covers NHS staff, the police, and social services. Everybody also has the right to use public services and facilities; by being rejected or subject to conditional access, women are being denied equitable access to public services and amenities. I also include the WHO definition, ‘Access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.’ (WHO, 1946).

*etc., etc., and they said, 'Oh well that's not what we're here for, you'll have to bring that up another time' and I just got put in a cell. So that doesn't give you much confidence about if there's historical abuse. So, they weren't really bothered. Obviously, they probably just saw me, and I don't blame them, I was probably like the tenth drunk person they'd arrested on that Friday night. But perhaps noting these things, and giving people the opportunity, like 'Right you mentioned this when you got arrested, this is x worker, do you want them to ring you', or do you want to discuss it. Because that might've been an opportunity to bring all that historical abuse up at that time.*

The lack of concern from the police for Katie's childhood sexual exploitation demonstrates a significant missed opportunity for intervention, a negligence of duty (due, arguably to a punitive rather than protective focus when dealing with 'deviant' women) and the perpetuation of Katie's societal and relational messages of low worth.

This exclusion from the social and human rights more accessible to non- criminalised women continued into adulthood especially for SSW, perpetuating a reductionist, criminalising approach to symptoms of trauma and need. As Dina identified:

*People are not looking at these women. They're not going into the depths, into the deep ends and saying there is a way out, there is options... It's not good you keep arresting them for loitering and giving them a referral to a drug centre. ... Why aren't their people that go into jails, you know like you've got your CARAT workers and your recovery workers, why isn't there specific things for working girls, you know, 'We can offer you a six-month residential follow up?'.*

Dina captures the flaw in the criminalisation of sex working women in tandem with a laissez faire attitude, where the criminal justice system responds only to their transgressions, failing to explore their deeper histories and needs and to provide tailored ongoing support.

Despite being repeatedly publicly assaulted including nearly being run over by her ex, Anna found herself dismissed by the police. *'Every time I tried to get help; they were like 'oh you're exaggerating'.* When she persisted and insisted on submitting reports, she was put in further danger by the police's actions; *'I reported him and made statements. In my naivety I didn't realise he'd get a copy of the statement and that's when the head butted me in the face. He got it copied and gave it to people. I dropped the charges and he disappeared.'* This disregard of Anna's safety and police failure to protect her when she was intimidated into dropping charges belies a worrying degree of retrenchment of the purportedly universal protection from public services described in the UK Human Rights Act (HM Government, 1998).

Relatedly, Cathy referred to the lack of professional curiosity accorded to street working women by criminal investigators who appeared to rely upon stigmatizing assumptions, persisting with penal approaches despite their repeated lack of effect:

*So, it went to court, and he said I had invited him back for coffee. How or why on earth I would invite a man back for coffee at half past three in the morning, you know, just walking up and down a known red-light area. But I got a three-and-a-half-year prison sentence, and it was my first offence. So, looking back I'm quite thankful that happened but looking back, it wasn't looked into; why was I doing that in the first place? Where has services failed? What good is it gonna do by sending me to prison for 3 ½ years where clearly, previous to that, anybody else that went to prison just went in and out of prison, it was a revolving door.*

Here, ready punitivism due to assumptions about agency and malicious intent were used to excuse a failure to explore the roots of women's problems and the culpability of elements of the system. By failing to address these root causes, punitive responses embed a cycle of survival/strategic offending and futile custodial sentences that only entrenches exclusion. The revolving door of custody has long been a concern for the

criminal justice sector, yet attempts to address this<sup>37</sup> have fallen short, especially for women: it is argued that opportunities to invest in gender aware and appropriate community support for offenders has been missed, bypassing quality in the focus on pursuing quantity (Annison et al, 2015; Birkett, 2019; Trebilcock and Dockley, 2015).

*I just think even though I was traumatised before, I think during I was a lot more traumatised. The things that happen along the way, like attacks and rapes... I had somebody smash a bottle in my face, I've got a big scar all down here, and that was a case of mistaken identity, it was all very traumatic. She went to prison for what she did to me and then I got arrested for driving and went to prison so we were in the same prison together which was very awkward. They were supposed to keep us apart, but they didn't. I bumped into her a few times, and I did get beaten up; she had photos of my face and the photos of my face were evidence of what she'd done, the scars and stuff. But then she had them in prison so she could show people who I was, and I obviously was a grass. (Kim)*

Kim should have been protected from her attacker in prison, and for reasons known only to the prison service but indefensible nonetheless, she was left vulnerable to further assaults while serving her sentence. A custodial sentence perversely exacerbated her exclusion and trauma.

The criminal justice system also failed to protect Sonja, and through negligence exposed her to further violence. Eventually the judge did accept what happened (years of stalking and violence) and he awarded an injunction with power of arrest. However:

*That night, he turned up at my flat. I was petrified, hiding under the bed on the phone to the police...I was in such a state of fear. The police turned up and it was 'Oh well we can't see any of the paperwork'. I said, 'It was served today' and she said, 'Well we haven't got the paperwork*

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<sup>37</sup> Such as 2015's Transforming Rehabilitation reform  
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*so all I can do is arrest him now, but he will be released and if he does come back, we can then rearrest him for harassment’.*

While outwardly this could be excused as an administrative failure, the lack of determination to investigate further despite the potentially fatal consequences, belies a lack of regard for Sonja’s safety and rights as a victim.

Consequently:

*It was early hours on Sunday morning, and he called me from the police station and said, ‘I’m coming round to get my stuff’ and just put the phone down. And I can remember opening the door to him and he just battered me on the doorstep. I didn’t phone the police again because I’d lost faith in them because of, well, everything.*

Here, the failure of the criminal justice system resulted in not only horrific violence to Sonja, but after a lifetime of experiences of neglect from the police, Sonja lost all trust and gave up on pursuing her rights to protection entirely.

Anna also had a history of being repeatedly let down by the police. In over ten years of working on the street Anna experienced many incidences of *‘really traumatic violence and events, I’m not gonna go into them’*. Anna had already bravely discussed with me the stalking and brutal violence she experienced at the hands of an ex, so I felt these must be even more traumatic and did not want to press further. Among these series of attacks, Anna did feel one was so horrific that it warranted her reporting to the police, despite their failure to support or protect her against her ex in the past:

*At one point I did report something to the police, and it was awful. I went to this suite and had all the tests and everything, and it was... I felt like it was a waste of time, that’s how I felt, why the fuck did I do that, I could’ve been scoring.*

Anna's experience attests to the trauma of forensic examination following sexual assaults and the common feeling of abandonment and futility that follows when no further action is taken, and no other support or aftercare provided.

Lily, too, experienced the harrowing retrenchment of rights sex workers often experience from the police, attesting to the horrific stigma faced by sex workers who, perceived as 'choosing' to sex work by police, are denied the high levels of protection and justice accorded to women considered deserving victims:

*I was attacked out there and I got away from the guy and I was I got out of his van, and I was trying to get back to where I'd been working, and I was all bloodied, because (laughs drily) we got in a fight in the back of his van. See I laugh through nerves, if I laugh sometimes, it's not cos, I find something funny, it's my nervous reaction I think...I got away from him and my tights was all ripped, I was all bloodied and I'm running down the street. And the police car went past me because they knew me from being out, and I just blurted out 'He's just done this', I had his car registration and everything, I still can see the guy's face in my head. The police just looked at me and went (I used to tell them my name was Kelly, I would never give them my real name) and they went 'Well, Kelly, you choose to come out here don't you?' and drove off and didn't even... and then I reported it through Ugly Mugs and I reported it there and give a statement to the police woman who worked at the local vice thing to do with Ugly Mugs and then I didn't hear nothing, nothing, nothing. And then the guy went on to rape another girl, she was a student, a 'normal girl' shall I say, and then they come to me and was asking me to go to court and all that. But I didn't go because I was so chaotic then and they weren't gonna listen to me as a heroin addict and the dock are gonna rip me apart, so I thought I'm not gonna put myself through all that. And even the police said to me when they caught him for doing it to that girl, they said (voice breaks) your description was spot on, it was spot on. Because he looked just like Freddie Mercury, and that's what I said to them. And they were like yeah, it was spot on. But they had his*

*registration and everything, so they could've stopped him, the student girl, that didn't have to happen, and however many other girls he did that to who didn't report him, it didn't have to happen. I think things are changing a bit, but I think there's still a long way to go.*

Lily's account illustrates the devastating reality of divergent approaches in the criminal justice system where 'deserving and undeserving' victims are delineated. Lily's account echoes the Yorkshire Ripper case, where it was only when a 'normal' girl (again a student) was murdered, that attention was paid to the spate of killings that had previously occurred in the red-light district (Charman, 2019).

Kim also experienced the duality of certain police approaches to sex workers as victims, having been (by proxy, effectively) facilitated to use drugs and bribed to perform as a witness to support police prosecutions. Despite this, Kim's own assaults remained unprosecuted, something she attributes to her stigmatization as an active user:

*For about ten years I was working the streets and lots of things have happened like I've been raped, and I've been kidnapped. One guy got 6 years because he'd raped a few of the working girls and we had to go to court against him.*

*R: Did you have support with that because I know court can be retraumatizing?*

*K: So, there was a charity that worked with street sex working women and the worker from there came with me to court. The police put me in a hotel because they didn't think I was gonna stay because I had a habit. So, they got me up first and they actually gave me money to stay there, basically bought me drugs. They didn't say what it was for, but they were like 'if you need to do what you need to do, go and do it but you need to give evidence.*

*R: Wow. What do you think about that now and what did you think at the time?*



*K: I think at the time I thought it was amazing, but I don't know how I feel about it now. I think I was a bit entrapped; I didn't really have a choice; they gave me money and I had to do it. I was trapped at the hotel, I had a worker there with me, I couldn't really go. And after everything I went through, he got found guilty of the other two rapes and not mine. And I believe he didn't get done for mine because I was still actively using at the time. So, after all of that, he did go to prison but not for what he did to me. So, I don't know what I feel about it. It is wrong because the police shouldn't be doing that, but I do think it was the only way to keep me there.*

Ironically, while Kim was valued enough as a witness to be coerced into providing evidence to help the police record a success against a prolific and violent offender, to achieve this, the police knowingly enabled her addiction and provided no support. This is despite addiction being the reason for her working the streets and exposed to the violence that she suffered:

*After the court case I was just gone, I didn't get any counselling, I didn't get anything. I'm not sure if it was because if it wasn't offered or because I still wanted to be out there using... well I didn't want to be out there using, that was just what I did.*

This was yet another experience of exploitation and neglect in Kim's history, this time at a systemic level as well as interpersonal.

Where women **were** offenders in the criminal justice system, they also experienced a retrenchment of support and resources, having their housing, benefits and even belongings removed from them if their sentence exceeded a certain period (Casey, 2022; Williams and Earle, 2022).

For example, Gina:

*I managed to keep my flat. I ended up only doing 4 months. My mum was really supportive. They thought I was going to get 2 years which*

*would've meant I would've lost my flat, I'd have lost all my belongings.*

*How is that helpful?!*

Although Gina was fortunate due to the protective factor of her mum's support and the fact her sentence was below the threshold for loss of housing, the dearth of support and implied attrition of opportunity presented another obstacle:

*When you're doing your care package for coming out, they try and find alcohol places, support groups and stuff for you to go. But the closest place for me to go to was 40 miles away. Which I did, I went to it, and it was good. But the closest place was 40 miles away and as I said I was alright; I had my flat and I had my mum who was supportive. And I think I still had my alcohol nurse, an addiction nurse when I got out. But you'd no help with employment or anything like that.*

Again, while Gina was protected to a degree by the emotional and financial support of her mother and her previous support workers, many women do not have these assets and so can be released from prison into homelessness, destitution, and an absence of vital support (Birkett, 2019; Casey, 2022; Williams and Earle, 2022). Indeed, a third of female prisoners lose their home as a result of imprisonment and anticipate homelessness upon release (Birkett, 2019; Trebilcock and Dockley, 2015; Van Olphen et al, 2009).

Although it was evident that most women would be leaving prison with no external source of income, they were inadequately supported by the welfare state. Even when able to pursue support, this was not given readily. It seems that Gina's purported transgressions justified the denial of the resources she was entitled to. She disclosed that after prison:

*You have to reapply for all your benefits... The doctor I went to see basically said I had been cured, because I was getting quite a lot of benefits. So, my mother decided to write a 6-page long letter of complaint! I had to see the psychiatrist, we didnae really get on, I threw a bit of threatening behaviour in and turning up uninvited at places....*

*The psychiatrists don't really get involved with the GPs and benefits testing. I basically said, 'Could you employ me?' and he said nah, so I managed to get my benefits sorted, I was alright!*

In addition to withdrawal of support in response to non-compliance, this indicates the welfare system's disregard of the relationship between mental health problems and addiction. The impact of this narrative seems debilitating, especially when supported by healthcare professionals' equivocal collaboration in unyielding eligibility testing. Gina had the resourcefulness and determination to confront this and to behave tactically to ensure she was recognised as entitled to support. However, many lack the capacity or confidence and so are unable to advocate for themselves, despite having the legal right to support from the state.

#### 6.4.7 Access to Resources and Freedom of Practice

As illustrated by Vacchelli et al (2015), the ongoing retrenchment of funding to the public sector is complicit in the increasing paucity of support available to women. Consequently, in addition to a symptom-focused, outcome centred business model, services are greatly limited in their ability to be accessible, responsive and flexible.

Rosie's professional experience illustrated the striking difference made when approaches to investing in marginalised populations shift at a macro level. A decade ago, Rosie was able to engage in partnership working to focus on women's needs and did so by developing a network of support to guide women at every stage of their journey. Upon achieving safety and stability for women, she was then able to advocate for them to receive specialist residential rehabilitation:

*We did 19 community care assessments in the first year and of that, ten we got into treatment.... Now I'm in a different locality, different commissioners, back to what you're describing (lack of support and conditionality restricting what is available) which is absolute crap and I've managed to get one woman into treatment in two years of working here and that was a charity bed.*

Rosie noted that this was partly due to the paucity of investment in specialist women's services; *'Its back to what it used to be and what's happened is all the really good female only treatment centres that we used to use, both of those have closed down, the one I went to closed down.'*

Although the state defends this curtailment by claiming paralysis due to their own poverty, as the COVID-19 pandemic has illustrated, resources can be found given the right motivation (Vilenica et al, 2020).

Rosie commented that:

*Homelessness, street homelessness is huge here, it has improved with COVID because they had the 'everybody in' directive from the government. We were like 'bloody hell! We can get these women in!' It was really great for us, like 'you can go to a B and B tonight', we'd just have this number to ring to get people into these hotels, it was amazing.*

*R: Amazing but scary they can do it....*

*Rosie: Just like that! (Clicks fingers) Yeah.*

This eradication of risks or adversities for criminalised and marginalised populations when motivated by reputation and concern for the 'deserving' of society is redolent of Thatcher's refusal to contemplate needle exchange services until she was warned she would otherwise be culpable for a public health scandal (Monaghan, 2011).

The availability of appropriate support for women appears to be debilitated by the retrenchment of rights and resources, and the dominance of individualizing rhetoric that assumes increasing penalism can compel recovery. Women described a significant proportion of the approaches taken and attitudes displayed as not realising strengths and possibilities, but hypervigilant to risk and feeling negligent or punitive.

## 6.5 'Bad Girls' and Other Tropes of the Criminalised Woman: Experiences of The Criminal Justice System

We have already seen some of the ways in which women were punished via custodial and community sentences for what can be perceived as criminalised responses to trauma and unmet need. This section delves further into the experiences of women within the criminal justice system, the manifestation of their criminalised status and the gendered particulars.

### 6.5.1 Victimhood or Criminality: Confusions around Sex Work and Criminal Justice Strategies

Women's experiences of police strategies towards SSW were that custodial sentences were mostly a thing of the past, though accounts also suggest these varied regionally and historically. However, the extent to which penal approaches persisted and women were perceived as in need of protection and support or of reform and deterrence, was more varied.

Brenda commented on the shift away from the criminalization of women in her area, a development she credited with reducing the risk of violence:

*I don't think they arrest people so much now especially in Sheffield. But I do agree with it (managed area). When I were working up on (street), there were a girl working, I can't remember her name, who got stabbed to death in a car park. They still haven't found the killer. Now if they had more cameras round the area and more policing that man would probably have been caught. Going back to 2000, we're looking back, police weren't... girls didn't go report things to the police back then because they would've just been 'well you got in the car', that were the attitude back then. It has changed, I've noticed this time round that it had changed. They're more understanding and they worked with (the service) as well so the police will tell them if there's any dodgy vans around or the girls will tell the service and they will tell the police. It's a give and take street and we all stand in it, whereas before it weren't.*

Sonja's experience was complex but also suggested a localized shift:

*Police do work very closely with the girls that work on the street, so there's a lot less arrests now. I know for a while there was a thing where they were prosecuting punters rather than prosecuting women, but I think that's faded out and women are still getting arrested. Obviously if a woman gets arrested and charged with prostitution it goes on their CBR as a sexual offence, which my friend has done a lot of work to get taken off.*

It is critical to note, however, that this shift in approaches by the police is by no means widespread, with discriminatory attitudes among police forces still pervading sex workers' experiences, preventing them from receiving due protection and support (Campbell and Sanders, 2021; Sanders, 2017)

The effect of criminal records for street sex working persists even when women are in recovery. Lily described the indelible mark left on women's reputations by a criminal record and the harm of the formal documentation of this:

*But obviously, because I've been arrested, I've got convictions for prostitution; fines and that, I've never been to jail, it was all fines. But when I go for a job now, or to volunteer at my son's school, you have to fill out a DBS and it comes up on your DBS. I've had to sit down and write a whole essay on 'how I got into prostitution' and still not got the job, do you know what I mean?!*

*R: Oh my god! That's so...*

*L: Yeah! And it's like my friend, she wanted to go to uni, she's away from that life now, she's clean from drugs, she's done really well. And she wanted to go to uni to do what you did, the social work, and she had to sit down with a panel of five men and explain to them how she was pimped like this, and how she ended up. Just to get on the... even though she's stepped away from that and is trying to better herself!*

Lily and her friend's experiences indicate the continued acceptance of subjecting women labelled as sex workers to prurient questioning. It is hard to imagine that the details the women were asked to disclose would otherwise be required of an applicant.

In recovery Lily was campaigning to have this enduring stigmatisation and restriction removed from women's records; *'I'm involved with a court case with a human rights lawyer who does a lot of work with women, and we've been fighting a case at the minute, I'm so buzzing because we've won the first part of it!'*

Hopefully Lily is successful and these barriers to moving on are recognised and removed; from women's accounts it is evident that these place obstacles to progressing with life and making the kinds of changes desired by the state and by women themselves.

### 6.5.2 Inequality and Incarceration

While statutory approaches to drug use and possession have been dialectically focused on public health rather than criminal justice<sup>38</sup>(especially in Scotland), punitive approaches to and treatment of addicts persists. Gina remarked:

*I've sat with the government who've had two big conferences, one where I had to speak at, and each time they've provided an MP for criminal justice, even though D and A is supposed to be public health now and its garbage! People are still getting arrested now for having small bits, maybe not going to prison as much now but they're still certainly getting convictions and once you've got a conviction it stops you from doing loads of other things.*

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<sup>38</sup> Although the 2021 UK Drug Strategy is reversing this shift  
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Several women spoke of their experiences of prison due to survival crimes, which illustrate the persistence of incarceration as a penal measure as opposed to rehabilitative.

This included direct punitivism in the form of miserable conditions and continued deprivation, and indirect punitivism in the absence of support in the community post sentence. As Kim describes:

*In prison you've got your routine, you get your food, you get locked up. I didn't get any support in prison, even when I was in there with the woman that had cut my face open, there was nothing. So, you have to fend for yourself. They don't sort any housing out or whatever. I did have a worker, they came and picked me up from prison and bought me back. As far as housing or drug support, there wasn't any. I don't think it's got any better, I think it's got worse.*

*R: Ah they seem to say community treatment orders are better now.*

*K: And they're not, they're shit! I work in a community treatment order, and I would never have got clean if I had what's on offer now. I just couldn't have done it.*

In addition to the failure of some prisons to provide through and aftercare to redress women's needs, Kim highlighted the unsuitability of community treatment orders, currently (re)experiencing somewhat of a political zeitgeist and lauded as more compassionate, appropriate and rehabilitating alternatives to custodial sentences for addiction related crimes (Malloch and McIvor, 2010 and 2011).

The below exchange with Gina suggests that most women in prison are there for drug related crimes or those they had no direct involvement with, further indicating the continuation of criminalisation both of addiction and of women's purported deviance, no matter the transgression. Furthermore, as Gina describes the population within prison also demonstrates the high levels of deprivation and isolation among women, with most lacking education, family, visits and opportunities. Rather than attending to this level of need, both in prison and in the community, Gina describes cursory



treatment that was ultimately ineffective. As a result, some women deliberately stayed in cycles of offending and custodial sentences as it was preferable to life in the community:

*Mine was all breaches of the peace so I got sent to prison for fighting a guy in a pub and failing to comply with community service. It'd been going on for ages, I've got loads of convictions and it got to the stage where I didn't care anymore so they'd no alternative but to send me to prison because everything else, I didn't care. But most of the girls were in for drugs, mostly for the drugs that belonged to their girlfriends or boyfriends. And it was quite sad. I was in two prisons, and you'd get visiting on a Saturday and my mum would come up. In one of the prisons there was only 60 female prisoners and it's a man's prison. But on a Saturday, you would think the visiting room would be mobbed. Nah! Half the time I was the only prisoner getting a visit*

*R: And what was that about do you think?*

*G: From the girls, I didn't really talk to them because I hated prison, I was so bored, I didn't get on with them. I don't inject into my forehead or anything like that, or put drugs up my arse, I was never a prostitute, so I never had much in common with them. And I don't mean this in a bad way, but I can read and write, I'd had an education, I felt sorry for them. Every Saturday they'd be waiting for these boyfriends to visit and they just... never, and they kept making excuses for them. And when you go in you have to declare if you're an alkie or a junkie or anything like that, and I didn't detox. So, you're automatically, when I was in for alcohol, you go to drug classes, education stuff.*

*R: And what did you reckon to that?*

*G: It was basic, it was ticking a box. I don't believe that anybody was ever going to have a lightbulb moment and be rehabilitated. Because there was nothing for these girls to get out to. One of the lasses was going out,*

*the day she got out, she'd stashed her uniform and crisps and juice. Went to court, got released and committed another crime so she could come back straight away. She was back in the same day because she'd nothing on the outside. Most of them had their kids taken off them*

Furthermore, the punitivism within Gina's prison (the infamous Cornton Vale (Malloch, 2016)) required a humiliating gendered form of supposed rehabilitation:

*They used to try and make you work, well I refused to work, as I told you it was a man's jail, and there was no way I'd be washing any man's sheets that'd been dugged up 23 hours and I got in trouble for that, but I didn't care, I wasn't gonna do that...23 hours of a weekend, they were dugged up the whole weekend I think an hour they got out on a Saturday. So, there's no way I'm washing crusty sheets!*

The disparity between approaches to different genders' experiences of incarceration became further evident when Gina learned of the opportunities in the men's prison:

*When I got moved to the men's jail, it's got a brotherhood and the conditions are better, you get a proper cooked dinner. In Cornton Vale you'd get the steamed ready meals with a packet of biscuits once a week. Whereas in the man's jail they had a big gym to go to, proper NA meetings, AA, CA meetings, entertainment stuff, drama classes... far more in a man's jail than in the women's so they're only out for themselves, they're in survival mode. And you can see that they'll never change, even when they come in to see who you are at first, they're scanning to see what kind of trainers you've got, if they're Nike Air Max just in case you're going to visit! You're nobody if you've not got a pair of Nike Air Max, but you can see them sussing out, scanning for vulnerabilities, which is a shame, as their living conditions are much worse than the guys.*

In addition to a systemic patriarchal impulse to exert increasing punishment upon nonconformist women (Howe, 2005), a further explanation for this difference may be found in Coyle's (2005) observation that as women's prisons are fewer and farther

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between, women are more likely to find themselves under high security measures regardless of their crime.

Exemplifying the trajectories of disadvantage that characterise many of the women's journeys into addiction, this disparity attests to the persistence of marginalisation and exclusion throughout women's lives. Far more effort was put into generating an atmosphere of rehabilitation and possibility in the men's prison whereas the women's prison entrenched depression, futility, and deprivation, obviating any possibility of camaraderie.

### 6.5.3 Mothers Enduring

Several women remarked upon the ways that normative expectations of womanhood permeated and shaped their experience, regardless of their historical and environmental barriers.

Dina observed that:

*Women with addictions, their needs are different from men because women are usually the primary carer to the children, where men can use and up and graft and go to jail, when it happens to a woman, they lose their tenancy, and they lose their children, so a woman's needs are different to a man's.*

Where sentences exceeded a couple of months (or for 'repeat offenders'), women would lose their accommodation which some reported meant the loss of their children. Neither loss was remedied or even looked at upon release, despite women having 'served their sentence.' The impact of losing children was also a significant factor in women's relapse or the worsening of their addiction. While coercion and conditionality from social services was an often-deployed tactic to try and ensure engagement with treatment, the grief and distress caused by the threat or the actuality of loss of custody inflicted debilitating trauma. Therefore, the outcome was not of the desired compliance or motivation, but exacerbated drug use and a sense of futility and fatalism. Dina attests, *'My guilt from losing my kids kept me out there*

*using because the pain from having my kids took off me, it's not enough to make you stop, it's enough to make you worse.'*

The normative expectation that children are the focal point of women's lives can also be misguided as this fails to acknowledge the subversion/disruption of the hierarchy of needs that is caused by addiction. The loss of a child and consequent self-soothing with substances served to entrench cycles of use and grief, as abstinence bought realization of the devastating reality of loss. Dina reflected upon this:

*Once the kids had gone, my initial thoughts where I was happy, I was glad they were gone because they interfered with my using. Then when I would go to jail and the drugs would be out of my system, then the reality of the situation, that failure, that guilt, it took its toll and then before you know it, your sentence is over, you're back in the community and the only thing you do know how to do is score and use.*

Dina's example illustrates how the use of substances in numbing trauma can lead to what may be outwardly perceived as immoral or selfish attitudes.

There was a palpable difference, as identified above by Dina, in the treatment of mothers and fathers in addiction, where conceptualization and assessment of risk centres almost universally on women (Featherstone and Peckover, 2007).

Such was the extent of risk aversion, an alliance between drug treatment and social services in Keira's area operated to respond punitively to women's support seeking. Keira's appeals for reassurance from drug services about her anxieties around motherhood resulted in a stigmatizing and castigating response from social services when she did become pregnant:

*Before I fell pregnant, I actually went to a service, in the local area, and what I said in that service, because I wasn't sure if I'd be a good mum and there was addiction involved and so the social work was involved. And there was a part of my pregnancy where the social work said we might take your child whether you want to keep her or not, and that was the point where it took it out of my hands. And I was like well 'no you*

*won't be because I know if I want to be a mum, I know I can be a good mum.' And what I said at the drug service was used against me in the child protection meeting.*

Keira eventually found her initial qualms (insecurities not uncommon among women contemplating motherhood) to be weaponized against her and recorded as evidence of maternal incapacity.

Keira herself remarked upon the unfairness of this, where drug using women are seemingly denied the opportunity to safely raise and process quite normal concerns about motherhood:

*And I think every person when they're pregnant goes through that 'Oh my god am I gonna be a good mum, am I gonna be able to do this, am I gonna be able to do that.' And I think that was one of the things, the social work wasn't taking into consideration, that is normal first-time mum things they go through. They were just putting it all down to the addiction, was I gonna do this and that, they made it a lot worse for me.*

The fact that Keira had reached out to support services and vocalized her concerns before becoming pregnant was ignored, and perhaps a window for opportunity to engage Keira and help her contemplate what she needed for recovery was missed.

Jill was stigmatized by virtue of her addiction, too. She was called into a meeting where social workers raised unproven concerns about her parenting:

*Social work was all one-sided. They said I wasn't feeding him which was then found out to be untrue through the midwife that had been out to see me, but I ended up with a social worker.*

Jill's experience indicates how assumptions about neglect of the basic tenets of childcare may be fallaciously made about mothers based upon stigmatizing beliefs about addiction. Even when demonstrated to be unfounded, the dominance of the hierarchy of risk meant that Jill was still monitored by a social worker.

Kylie also felt responsabilised due assumptions about motherhood, while the culpability of her partner who was committing abuse appeared to be neglected. This was exemplified further in the refusal of social services to acknowledge the impact of Kylie's own childhood, the trauma of which, as we have seen, she had shared at a Child Protection Plan meeting.:

*The support from social work was zilch. Everything was my fault, all my fault. You're the mother you should be looking out for your children, why do you not just walk out the door. And it's not as easy as that, it's just not as easy. I'd lost all my family; I'd lost all my friends to him. They were all scared of him, he was constantly going to their doors, and nobody wanted anything to do with it, so I felt I had absolutely nobody.*

Assumptions regarding the mother's responsibility for the entire family also had a financial aspect. Megan felt she had been failed by the welfare state and legal services, as benefits payments were withdrawn, and her family left financially vulnerable due to presumptions of the father's contribution:

*I was trapped in a place that a lot of people are now...I ended up with three repossession notices on my house, I'm pregnant, I can't get onto the benefits system because I'm meant to be getting paid maintenance, that never came. So, our systems are broken I considered going out and working, I did, because I was desperate, I considered all the things I've since seen clients doing.*

Differences in expectations of parental responsibility and behaviour also operated at both systemic and social levels. Megan commented:

*The truth is, as a woman, with my ex, everybody stepped in to support him, to make him bowls of soup, to support him. He could stott about any way he wanted. But for a woman to do that, for a woman to be drunk in charge of two children, is unspeakable. I got ridiculed for that. I also lost a baby and was put into the maternity ward, and they wouldn't do the DNC (diagnosis of cause of death) because I was intoxicated... and*

*the staff in the hospital, oh the treatment I got was unspeakable, because I had a problem with booze.*

The difference in the treatment of mothers and fathers is encapsulated by the disturbing experiences of Anna. Both herself and her partner were intravenous drug users and she suffered ongoing persecution and violence from him. However, this was disregarded by social services who removed her children from her care and awarded her partner custody:

*I got into a relationship with a guy, and he'd been a speed freak before, and we both ended up injecting. Then I had another child, and he was, once again, incredibly violent, more violent than the first partner. When I tried to finish with him, I think his mindset was 'I'm gonna destroy you'. So, he stalked me and then he took my daughter, when she was 14 months, and my son was 3...social services back him but I knew he was just a complete wanker.*

In response to this grief and her historical traumas Anna's drug use escalated, which in the eyes of statutory services made her a less credible victim and a greater risk, simultaneously leaving her unsupported and subject to further systemic punitivism:

*I wanted to escape my reality; it was too painful. So, I carried on using speed really heavily and ended up putting my son into foster care because I was being stalked, he came to the house and kicked my door open, and it hit my son in the face. So, I suppose the only time I safeguarded anyone was when I put my child in foster care. And it wasn't just about safeguarding, it was about the fact I couldn't cope. And so, he got a flat near to me, and he'd see me in the street and punch me in the face in front of my daughter, he split my head open, head- butted me in the face, split my eyebrow open... he tried to run me over actually.*

Despite the horrific campaign of fear and violence Anna was subjected to by her ex, he continued to be privileged by social services while she was left without the support, she needed to process her trauma and to sustain and protect herself and her children. Anna blamed herself for her failure to 'safeguard', mirroring the language of social

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services, despite the debilitating impact of her past trauma and her ongoing experience of repeated violence.

There was also an element of normative gendered assumptions at play in experiences of motherhood and lack of support. As Anna opined:

*People think they should just know how to do it. We shouldn't assume women know, I wasn't maternal, I didn't feel maternal and had very little playgroups. In some of the really underfunded areas we need education, parenting groups and where people can support each other.*

Anna's experiences echo many of the other women, where an inherited lack of connection with their mothers meant motherhood had never been positively modelled for them in their developing years.

Given the above experiences, it is unsurprising that, echoing other research, many women were deterred from seeking much needed support and from being able to engage with support when available due to fear of social services intervention (Kurtz et al, 2005; Powis et al, 2000; Stone, 2015).

Megan attests:

*And so, we learn innate behaviours that actually keep us sick because of fear, of misinformation and because of how services are designed. So, the biggest fear for me was losing my children. I needed help desperately, there was no two ways about it. Even I knew I needed help then, but I was terrified to go and get help because they would have put social services in place to come down and there was a very good chance I would've lost my daughter, so you try to go it alone.*

Megan highlights how addiction and its related behaviours (often considered deviant or disruptive by services) such as avoidance can be perpetuated and entrenched by systems which instil fear and so deter engagement, forcing vulnerable women 'underground'.



However, not every woman's experience with social services was punitive and suggestive of the dominance of risk aversion (Featherstone et al 2014; Featherstone and Gupta, 2018).

Sonja recalled:

*There were times when I was off my face on alcohol. My social worker turned up with her manager and I was in a right state, drunk, and sat there crying, 'oh no you're gonna take my child away from me' and the manager saying, 'no we're not'. And I look back and I think really you failed my son because ... even though I wouldn't have wanted him to be taken, I wasn't in a state to look after him and then you turned up when I wasn't capable of taking care of him and you didn't do anything.*

It is striking that there are women I spoke with who lost custody despite still meeting their children's needs (Paula) and expressing desire to engage, whereas what could be interpreted as active cries for help and explicit demonstrations of risk to children were ignored. This suggests varying interpretations of risk aversion that might be contextualised by local capacity and need.

In her professional life Laura worked closely with children and families' social workers and was able to provide an insight into the complexities of this work with families where addiction was an issue:

*The majority of the social workers I've worked with are probably pretty good when it comes to children and families at trying to understand, you'd make referrals to addiction services and to community services to support parents to try and look after their children but it's the quality of those services and whether they're meeting the needs of those parents. Because addiction is a really difficult issue to overcome. And the bottom line is, we always come back to the children's needs, are they safe, are they having their needs met. And that would always be prioritised.*

Laura noted that social workers weren't necessarily lacking in good intentions or even empathy, so the experiences mentioned by the women above may be due to the lack

of suitable support in terms of addiction and community services to meet parents' needs, in addition to the focus of social services on children's needs.

However, Keira remarked that that despite rhetoric claiming an emphasis on keeping children with the mother, experience, and anecdotes (as illustrated by several women), demonstrated otherwise. Keira's personal experiences and those she had witnessed emphasized to her the punitive nature of social services, illustrating how individual and community experience trumps authorities' narratives where threat is involved. This deterred Keira from seeking any further help:

*I would be scared to go to some of these services and say openly I was a cocaine addict because I would be scared of the repercussions, them coming in and taking my kids off me. Personally, I wouldn't go to a service and say I've got this addiction and need help because of them taking their kids off me. And I know people say, 'oh social work are there to help you and they'll never take your kids off you unless there's a reason' but there have been stories out there and I've seen it with my own two eyes, how bad the system can be.*

## 6.6 Conclusion

The accounts of women's lives during addiction depict an overwhelmingly traumatic time where the traumas experienced prior to addiction, often from a very young age, were amplified by the consequences of their neglect and the accretion of further traumas in adulthood. Among these consequences, women's addiction (and for many, street sex working) was an outcome of these traumas, but these also now operated to expose them to a multitude of further traumas.

We have seen how emotional vulnerability and the desire for warmth and validation meant women experienced devastating trauma in their interpersonal relationships. Trauma responses including risk seeking and replication of traumatic experiences may have added to this vulnerability. For those labelled deviant, 'naughty', and subjected to exclusion as a child, this could have been perpetuated in adulthood through their

behaviour as they carried this into their relationship seeking, for example by ignoring warnings about dangerous men (Lungu, 2016).

Community trauma manifested in women's surroundings typically being replete with risk, illegal activity, and deprivation, including the drug and sex markets (especially red-light districts), hostels and other housing options. Housing in risky areas or 'shitholes', as Gina describes them, were offered enforced by conditionality clauses concerning 'intentional homelessness' that operate as a Catch 22, offering women no alternative but continued deprivation and exclusion. Having lived most of, if not all their lives in such environments, the women faced bleak horizons, where dependence on drugs was normalised and even served to drive refusing housing of better standards. Again, this could have been due to the normalisation of deprivation, and the accessibility of drugs reducing the experience of othering when moving between 'worlds.

In active addiction women were struggling with greater individual traumas and often inhabiting environments that were further on the peripheries of mainstream society, marked by neglect and instability. This accretion of traumas exacerbated their symptoms, including PDU and SSW, which exposed them to even greater stigma. Resultantly, women experienced a myriad of directly and indirectly punitive responses from services who misinterpreted, refuted, or ignored their symptoms of need and distress.

The indicators of PTSD formed a significant part of this, including the impact on the body, dissociation, risk taking behaviour and emotional dysregulation. These symptoms were not just disregarded or misunderstood by services, who often rejected or disciplined women for exhibiting them, but also triggered by and within services. Exemplifying experience of systemic rejection, Gina was branded a troublemaker, repeatedly thrown out of services and housing for mental health and alcoholism related fitting, overdoses and suicide attempts.

This chapter has shown how when women were able to receive support it was often either insufficient or felt to be punitive, and misinterpreted women's trauma-related behaviours and needs.

This paucity of suitable approaches and resources can be understood in terms of austerity, the individualization of socioeconomic deprivation and the criminalisation of survival behaviours. This is attested to by Stuart and Grenfell (2021) who describe the destruction of SSW services due to cuts and the harmful impact of this upon the women. This has a range of implications, especially in the healthcare and criminal justice domains where it is evidenced that stigma and distrust function to exclude SSW women (Bungay, 2013; Campbell and Sanders, 2021; Lazarus et al, 2012; Mastrocola et al, 2015)

However, when women did receive support that was trauma-informed, holistic, with an open-door policy, understanding of relational needs and centred upon women themselves, several women who felt they would otherwise have been dead were able to recover.

Certainly, the battle for support was overall an uphill one, and the overwhelming experience was one marked by systemic retrenchment and inequality of human rights (pertaining to the access to and support by public services). This operated through conditionality such as Catch 22 requirements to demonstrate sobriety before being given support to achieve this.

The burgeoning destruction of public services through funding cuts and neoliberal ideologies also demonstrably impacted women's systemic experiences. Results-based funding and an overarching focus on hard outcomes can encourage services to 'cherry pick' clients and deter them from working with service users with more complex needs (Christopher and Hood, 2006; Maynard et al, 2011; Savic and Fomiatti, 2016; Whitfield, 2012). In the evidence, this manifested in exclusion due to relapse and inability to meet behavioural criteria such as contact and attendance arrangements and expectations of abstinence.

Lack of resources was also referenced by several of the women now working in the drug treatment sector who noted that workers are overburdened by caseloads, and so the time and flexibility they can give to each client is severely restricted. Paucity of funding also contributes to time-limited expectations and interventions, with support

offered for a matter of weeks being expected to remedy problems resulting from decades of adversity and trauma.

Conditionality operated in a unique fashion in matters of dual diagnosis, where mental health and addiction services exhibited an ambivalence towards accepting joint responsibility, instead trapping women who are pushed pillar to post while services argue over 'which came first'. Mental health and addiction is a joint issue and does not conform to unidirectional causality; substances were used by the women to self-medicate their mental health problems in the absence of appropriate service provision. But addiction also exacerbated or triggered mental health problems. Regardless, siloed treatment and a reluctance of services to claim ownership is abandoning women with dual diagnosis to vicious cycles of self-medication and worsening health.

Multiagency partnerships also operated in attempts to coerce desired outcomes, for example access to or custody of children being conditional upon successful completion of community orders or attendance of detox. As several women pointed out this was futile as it only added more pressure upon women who were already unsupported and struggling, and was purely symptom focused, failing to tackle the root causes.

Systemic trauma also occurred through other inappropriate responses based on the individualization of problems, such as an overwhelmingly medicalized approaches neglecting to acknowledge the impact of women's environments. Illustrations of this include the increasing of medication in response to worsening mental health during a violent relationship, or mandated alcohol counselling focusing on abstinence as opposed to the reasons for alcohol abuse.

Where unconditional, compassionate, trauma focused support was offered it was transformative. However, as demonstrated, this was relatively rare and as mentioned, there have been many women who did not make it to the point these women could be able to receive this scarce suitable support. The overwhelming inflexibility and conditionality that typifies service delivery instead means services are unable to

immediately respond to what several women described as an often fleeting but hard to predict window of opportunity.

A gendered iteration of punitivism is indicated by prison sentences which focused more on antiquated middle-class notions of the ideal working-class home than on providing the more holistic opportunities offered to men in prison.

Finally, mothers felt punished by social services and disciplined for being at risk and treated perversely as the source of harm. Partnerships were felt to monitor, coerce and make lasting judgements upon mothers, who then suffered for their children's father's behaviour.

It is tragic to close this chapter with the remark that the interviews in this thesis are unintentionally censored by virtue of the fact that the women I have spoken to are the ones who did manage to survive the horrors and adversities inflicted upon them from a young age. This and the preceding chapter have illustrated the terrible burden of the individual, community, and systemic traumas suffered by the women across their life course. Unsurprisingly but heartbreakingly, there are countless others who could emotionally and physically endure no longer, and who lost their lives. It is vital to remember this when looking at the measures that did reach women when in chronic addiction, and to focus on the mitigation and eventual erosion of systemic and community trauma, and, by proxy, of individual, often lifelong experiences of trauma. Consequently, in the final chapter, we look at the experiences of the women I was able to speak to, which serves to illustrate how best practice can mitigate and ameliorate the impact of traumas and deprivation and includes a preliminary discussion of the women's advice to policy makers on how to stem the tides of addictions and trauma.

## 7 Findings 3. Recovery and Onwards

This chapter explores how women were able to achieve recovery and where relevant, the specifics of the support they received that empowered them to do so. These assets and barriers mirror the tri-partite structure of the adversities that led them to addiction in the first place, occurring at individual, community, and systemic levels. We also note in this chapter the barriers to appropriate support and to successful early intervention that persist at systemic level today, and the women's experiences and opinions of these.

### 7.1 Individual Trauma

A significant factor in women's attainment of recovery is the role of individuals in their personal lives and their experiences of professionals who were able to provide stability, validation and care without any attendant expectations or demands.

Kylie's partner continued to play a huge role in mitigating the impact of her trauma, providing her with a safe space within which to vent yet still be contained and understood:

*I met my partner, and I could talk to him, and I could start talking to people and I was building up the support network that I needed years ago. It made me feel that I didn't need to talk about it as often because I was starting to get into a normal routine...It's just when you're talking about it you relive certain things, but... (visibly brightens up) my partner's been really good, any time I'm feeling a wee bit down or overwhelmed I can sit, and I can talk to him. He always knows the right things to say!*

Kylie's partner worked in mental health services and so had the professional expertise as well as personal compassion that was crucial in providing Kylie with the strength and stability needed to embark upon establishing a 'normal routine' and a social support network.

Therefore, while Kylie had achieved everything herself, remarking ‘*Any help I had to get I had to get it on my own, I just seek things out and done it myself*’, she was met in these endeavours by a man with the expertise and emotional assets necessary to provide her with the love and compassion to empower her to continue her journey of self-rescue.

It is pertinent to note that several of the women still struggled with symptoms indicative of ongoing trauma, and it would be misleading to suggest that abstinence from substances, a place of safety, a supportive partner or any such assets other than trauma-focused support was able to do more than **contain** this.

Kylie, who we have seen suffered unimaginable violence for years, struggled with explosive anger, and was very troubled by her dysregulated emotions, suggesting CPTSD:

*We never really argue but it's just wee disagreements, and I'll start shouting at the top of ma voice, I'll throw things, I'll slam the gates. And that's no like me but it's like a defence mechanism that's built up over the years. I could never speak back to (ex), but inside I was wanting to, I was wanting to scream, to shout out to the world*

*R: And now you finally can...*

*K: Now I finally can. But I need to find a way to control it because it's no fair to my partner to start screaming at him and shouting at him but when I do that, I always end up bursting out and crying and telling him why. But he understands, he's really understanding. So, if I could just get the anger under control, I think everything else would be OK. Aye, there's still a lot of anger.*

I provided Kylie with information on trauma stabilisation techniques and some other resources as she was unsure if she was ready to face counselling, and NHS access to trauma focused therapy is currently contingent on local approaches.



### 7.1.1 Interpersonal and Intergenerational: Trauma Transmitted and Travelled Through

In recovery the opportunity or reality of regaining contact with and/or custody of children was a varied experience.

Although Kylie's treatment by social services was unsupportive, with her remarking that they did nothing but trap and punish her, she was able to begin to rebuild relationships with her sons, but both struggled with trauma from the abuse and separation of their childhoods:

*My son (I had at) 19, he's really struggling at the moment, he's in foster care, they took him when he was 12 and he's still getting counselling for things that he's witnessed. And he's now going through EMDR<sup>39</sup>, and his foster carer phoned me two days ago to say look just to let you know he's in a really dark place right now. He's waking up with nightmares through the night, and I didn't know any of that. I thought he'd got over quite a lot of it. But there's maybe stuff I don't know about that has happened, like if I've been out or I've been upstairs, and he'd come down the stairs. I don't know. So, I don't know. He's been going through counselling since he was 12 and it's just not fair, it's not fair.*

The struggles of Kylie's younger son illustrate the intergenerational transmission of trauma and the consequences of a laissez-faire approach by the police and other protective services with regards to removing both mother and children from a harmful environment and supporting them together to achieve safety prior to rebuilding relationships and processing trauma:

*(I'm) Building up relationships with my eldest sons now which is really good as well. The two younger ones, I just recently found out, that they want to start having contact with me as well now (R: Oh wow!) It's just gonna start off with letter contact then hopefully video call. So that's*

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<sup>39</sup> Eye movement desensitisation and reprocessing- a form of therapy to treat the symptoms of trauma  
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*really good, I've not seen them for years. Even just to know now that there might be some wee bit of contact starting back up.*

Kylie was evidently looking forward to continuing to rebuild bridges with her other sons, indication that she was not an unwilling or unfit mother, but one disempowered by deprivation and both systemic and interpersonal neglect and violence.

## 7.2 Access to Inclusion: Opportunities and Acceptance in Mainstream Society

Countering narratives of deviancy or identification with subcultures, many of the women took pleasure in their recovery roles as contributing, conforming citizens, and wore the badges of convention with pride.

Kylie embodied and encapsulated this delight in visible membership of mainstream society, and the comparison between social service's depiction of her as a mother choosing a violent partner over her children to her pleasure in the responsibilities of paying bills and taking care of her children, is remarkable<sup>40</sup>:

*I just feel now that I'm like nearly 42 and I'm normal, I mean what is normal nowadays, but I feel normal! I pay my house, I pay my rent, I pay my bills. I love doing that! I love it! People moan about paying bills, but I love it, I feel as if I'm the only person that does it, does that makes sense! I feel as if I'm the only person in the whole world, like I pay my rent, I pay my gas and electricity, I do my food shopping! And it's great... like I look forward to getting my pay and going right, I need to pay this bill, I need to pay that bill. I just, I love it now! And it's that new routine, getting up in the morning, shower, doing your hair, your makeup... ma wee ID badge for ma work, I wear that with pride! I'm constantly wearing it because I want people to know, 'Ah look she's working!'.*

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<sup>40</sup> During our interview, one of Kylie's now adult sons came in (I stayed in the call with her permission) and there was a very caring exchange during which she insisted he take away some soup that she had made for him. This was an evocative illustration of Kylie's care for her son and her enjoyment in performing normative 'maternal' tasks.

These challenges theories of desistance which assume offenders hold disdain for conventional society, instead illustrating how when given the right support and access, women previously deemed deviant can receive and capitalise on opportunities.

Therefore, the issue is one of exclusion and marginalisation from society and its assets, not of rejection of or deviation from society.

Having been able to stop sex work due to freedom from addiction and poverty, all the women who reflected now considered it as a form of gendered oppression and violence. This contradicted my position (best described as 'sex positive') and that of many vocal allies of sex workers, perhaps demonstrating the nuances of experience within sex working and/or the retrospection allowed by being able to exit sex work, regardless of financial goals.

Lily associated sex working with a feminised form of deprivation connected to women's lack of opportunities, the lack of formal fiscal recognition of normative 'women's work' and the commodification of women's bodies:

*Really, I would love it if they said no, sex work is illegal and women don't have to, for whatever reason, whether it's financial or whatever, that no woman should have to do that. But that's going into all women's rights and equality and all that kind of stuff! If women were on a level... Why aren't there loads of men out there selling themselves to make money and feed their kids, because it's not all women doing it for drugs. So why is it OK for women? And being a mum and keeping a house is just seen as 'Well that's what you're meant to do, so what do you want for that?!' and it's like 'Well actually, we're raising the next generation!'. A lot of it comes down to women's rights and buying into that thing of, I don't see that any man should be able to... I think men and women are wired very differently.*

She also felt that harm reduction measures such as decriminalisation or tolerance zones obscured the root issue of the acceptance of this inequality and of the systemic and social devaluing of women.

Lily remarked regarding the 'Managed Area' in Holbeck, Leeds:

*And that Leeds Holbeck area, the 'Safe' area, that then a girl still got attacked so then it was called the managed area... I think it's the totally wrong message to give out. I'm not a prude in any way but for young girls growing up now, what message are we giving them that that's OK? It's like oh that's ok, that's an option, that's all you're worth. And we're blamed for stuff, but when you look at a lot of what women have done and are blamed for, whether it's a buyer of sex or a pimp, whatever it is. And it starts to get a bit political but that's why women will be criminalised, because it's the men that are buying it, it's the men that make the laws, they're protecting themselves, like really! Don't get me started! But I'm not a man hater! (Laughs) But I do think that its inequality and a raw deal, what women are meant to put up with. That it's ok for women and not for men, is huge.*

Lily felt that the terminology of safety and security attached to the managed area belied the fact that the violence done to street sex working women is an unavoidable constant and that the focus should be on raising women's status and rights to empower them to resist exploitation and oppression by men (O'Connell Davidson, 1996). However, in the short-term, the Managed Area has been demonstrated to reduce risk, increase opportunities for harm reduction and improve relations between police and street workers, and so is evidently of value to women currently street sex working in the absence of broader socioeconomic and political change (Roach et al, 2020).

Brenda opined of the criminalization/ decriminalization debate:

*People think if we weren't there men wouldn't be there! And that's the circle. It's always gonna be like that and plus the men aren't seen. People*

*don't see the men. They see a car pull up, but they don't see it, but they do see girls standing on the street corner. Or loose johnnies. But believe me if I lived on (RLD) road, I'd probably feel the same. But that's not gonna change anything but we need more understanding of the reasons behind it. If you can deal with the reasons behind it, you can deal with the cause.*

Brenda asserts that debates around the prosecution of sex buyers and decriminalisation continue to ignore the root cause of street sex work, deprivation and trauma. If these issues began to be addressed, it could clear the field for a discussion about legal processes surrounding sex workers and clients for those who are not motivated by desperation.

### 7.3 The Irony of Individual Change Versus Systemic Stultification

Pockets of well-resourced practice that ran contrary to the mainstream were transformative in terms of fiscal, psychological, and environmental stability and safety. They also worked with women to support positive relationships, trauma mitigation and the development of self-worth and purpose. However, the broader landscape still indicates the widespread prevalence of the issues that contribute to multi-dimensional trauma and addiction and inhibit recovery. We discuss these issues and the illustrations of good practice that were transformation for women in further detail below.

#### 7.3.1 The Persistence of Inequality and Retrenchment

Several women remarked on the intractable nature of problem drug use in a society where deprivation and inequality persist.

When asked what she felt was important policy makers be aware of, Kylie attested to the impact of community deprivation, including disenfranchisement and futility. Consequently, she argued that this paucity of opportunity left children susceptible to

the comparative opportunities for pleasure and belonging offered by drugs and alcohol:

*That is where they need to put their money, they need to put their money into places where it is poverty stricken so there's more community centres, more groups so there's more activities for kids to do.... But there needs to be money being out into these areas so there's education going into these areas, there's more activities for the kids to get them off the streets... Ah, there's just so much that could get done.*

### 7.3.2 More Than a Room of One's Own: Security, Safety, Nurture and Opportunity

Conversely to the landscape deprived by Kylie, Rosie was able to find a retreat that provided a sanctuary compared to the community she grew up in:

*I put it down to being a really loving environment...It was very gentle but very safe...It was a beautiful house, there was lots of environmental things about the way they'd set the houses up. Some of these dry houses are just absolute shit holes, aren't they? Like how is that going to inspire anyone to do anything? This was a beautiful house in a beautiful area, the women I was in with were a really great bunch of women. We formed really solid friendships...so that's been a massive part of many recovery journeys.*

Rosie's experience of rehab allowed her and the other women space to enjoy and feel safe in their immediate world for perhaps the first time, to explore their pasts and selves, and in that pleasant and safe environment, to make meaningful connections with each other.

Consequently, the women treasured the opportunity to escape from their environments, to have safety and independence while being supported; to have the time and resources to contemplate mainstream life essentials in the absence of the paralysing flight/freeze/fawn/fight instinct, and to devote time to self-care and realization.

Dina attested to the importance of this:

*So, if you're using 16 to your 30s you've still got a 16-year-old head on your shoulders. And I found that part of recovery very hard because, my first time clean, I had to learn how to pay bills and handle all that responsibility. Even getting up and getting dressed every day and eating three meals, that was really hard for me because I'd had such a chaotic life.*

Having fled a violent relationship, we saw how Kylie was provided with housing and support by Women's Aid. This offered her the space, place and support to gradually regain confidence in, and experience of, living in a safe environment after years of home being equated with persecution and unpredictability:

*I was there for about a year after, and it was great because I had my own wee house. I had my own kitchen, bathroom, and bedroom. And my wee front door and a back door. It was like two council houses knocked into one and made into 9 individual flats. So, it was great because you could go get your shopping and come in and it was actually walking into your own wee apartment, and that was just so good. That was the first time I think I'd actually felt ... you know because I could go out and in and I could never leave without my ex, I wasn't allowed to do this or do that. But for a while I couldn't go out the front door because I was too scared, I was panicky, I was, I'm not used to it... it was I'm not used to going out myself.*

The above examples attest to the importance of women's housing as more than a roof, of providing security, privacy and a pleasant environment rather than, say, the zones of exclusion represented by most hostels and some of the housing options described by women. It is also crucial that the provision of housing is accompanied by an understanding that women may need support and time to become acclimatised to their new ways of living, from the routines and rituals of daily life to developing the confidence to be able to leave the housing and feel safe. Therefore, while Housing First has much to commend it, it is important to recognise that this approach is also

contingent on the suitability of the housing, the environment it is situated in, and the tangential support provided to help women become accustomed to and ease into their new lives.

### 7.3.3 The Recovery Needs of Women

Although not universally available, access to women-only space tailored to their specific needs was widely recommended. Kim remarked on the risk of exploitation that women can face in mixed spaces, and the lack of therapeutic interventions that recognise and respond to women's needs:

*You need a woman only space. If you're gonna do groups, you need to have women on their own. I see it myself, when I do groups, if there's a vulnerable woman in there, you can see it, she's a target for these guys. I can see it coming a mile off so I'm very protective, I'll sit next to them. I can't control what they do but I need to make sure they feel safe. But I think women only groups. There should be groups where women can be honest about what they're actually doing and the risks they're putting themselves through maybe that could be different for women in sex work. But I think most women in addiction sell sex at some point, whether it's a transaction for cash or drugs or whatever it is. A woman only space, more therapeutic stuff.*

As Kim acknowledged, sex working women are often reluctant to open up due to stigma and anticipation that they will be misunderstood and subject to judgement, and so this population especially benefit from women-only space that is tailored **to their needs**.

### 7.3.4 Specialist support: Faith, Familiarity and Meeting Needs

Maria's account of the punitive treatment she experienced from the police during addiction contrasts starkly with the compassionate, needs-focused approach of the women's service she ultimately credit with saving her life:



*I was being a prolific offender, arrested on many occasions. However, the charity still continued their outreach and engaging with me, building a relationship up with me and building trust with me. What I received from them was a consistent lifeline, really. They supported me, provided us all with support, and condoms, because we don't care, we just want to use, we can't show up to appointments. They were there providing us with baby wipes just to make us feel a bit human, hot drinks, fresh clothes, the nurses were doing sexual health tests on us, which was really important, cos I wasn't able to go to any appointments to do that sort of stuff, clean needles. But on top of that they were just kind, they were non-judgmental and just really caring, and that was really heartfelt for me. And do you know what, I used to look forward to seeing them on those days with the van because I used to go over there and have a proper giggle with them. So, what I said to the police, when I look back when I got arrested, they've got windows of opportunity. It's no use when they're using but when they've been arrested and are in custody, they've got windows of opportunity to engage them, it doesn't matter if you think they're a no hope or whatever, just keeping referring them to somewhere like the women's charity I had, because if they're consistent and do this intervention, just that little small thing, it might save someone's life and I can't stress this enough for them.*

Maria illustrates several things in this excerpt: Firstly, that specialist women's services can approach and engage with women in ways that services women have had punitive and harmful experiences with (such as the police) are unable to. Sadly, as Stuart and Grenfell (2021) observe, the impact of cuts has been devastating for the women's sector, especially for SSW services and their capacity to provide the kind of support and care Maria describes.

Maria continues:

*I was off to talk to a drug and alcohol worker and I didn't want to because they didn't build up no relationship with me, it was pointless,*

*there was nothing there. It was some little program thing, you go in get authorised detention, get in a cell, ask for a nurse because you're ill, I felt pointless, I was withdrawing, and I just wanted to get out and use. I suffer with OCD and when I obsess, I have to satisfy that urge and it was drugs at the time. So, I waived my rights several times to solicitors and gave no comment interviews. I was very vulnerable underneath all this, I was scared. So many times, I wasn't honest because of other addicts finding out I was in custody and talking to police. The stigma of if they found out was a whole other thing, being scared of being labelled a grass. Even though they try and say to me 'How can we help', I'm trying to say you can't, you really can't. it's got to be someone who's outside the police station like the women's charity, or someone with lived experience.*

The value of being approached by people who are familiar or who women are confident can understand their experiences, was also demonstrated by peer support. Cathy found there to be great therapeutic power in the presence of peers and the incorporation of lived and shared experience in treatment:

*I think with doing that program it gave me the opportunity to sit with other women where other women could say 'Do you know what, me too'. And that I think was one of the most powerful things. For me I remember growing up with a warped image, at 8 or 9, playing games with my friends for example, where we'd do sexual things. I thought growing up I was wrong, I was naughty, I was dirty, I was somehow a perpetrator of something. and I took that on with me onto later life thinking that's what I was and that's who I was, and nobody knew my dark little secret. But when I got that opportunity to do this group and we all sat there and talked and did a timeline of our lives, I wasn't the only woman! I wasn't the only woman that had had sexual experiences at a young age and things like that, so it changed a switch in my mind.*

Cathy and Maria's attestations illustrate how specialised sex worker services can undo harmful self-image built up over years of trauma and ostracisation. This can be further enhanced through peer work which can mitigate the common sense of otherness and

deficiency that has been embedded by individual, societal and systemic experiences across women's lives.

Secondly, the value of such services was found not just in measurable deliverables such as harm reduction and sexual health testing, but in tangible and intangible comforts such as clothing and hot drinks, and on a broader level, patience, and care. This suggests that where a service has the freedom to act outside of the remit of controlling 'deviant' populations, or from the restrictions of withering budgets and rigid outcome demands, they can provide approachable and trustworthy support. As the testimonials of the women asserts, the support they are able to provide is also then tailored to the women's practical and emotional needs, responding to them holistically and empathetically.

Maria spoke further to the importance of women's services being able to work outside of an outcome-focused remit, referring to the revolving door and quantity over quality focus highlighted in the criminal justice system:

*There are places that do women's services but it's just figures going through the door and it's really sad.*

Conversely to the surface-level approach Maria describes the transformative power of the service she experienced came not solely from its gender focus but from its unconditional provision of tangible and emotional resources and support. The service also understood and approached symptoms *in relation to causes*, as opposed to being limited by a preoccupation with symptoms alone.

### 7.3.5 Trauma-informed services: More Than Just a Plant in The Corner<sup>41</sup>

Maria's experiences also attested to the value of trauma fluency in services, who conduct themselves accordingly:

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<sup>41</sup> Paraphrased from Sharpen et al's (2018) Jumping Through Hoops report, by a respondent discussing the tokenistic approach to trauma-informed practice  
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*So what happened in these transactions, when the charity intervened with me at those early opportunities, what really meant a lot to me was instead of their saying 'What's wrong with you?' because that's what the police normally say, they asked me 'What's happened to you?', which is caring and compassionate, and I started opening up to them .It gave me a better idea of me, and they started identifying treatment needs about me to me, they were always caring and kind.*

The discursive shift from the moralistic/pathologising approach of 'What's wrong with you?' to 'What's happened?', which facilitates understanding of (for example), addiction and aggression as symptoms of trauma, and is one of the core principles of Trauma-informed Practice (Harris and Fallot, 2001a and b). The effect of this shift on Maria was to convey a feeling of safety and of being understood and accepted in a protective environment that would not punish, but positively respond to her disclosures. Ultimately, this led not just to the development of trusting relationships with the service, but Maria revealing information that explained her coping mechanisms and allowed the service to provide appropriate support accordingly.

#### 7.3.6 The Benefits of Residential Rehab for Women: 'We Understand Women, We Understand Trauma, We've Been There'

As several of the women pointed out, the disruption and chaos of their lives meant that they needed to learn basic life skills and suffered stifled emotional and practical development due to living in flight/fight mode from childhood. It also meant that brief intervention treatment was often insufficient to counter the decades of trauma and isolation that accompanies addiction (and sex working). Dina remarked:

*I believe that women in addiction and sex work would be better to have inhouse residential treatment for 3 to 6 months where they just live in and learn to be human beings again...A lot of people, they get clean and are so full of the joys of being clean and 'I'm gonna do this and I'm gonna do that' and when reality hits them and they're back in the community, they crumble, and it's all through not having the right education and the right input.*

We see that when services do provide long term, ongoing care, empowering women practically and psychologically to stand and survive in the community, this was credited with women's attainment (when ready) of long-term recovery and resilience.

It is also important to learn from this that long term rehab is not a guaranteed panacea; that the process of recovery can require repeated attempts and interventions. This was illustrated repeatedly, where services who kept the door open did not miss opportunities to engage women and were eventually the resource credited by women with supporting them into recovery. Although Dina relapsed following several treatment episodes including rehab, she was also having to overcome past experiences of a system that didn't recognise her needs as a woman and didn't respond to her requests for help. However, she acknowledged that *'the foundations that rehab gave me it's what's made me be able to come out the other side from three relapses.'*

Indeed, residential rehab was the formal treatment that the majority of women who had recovered through treatment experienced and commended for focusing on and responding to their specific needs and experiences.

Anna had support workers who were able to advocate for and access funding to help her find rehabilitation that met her needs after she struggled with the lack of flexibility and punitivism from one establishment; *'It was so strict, I felt so fragile, I just couldn't. I found it regimented and I couldn't cope, so I left after I did two weeks detox and three weeks there.'* Because of her extensive history of abusive and controlling relationships, a restrictive and withholding environment was triggering for Anna, who described herself as 'fragile'; consequently, she fled. However, her support worker was able to access more funding and find a rehab that did meet her needs:

*She picked me up and brought me to another rehab that was about self-empowerment, you had a bit more responsibility and it just suited me.*

*When I went for the interview the woman said, 'Right this is for you. We understand women, we understand trauma, we've been there', and I knew I could work with that.*

For Anna, it was this trauma sensitive and gender fluent support, focused on building women up and giving them the confidence and capacity to know, advocate for and act on their own needs, which was life changing.

Rosie was also supported into intensive, women-only residential rehab that understood trauma and worked as best they could on the causes of symptoms. Rosie attests to the suitability of this approach for women; *‘Not everyone in there had a trauma history, but most of the women did, a lot of the women did... family history stuff that had contributed to everyone in there being in the situation they were in.’* As Rosie’s history demonstrates, ‘family history stuff’ denotes more than individual ‘bad apples’ in families or even ‘risky families’ in isolation, but the consequences of communities suffering generations of inequality, trauma and precarity. Consequently, we can understand ‘family history stuff’ as an indication of compound community trauma, which has been demonstrated to correlate with socioeconomic and environmental deprivation (Atkinson et al, 2014; Duane et al, 2020; Kiser and Black; 2005). Therefore, family histories are wedded to the community around them, to the histories of habitats and to the political systems that nurture or deprive them, encourage or castigate them.

As touched upon by Kim in 7.3.4, for sex working women there was a need for specialist support even within women-only rehab services. Rosie emphasised the value of peers in helping sex working women feel safe to disclose their experiences:

*Even among women, there’s women that haven’t sex worked, that whole shame thing going on about ‘Even if I’m in a safe place I’m not going to share this.’ So, they (commissioners) identified there was a gap, even in residential treatment services.*

Safety and the establishment of open, empathetic and supportive personal and professional relationships was repeatedly described as crucial for women to engage with and benefit from interventions. Therefore, the presence of peers and of a specialist safe space for sex workers seems essential.

Despite concerted advocacy by women with lived experience for specialist residential rehabilitation, such resources are few and far between. Where they do exist, places are often given to service users who are seen as ‘guaranteed successes’ to ensure outcomes for the service, rather than allocated to women who most need that level of intervention. Rosie’s personal and professional experience meant she was able to offer insight into the motivation but also the fallacy behind this dearth:

*It’s all costs, isn’t it? So, my treatment back in the day was £25,000, to put one person through treatment for 6 months, but then you look at the long term costs of prescribing, prison, court costs, children’s services, fostering. I know people have looked at the costs, especially a woman who’s lost her children and what ten years in addiction can look like in terms of the cost to society and the cost to everyone involved and its way more than that. It’s more to be in prison than it is in treatment, it costs more to keep people incarcerated.*

As Rosie asserts, the cost of residential rehab is a significant outlay, which partially contributes to political reluctance to invest rather than punish, especially where stigmatised populations are concerned. Clark (2001) has illustrated through cost-benefit analysis the long-term value of providing residential rehab for pregnant and post-natal women, however opportunities for such support remain scarce. This suggests that punitivism may be both ideologically and cost- driven as it seems more politically and systemically appetising to keep short-term costs down and ignore the justification for long-term investment in criminalised individuals. It also speaks to the short termism of politics and the disabling desire to demonstrate action and success within the windows of electoral periods. As Rosie commented, *‘It’s just so short sighted. There’s a complete lack of sympathy for people that are homeless, drug using, street sex working. It’s not an easy sell.’*

Partly due to this lack of sympathy, socially and systematically, resources for marginalised and vulnerable women have been decimated over the last 12 years especially (Dabrowski, 2018; Vacchelli et al, 2015). This is attested to by Rosie:

*And it's getting worse. I don't believe that I will have a period of my working life where I'm able to get women into places where they stand a chance of being able to exit ever again, not under this government.*

This suggests that the reluctance to invest may be obliterating opportunities for women with histories of PDU and SSW to recover and, counterproductively, increasing the adversities that contribute to the development of these histories.

### 7.3.7 The Power of Individual Action and Street Level Bureaucracy: A Stranger to Kindness

Whilst incidents of being dismissed by services permeated most of the women's lives and appear culpable for missed opportunities to intervene, there were also striking moments where individual's professional diligence and compassion was truly transformative.

This willingness and determination to work 'outside the lines' was also adopted by the women who had taken up professional roles following their recovery, recognising the inability of services to meet women's needs under the constraints of austerity, risk aversion and conditionality. Recalling her personal and professional experiences, Rosie commented on the importance of being able to offer street sex working women more than the usual statutory sector harm reduction provisions of needles and condoms:

*I hustle all the time! Our store cupboard is like Aladdin's cave, we've got food, toiletries, hats and gloves, everything! When I first came here, on outreach we used to just give out condoms and pins and I was horrified because I'd worked in a service where we were a charity, and we gave so much more. Now the women can't believe it, we're like 'Do you need toiletries, do you need a hat and gloves' ...It was so depressing when I came down here because it was NHS, and we have to do this all on the quiet...But working in the statutory sector has been a big eye opener because you're not supported to do any of that extra stuff.*



By being able to exercise discretion and work around the limitations of statutory services, Rosie could provide women with more than the tools for cursory self-protection and to engage them on in the long-term through comfort and warmth, both practically and emotionally.

Maria also attested to the life-changing potential of services that provide unquantifiable support such as consistency, compassion and faith:

*What happened to me though, this charity, what they do is provide support for vulnerable women and they have a few bases round here and its only women allowed to go in there. They started working with me, they supported me, they loved me, they believed in me. When I was out there working in the madness, they supported me to appointments, visited me in jail, they were kind and caring. And when you're abusing and in addiction you've just got nothing about you, you've lost all faith, all hope, you're dead. That was just my only human connection I had because they stayed consistent with me.*

As Maria attests, the demonstration of unconditional care can serve to not only provide positive human connection but to counter the abuse and rejection that many women experienced throughout their lives.

Rosie repeatedly described herself as lucky, and this was in part in response to her experience with a worker who showed understanding of her needs and had the conviction, ability and the resources to meet these:

*I had an amazing female social worker who to this day I believe saved my life because she said, 'You need treatment, you need residential treatment and I'm prepared to get you funding.' So, I got 6 weeks of funding for there which at the time was 1500 a week, a lot of money. Then I got 20 weeks funding in a specialist all women treatment centre...It's shut down now. I know how good a place it was because now I work with other treatment centres and it's such a shame that doesn't exist anymore.*

Rosie's story exemplifies how the combination of a determined worker, and the availability of the right resources can instigate change for women who may otherwise have become a tragic addition to the UK's damning drug related deaths statistics (Mahase, 2019; Parsons, 2019; Tweed et al, 2022).

In her recovery Rosie perpetuates the exemplary professional conviction and willingness to fight for 'risky bets' that she received:

*I've spent my whole professional life arguing with commissioners about where they should put their money and being at a panel and them saying 'we think she needs to try it in the community a bit longer' and me saying 'She's dying in the fucking community; she's been out there for ten years!'*

Sonja also attested to the power of the dedicated individual; she had been repeatedly rejected and neglected by the criminal justice and healthcare systems throughout many experiences of domestic and other abuses. However, when one nurse recognised the indicators of violence, she intervened:

*So, I remember the last time he beat me up badly to the point, he fractured my nose, both my eye sockets and my ribs again... my son said, 'Mum you're going to have to go to the hospital, your eyes are properly closing up now'. And I can remember this lovely nurse, she must've known it was domestic violence and she got me and said, 'There's something gone on here' and I said, 'Yeah my partner beat me up'. And she referred me to an organisation that deals with domestic violence and that was the first time I ever got some proper support.*

Due to a nurse taking the time to explore the reasons behind Sonja's physical condition and to make the effort to reach out to her discreetly and sensitively, Sonja was connected with a one-to-one support worker who provided her with safe housing as a priority and connected her to a women's service. The support of this worker allowed Sonja to escape and be protected from her violent ex and safely and confidently receive ongoing help for the first time.

Sonja explained:

*The women's service has been a total turning point for me. Even though they've been going for years, back then I was so locked away, even if I had tried to reach out to a service like that, I know my partner would have shut me down straight away, I would never have been able to go and oh my gosh, they've changed me so significantly.*

This shows how individuals' care and willingness to 'go the extra mile' can trigger a chain of events that incrementally connect women to the people and resources crucial to rebuilding their lives.

### 7.3.8 Collaborative Working, Mutuality of Purpose and Effective Network Functioning

Where these transformative moments with services occurred, they were often set in motion by an individual. However, the ensuing trajectories were made possible by macrolevel factors, sufficient funding and collaborative working. Specifically, fluid multi-agency working involved a mutuality of purpose and effective network functioning that centred around this shared purpose.

Sonja's story demonstrated this, with an astute nurse linking her to support that led to her receiving safe housing and trauma focused, sex worker specific support. Sonja commented on the systemic barriers women in violent relationships experience and how these can disbar them from accessing support:

*I think frontline workers, like doctors, hospitals.... It takes a lot for a woman to go through court proceedings, to go and even tell about a crime in the first place. But if you're with a hardened, violent man who controls you in every which way or form, to think you're going to get the police involved and potentially you could lose your life for it, for me that's what it was.*

This highlights the distrust and fear many women with histories like Sonja's have of the police as a result of repeated dismissal and the importance of frontline services

acknowledging this and instead operating as conduits to support that help women pursue successful or at least non-retraumatising criminal justice action, if desired, and most crucially, safety and the opportunity to rebuild.

During a period of her professional life that Rosie considered a golden age, an interesting intersection arose between neoliberal gentrification efforts, consequent concerns to eradicate visible poverty and partnerships between agencies built that took advantage of these concerns, united by the joint purpose of responding to women's needs. Rosie recalled:

*Coming onto my professional job, about ten years ago there was a big thing about, we need all the sex workers off the streets, because it was being gentrified so 'It's all clean, it's all nice, so we can't have the women. It doesn't match up with what we want it to be like'. So, my friend who had lived experience, she got the job in the council, and we were like 'Yes!', so they employed a sex worker coordinator based in the council and because they understood she was like 'Ok, to get the women off the streets you're going to need to put them into residential treatment'. So, we had pilot funding for a year to see what we could do about reducing the number of street sex working women. So, I got the Job.... specifically, my job was to get women into treatment.*

Arguably then, in this area and at this time, one of the unintended consequences of the attempted gentrification and NIMBYISM embodied in neoliberal ideals of place and conduct was the opportunity for women with lived experience to enact change. By seizing this window of opportunity, women were able to take positions in local authority wherein they could harness the requisite support and resources to make a real difference. This began, as Rosie remarks, with recognising and responding to the disruption of the hierarchy of needs caused by addiction and street working:

*We help women address those baseline needs, for food, shelter, clothing, warmth...the next level is that it needs to be safe and secure, so you don't just get someone a night shelter if it's not safe and secure, you advocate for a female only service, not that they're massively available.*

*But where I worked first, we did have a really great women's hostel and women's night shelter...I think it's a lot to do with the sex work project and the housing providers and how much joined up work you do, and we did loads of joined up work.*

Rosie and her colleagues had the resources and relationships to build genuine partnerships with all required services including housing, the criminal justice system and specialised rehabs which operated united by a mutual purpose of meeting women's needs in ways that also helped them transition away from survival sex work.

## 7.4 Future Barriers: The Marketisation of Public Services and the New Recovery Industry

The creep of neoliberal models and aspirations into the drug treatment industry has been demonstrated in the personal experiences of many women. It was also commented on by those who now had professional experience.

This was partly due to the solipsistic interests of many of the figures who had gained prominence through reflecting the state's ambitions. Abi remarked:

*It's actually societal, and I'm gonna say this, Rebecca, it's actually deliberate. If you think of capitalism and created markets, poverty has been created; all these markets have been created, to make money for people. So, it's actually reached its pinnacle, it's destroying the earth, it's destroying humanity and it's filling a very small percentage of people's pockets, and making them very, very rich... It's created markets and what bothers me is that we on the ground now have to take on board the outcomes, the actual research into the real needs of people and adjust the systems to suit because the systems are cruel, and they're actually institutionalised and its institutionalised fraud. So, if we are truly going to change things for people that are caught up in the firing line, all this monstrous, ugly, really brutal world, we have to take all this evidence on board and actually address people's needs, seriously address them.*

Abi describes the incompatibility of recovery and wellbeing with the marketisation of public services and the commercialisation of inequality. Her insights reflect the privileging of wealth over equality that underpins neoliberal policy's concerns with budget reduction, outcome demonstration and personal responsibility. These ideals also appear in *market logic* which has been identified in the Swedish recovery system as operating to the detriment of service users and professionals alike by undermining responsivity to population-based needs, causing fragmentation and excluding smaller providers (Storbjörk and Stenius, 2019).

We can see similar issues across the recovery landscape in the UK, albeit with a more pronounced focus on the ideals of neoliberalism, as we will see in 8.1.2.

For example, Megan described the damaging impact of the flourishing recovery political industrial complex. She described her experiences of the charity she had worked for abandoning the original principles of recovery it espoused:

*There are certain aspects of me working there and what's happened to me that's actually led to further trauma, so it was a horrible, horrible experience and I'm so disappointed in an organisation that's meant to be rights based, compassionate, caring, all of that. It's just been unbelievable.*

Although the service had begun as a grassroots organisation focused on compassion and rights, as the lures of prestige increased, Megan described the shift in focus from the rights and needs of PDU to the expectations and desires of political figures and other New Recovery 'policy entrepreneurs.

Consequently, Megan found herself overworked and treated callously:

*I was tasked with an event that seemed impossible to do, all these events in all these cities for 1000 people each, with no budget! .... But in order to do that you have to invest very much of yourself...I says 'Oh, my mum's taken very ill, just so you're aware of it, because I never played the sick card, I was never off sick, I never took time off, but she says 'Well let's hope she doesn't die this month'*

Megan also observed the kind of self-advancement idealised in free market doctrine, yet within a purportedly socially concerned enterprise:

*I've seen how ruthless it can be. So, for this one recovery initiative, the guy who actually started it off him and he went abroad! There's a lot of stuff that is unsavoury...I began to even question if they were in recovery at all, from anything, because I watched, I was their right-hand woman, bum boy actually for ten years.*

Within this environment, Megan describes how what Duke et al (2013) and Thomas et al (2019) term 'policy entrepreneurs' profited from and continued to thrive on this exploitation (Fomiatti et al, 2019; Roy and Buchanan, 2013; Walsh, 2020). Referring to a prominent New Recovery academic, Megan remarked:

*He's linked to so many people in the country...The only words I can describe it as is superficial and it's the great I Am. Then I look a bit deeper at what he's saying and go 'Oh my god, that's so and so's material!'. And the same with the new chief exec. They put their logo all over some output, but it was actually a collaboration with lots of people.*

Megan describes how this career of plagiarism through the exploitation of peer enthusiasm lay beneath what was an outwardly earnest and successful endeavour. Such ruthless and cynical self-promotion at the expense of genuine voices exemplifies the pernicious influence of creeping philanthro-capitalism, fuelling the New Recovery political industrial complex (Clark and McGoey, 2018). Resultantly, the convergence of neoliberal ideals and free market practices in public services can be argued to obfuscate the roots of addiction in marginalisation as eager individuals clamour to capitalise on politicised issues (Bone, 2012; Roy and Buchanan, 2016; Shapiro, 2012; Walsh, 2020; Watson, 2012).

Gina, too, had professional experience with some of the 'poster boys' of New Recovery, and described her frustration at business practices of 'stacking high and selling cheap'; promising state-desired outcomes (including swift results for minimal outlay) through insubstantial methods:

*Even the (national charity), I knew the chief exec at the time, I knew her quite well. I met the new guy. But our ADP (Alcohol and Drug Partnership) were talking about giving him £100,000 to put people through the recovery colleges. Now I was spokesperson for the area at their conference I was not polite, I was not helpful at all! And I tried to explain, there's no point, you're not asking people with lived experiences where to spend the money. You keep giving external, national organisations hundreds of thousands of pounds and I said no, everybody that I know that's on drink and drugs don't want to go to school!*

*That's exactly what they were trying to do up here, in this area there's about 90,000 people and I've worked with every place to do with drink and drugs here. They got ONE person to go, one wee old alkie woman. That was it. And I tried to explain to him that nobody, some of the people*

*I was working with didn't even want to go out, they were too paranoid to go to the shops for their cheap cider, let alone pick up their pencil and their briefcase up and go to his college!*

We see Gina's frustration with the deprivileging of the reality of lived experience in favour of the New Recovery ideals. These pledge the production of self-disciplined, compliant citizens created via collective education, encapsulating the New Recovery Industry's promise of behavioural outcomes rather than addressing causes.

It has been argued, and indeed Gina's experiences below endorse this position, that paralysis of the sector is the only true outcome from promoting a model that awards contracts to the bidder with the least expenditure and greatest promises (Roy and Buchanan, 2016). Instead of mobilising systemic change, competitiveness and adversarial dynamics between various bodies dominate, motivated by a focus on profit and popularity:

*We had all these people telling us they would help us, but they didn't. Another area has got its own recovery café but it's over 50 alcoholics who frown on addicts, don't want drug addicts in their group. Another*



*recovery café in the next town was run by a multi-millionaire and she never got on with anybody, it was always changing hands, it's turned into a soup kitchen now, I think. She used to pick fights with everybody! But again, the (national non-profit), this guy from there got money. I used to go over to the ADP to meet this guy, he's another one, he's doing whatever boxes he has to tick but whatever it is, nobody I know's ever seen any benefits of it. And it's very nasty all the groups between each other. Each group I would go to they'd all bitch about each other, it was completely unprofessional. No word about the folk that're dying, the attitude of some of the professionals, some of them're kicking the arse off of 60 grand a year. Do you know what I mean? They did some lived experience commissioned report, 50 grand I think they got paid for it and it still hasn't been implemented. He turned up at the meeting wanting someone from each locality, an individual from each place to meet with the others and WE were supposed to implement these policies and this strategic plan that they'd come up with. Now that should've been a paid job, not what 'Billy fae Oban and daft Gina fae Argyll' are supposed to be rolling out. That is an actual job! That's what I was trying to say to them, ah we'll be taking your wages for that then, earn that as a volunteer! So, he went off in a huff.*

This also suggests the cynical nature of some peer recruitment, with a hypocritical lack of respect shown in offering unpaid roles. This doesn't recognise the fiscal value of peers' experience and input and, as discussed below, fails to provide the training and opportunities for progression to ensure that lived experience people are matched with suitable roles that provide them with a career path.

#### 7.4.1 New Recovery in Policy and Practice

As touched upon, another manifestation of New Recovery comprises what can be described as the tokenistic exploitation of lived experiences in order to performatively demonstrate success and to cheaply bolster an overburdened workforce (Cowden and Singh, 2007; Deacon and Patrick, 2011; Froggett, 2002).

This contradiction between the values espoused in policy and the reality of peer employment was remarked upon by Megan:

*We drag our clients that're doing well out to share a story... and I'm all for lived experience of recovery, however we don't own it. I always think because the new government strategy has got 'rights, respect and recovery' in it you're trying to own that lived experience.*

While peer support has been demonstrated to provide invaluable and unique benefits, when processed through the lens of budget reduction and outcome demonstration, peer experience and goodwill can feel exploited (Cowden and Singh, 2007).

This was encapsulated by Katie, who observed the incompatibility between business market approaches and the less tangible and linear reality of recovery; *'It's all about having to put recovery into a KPI and measure it and it's not always that easy, is it?'*. The debilitating consequences of this investment averse, outcome-focused approach is described by Jo, who has extensive professional experience in her recovery, working with stakeholders at all levels.

*I think what we're doing by paying drug workers 17 grand a year and skimming contracts, and the big charities, the race to the bottom there, that was on for the last ten years, like they were viciously undercutting each other to win contracts. What they could've done, and I suggested it to them... you guys could be a fixed pricing cartel, stop the race to the bottom, stop working in isolation, conflict, and competition with each other which is obviously what they do and really serve the people that are suffering, this could be an opportunity, but of course they never (one charity) undercut everybody! So, policy making I would bring it back into health and social care. I would keep it in the third sector but recognising that it cannae be run like a business.*

While some services were beginning to take notice of the impact of trauma on service users, this did not extend to staff and Kim highlighted these discrepancies. Despite

being employed as a volunteer, then peer (eventually being offered a wage), Kim's historical trauma was disregarded by her next place of employment:

*I've never been offered anything. And then as a worker I'm still not offered anything. I have been to the GP. So, I was working in services and the funding got cut and then I got put into another organisation. The first organisation have known me since I was using and they support me around that, they're amazing and I've got some really good friends. But the one I'm in now, do things really cheaply, don't offer any support. When I went to them, because I was running groups of 12 people on my own and sometimes something might trigger me so I was like 'I would like another worker in with me, I don't want a peer, I want a worker'. And because I told them that they tried to say I wasn't fit to do my job. Which was another struggle in itself. So, I'm very cautious of what I tell my employers because I don't want them to think I can't do my job and I can, I've lived with this for years, just sometimes I'm listening to something or somebody that might trigger me and that's it, but I manage it. I'm still waiting. I'm on waiting lists to get some support from this place that deal with sexual trauma. So, I'm on a waiting list with them, and that's it. Just have to wait.*

Despite her known history and openness about her vulnerabilities Kim was overburdened and when she voiced concerns, her employer interpreted this as a sign of her incapacity. This seems ironic given that services want peer workers yet are reluctant to acknowledge the inevitability that many will and do continue to experience the symptoms of trauma. Shapiro (2012) raised concerns about peer workers being employed without due care being taken to ensure relapse is avoided, and this research demonstrates there is a trauma-specific element to add to this concern. This absence isn't solely down to a divergence in approach to trauma among services where current and previous service users are concerned. Kim also remarked upon the significant impact of the lack of resources on the scarcity of trauma support and on the heavy caseload recovery workers struggle with. Kim further experienced this when called upon to lead a group focused on trauma, finding her lived experience

and her professional requirements to be divorced by her employers, suggesting a dualistic approach to trauma and the impact of the lack of resources.

*One study I did take part in was a study for drug using sex working women. I was the worker in this. They worked with another charity and recruited women they thought had PTSD or traits of PTSD and they were sex working and using drugs. So, I would go down and run the drug group, that was my role with it with another drug worker. Once a woman had attended a few sessions they'd work with this woman that did EMDR: so, if the women could engage with us then they'd get that. It was a study to see if that would work because normally, they don't give women that kind of treatment if they're still using. And it's really hard for a woman to stop using if she's traumatised. But it's kind of never ... the women were very chaotic, and it was mental actually. I remember going back and saying, 'I need some support around this because they're telling us about their traumas', and they go 'Oh no, you're just running the drugs group!'. And I'm like 'But it's not the reason why they're using drugs is because of their trauma so of course it's going to come up.' The woman I was working with, she has a history as well, we used to come out of there hysterical, laughing and absolutely hyped or a bit mental, because of the things that we were hearing*

The irony of the separation of standards and approaches for current service users and those in recovery and now employed by services was also experienced by Kim with regards to the treatment of her past as a street sex worker:

*I mean they encourage people with lived experience but... I was quite shocked, when I went to my old organisation, they knew me when I was using, they support me all the way. So, when I had to do a CRB check nothing was a shock to them. So, when I went to the new job, they'd question me about something, what I do hate, is when I apply for a job, on my CRB if you've been stopped for sex working it comes up as a sex offence! So, on my criminal record it says sex offence, that's something that's always going to be with me no matter what. Then if I apply for a job in my line of work, it's*

*enhanced CRB, they're gonna see all that stuff. I don't think it should be there...So they (new job) pulled me in about my CRB, so I've had lots of prison sentences, shoplifting, sex work, driving offences... it's quite a hefty one, and I had to explain everything on and it's not like I haven't done this job, I've worked with vulnerable people for a long time now. But they want people in recovery, so I don't know how that works!*

This connotes a failure on the part the criminal justice system for leaving peers vulnerable to humiliation for their pasts and for failing to distinguish between sex work and sex offences which could not be further from one another. Resultantly, women continue to be required to recount traumatizing experiences from their past and to face stigma and traumatising interrogation, despite attempts to move on.

Jo also had professional experience of the New Recovery Industry and commented on the hypocritical duality of approaches that laud the value of peer workers but also fail to recruit peers with due diligence and a duty of care. Instead, Jo observed services recruiting people with lived experience as a tokenistic, virtue signalling exercise rather than looking for stability and specific skills alongside lived experience and a desire for employment (Cowden and Singh, 2007).

*So, what I would like policy makers to acknowledge is this isnae unskilled work. So, if you're genuinely wanting to help people being two years abstinent or being in recovery isnae enough and I don't believe it is. You have to be skilled, you have to have therapeutic experience, in an ideal world you would be a trauma specialist.*

Katie surmises that a business model is essentially incompatible with the reality of PDU as addiction is often preceded and accompanied by trauma and unmet need and cannot be laid to rest by a program of symptom-focused, prescribed sessions.

*I think recovery can't be achieved in these short, in the grand scheme of things, sessions. It can take years and it does take years and it never stops, dealing with traumas that caused you to have addiction and it's not only that, it's the things you did while in addiction, like me sleeping with men for money, dealing with that. Then you feel disgusted, and you've got your own guilt about that and all the baggage*

*before that, so having these really short, regimented treatment services, it doesn't fit. It should be the other way round, and I know it's all about money, and the funding. But if there is a way, and I think especially for women, because I think a lot of it does stem from abuse when you're younger and I think that it doesn't get regarded as much.*

#### 7.4.2 Recovery Capital: Motivation or Frustration

Although so rare as to be questionable as generalisable evidence, a noteworthy and interesting irony was that for Gina, perceived failures of the Recovery sector frustrated her to such a degree she was eventually propelled into recovery:

*I went to this group, and it was something like 'One Flew Over the Cuckoo's Nest', bored, folks sticking crayons up their nose, sitting in the dark, moaning about the world and I thought 'Oh this is just grim!' So, there was a woman there that ran another mental health group about 40 miles away again and she had taken on the post of coordinator and development worker. I started getting involved in that and the more I looked at it the more I realised she was fiddling the books! So, I decided I was taking the mantle on myself, and she left and went to another place so she could fiddle with the money there! We got another development worker who works for advocacy, and she came but she was hopeless, so I fell out with her as well, so she resigned in a huff. There was this other guy that came on and I couldn't work with him either because he was just the world's worst human being that you've ever met in your life. So that's what kept me sober. Usually, I was known for being drunk and shouting and bawling and stuff but now I was going to meetings, boardrooms, all this sort of stuff. The health and social care partnership was merging, and I got invited there, so they were bringing social work in the NHS and council in the NHS and set up locality planning groups and it was all heads of services. So, you had heads of psychiatry, mental health, domestic shelters, acute and chronic wards, dentists, social work. There was about 40 people and I got invited on that as a representative of the community. And it's kind of all stemmed from there and I just kept going*

*to meetings in and annoying folk and that kept me sober! And every day I would wake up and want to annoy somebody else and I had to be reasonably sober to do it. So, I did that for a few years then we got funding and I did the recovery café, and that was good. We did loads of things. And then I did my duty arguing with the ADP!*

Although unusual, it is worth making note that Gina's particular combination of spirit and resilience were ultimately stoked by the perceived ineptitude and corruption of the sector.

However, the reality is that for the majority of people, services that demand self-discipline and asset realization in deserts of opportunity can be argued to embody a complete disconnect from the realities of addiction.

Gina experience denotes this:

*When I got money off the lottery we took people away for the day, we went to the safari parks, we went to the sea life centre, on boat trip, to see pantomimes (I hate pantomimes, I went to the pub!). that's what people wanted. They didn't want to be stuck learning about how alcohol effects your brain so they can tell somebody else. They want interactions with new people and with their people, they want taking out of their shitty surroundings, they want away fae their shitty bedsits for the afternoon and I kept trying to say that's why you need to spend your money on activities, not schools, nobody wants to go to school!*

Gina describes the need for escape from and transformation of environment, and of the debilitating impact of deprivation upon communities. At the heart of this, the state's inappropriate and insufficient efforts are not without blame, and so its demands for self-improvement while simultaneously destroying resources, feel like a barbed irony.

## 7.5 An Ideal World: Women's Recommendations

This closing section details the recommendations made by the women for policy makers who are sincere about tackling addiction, trauma and inequality as a whole.

The essence of this is encapsulated below by Jo:

*Poverty and inequality. Tackle that! Tackle that. It's not gonna be a panacea but you're gonna eliminate a lot of harm. I would be really interested in a ... what is it they call it... a universal basic income! I think that would eliminate a lot of stressors, and it would provide a level of equality and it would be useful. But I mean, that's bigger picture thinking isn't it. In the short term they could provide in addiction services, mandatory trauma therapy.*

Rather than locating fault, sickness, or deviance within the individual, Shelly called for policy and practice to adopt a broader understanding of symptoms of distress such as drug use and street sex working:

*A woman doesn't just wake up one day and think 'I know what I wanna be when I'm older, I wanna sell my body', that isn't any little girls' dream and if it is, then something somewhere has changed that little girl's view of the world.*

*And I think what services don't do is they don't look at the behind reason. They see the drugs are a problem, if we put you on a script or get you clean that's it. That's not where the problem lies, it's after, what got you there in the first place.*

This attests to the need for an approach that adopts a broader socioeconomic and trauma informed lens. As Shelly poignantly asserts, no child aspires to addiction or to be so desperate for money that they are compelled into transactional sex.



### 7.5.1 Opportunities For Women

The lack of opportunities for women and the stultifying lack of horizons and possibilities were significant barriers prior to, during and after addiction. This arose as an obstacle in two ways; firstly, the lack of recognition of traditional 'women's work', whether in the home or in employment markets, and secondly the lack of lucrative opportunities for training and career progressions available to women.

Abi attested:

*I think women need to be valued, I think women's work needs to be valued, childcare. I'd like a definition of work that includes 'women's work'. One of the most valuable things a woman can do is be living in a community where she is valued and where she feels safe and supported, no pressure, and she's got enough food and the house is warm, it's the whole poverty thing.*

Women's contributions were not just noted to be undervalued and neglected in the realms of the home; Kim identified the absence of opportunity for women to be able to progress, noting that there was often a gap that remained precariously unfilled upon recovery:

*Women need more opportunities to move forward once they've managed to pull themselves together more, support to move out of that. Because it's alright once you get clean, what're you gonna do after that. If you've used all your life... I was lucky that I had opportunities but not everybody gets that so I would like to be able to set up a program for women, once they are clean and have sorted out their traumas, to help other people if that's what they want and stuff like that. Or opportunity to go to college courses, things like that.*

While employment and education are a key attainment in conceptualisations of recovery and desistance, the fact remains that funded opportunities for gaining experience, skills and knowledge which lead on to suitably compensated and secure

careers are few and far between. The employment landscape increasingly restricts low-skilled workers to precarious and poorly paid work while demanding greater levels of expertise for access to more sustaining and sustainable careers (Greer, 2016).

Jo's story is testament to the mitigating impact of access to opportunities and education, even when women have experienced significant trauma:

*I think it was that 15 years of trying to practice the 12-step program and during that time I went to university, so I really valued the education, it was something I thought I could never achieve, and I did, you know, I went and got a degree, and I got a master's degree.*

By being able to go to university and succeed, Jo could contradict the slew of messages of futility that had accompanied her throughout her life and build her opportunities for economic and social stability. It is worth noting that in Scotland, where Jo lives, higher education is not subject to the debilitating and daunting fees charged in the UK, and so boasts a more meritocratic and democratic approach to accessing education. Also, Jo was fortunate to have been supported in processing her past and building up her resilience and identity through the sponsorship of a trauma-cognisant clinician and so she benefited from intensive support from them which is not ordinarily available.<sup>42</sup>

The importance of working on historical traumas and instilling coping skills is attested to by Jo who stated, 'It's not being able to accept or heal or work through the trauma that has led to the addiction in the first place and I firmly believe that'. Jo's attests to the importance of a multifaceted approach to recovery which addresses all basic

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<sup>42</sup> 'Over the period of my first three years in recovery and I had access to her on a daily basis which you just wouldn't have in normal circumstances but because she was my sponsor. But we would have weekly sessions as well where we go into the psychodrama work. What that would mean is we would go into the situation as an adult, so I would be lying on a couch, sitting on a chair, she would ask me to close my eyes and we would go back into the scenarios where I was being abused, mainly the sexual abuse we did work on a couple of episodes of the physical abuse, and she helped me comfort the child'

needs, beginning with safety (in every respect) and supporting the individual to access and realise their abilities and interests through genuine opportunities thereafter.

### 7.5.2 Prevention and Early Intervention

Many of the women felt that while appropriately focused and funded support, desperation, or near-death experiences led to their recovery, the true window of opportunity was early intervention in childhood.

Kim commented:

*I believe, I really believe, when I was younger, if I had been given help then with what happened to me, I wouldn't have ended up where I was. If I was given support that I needed at a young age my life wouldn't have spiralled how it did in a complete mess. I've got three children and two don't live with me. It's a mess... well it's not, I've got a good life, but it's been a long way to get here, and I've done it all on my own, I've got no family support or nothing. So, I believe if people get offered the support as soon as, or a bit after, a traumatic event, I think if you act quickly, it will prevent people from retraumatising themselves, because that's what you do when you've had a trauma, you seek it out and you act up and then it just adds more stuff and spirals.*

Brenda had also grown up with her trauma unrecognised and interpreted through a stigmatising lens due to her mother's alcoholism and misassumptions made about Brenda's aggressive behaviour:

*I was a bully from the age of 6 – 11 until (abuser) was took out of the house. I went round and apologised to everybody I'd ever...but that was about me, not them. And the teachers just assumed well her mum's an alcoholic...they jumped to the wrong conclusions really badly. And it had an effect. Because it got ignored, nobody understood.*

Relatedly, Jo's recommendations also focus on identifying and addressing trauma and thus mitigating the desire for oblivion:

*Every single woman I have sponsored has been a survivor of sexual abuse or physical abuse, like extreme physical abuse and childhood. Or neglect. But usually, all three and more. So, I'm absolutely convinced in my 23 years of recovery anecdotally I can tell you every single person I've worked with has and the ones that haven't there in a minority, but I'm not convinced they haven't either. So, from a policy makers point of view, we have to recognise that people who become addicted are looking for escape, they're looking for oblivion. But why human beings look for oblivion. it's not about recreational drug use and gateway drugs leading to these really bad drugs. It's not about moral fucking degenerates, although my behaviour became immoral when I was addicted, there's no doubt about that. As soon as I was addicted it became immoral and after I got clean it wasn't immoral then, so the immorality is a by-product of having to feed the addiction, so we're unwell people trying to get well. Ultimately the focus has to be on trauma, on understanding that human beings don't self-sabotage unless there's something deeply wrong.*

The multiplicity of traumas detailed in this research and touched upon by Jo is also termed 'multiple disadvantage', so it could be that when referring to multiple disadvantages, we are referring to the presence and impact of multidimensional trauma, which is also more prevalent in areas of socioeconomic deprivation (Bullock and Parker, 2014; Fisher, 2014).

Keira remarked upon the growth of addictions of all kinds and the magnitude of the impact of this currently and in future:

*I think the government needs to wake up and realise addiction is a real issue and they're gonna have a full generation that's wiped out from one addiction or another, whether it's coke, heroin, legal highs, drink... even gambling. There's a full generation that's gonna be hurt with this, and that generation is gonna run this country one day! It's like, if you don't nurture the youth of the day when you're a pensioner you're screwed, because they're in control of your pension!*

Jo succinctly encapsulated the essence of this burgeoning problem, identifying the impact of the economic and social neglect of ostracised communities. Jo noted that the pursuit of oblivion becomes normalised in the face of constant trauma, and dearth of opportunity:

*We're talking about generations of trauma so when you talk about that as a community and as a family, that's the answer. And obviously poverty, massive poverty, and inequality... it was about poverty, about normalisation of oblivion and how acceptable that is. That's why it's worse than it's ever been. It was Voltaire who said love and work are the two most important things to human beings and if you don't have meaningful purposeful work, even work that pays like... we've got work now, you've not even got a fucking contract, a zero-hour contract.*

## 7.6 Concluding Thoughts. The Escalation of Community Disintegration, Neglect, and Despair

In some communities, generations of trauma, neglect and deprivation have inflicted such a degree of trauma that its inhabitants seem paralysed by apathy. Discussing a recovery café, she had been given a grant to set up, Gina opined (of how to address addiction):

*It's better to educate people when they're young and prevent rather than wait 'til they're 40 years old and completely broken but they just willnae. So, we just got fed up and then we shut that down and I got more money to set up a community hub for everyone and that was even worse, for the apathy! Nobody wanted to do anything, so I had to give the money back to the lottery! Yeah, we had to give the money back.*

Gina's experiences suggest that where communal trauma and poverty have been long unchecked, a collective sense of inertia and futility can result in unengaged populations who are suspicious of change.

Despite trying everything, Gina was unable to engage and motivate the community, and described her experiences as follows:

*But it was the apathy that got me, I got nearly ten grand off the lottery, and we started another one and we could not get the bodies in, we couldn't get people to come to it. We worked so hard, I got 35 separate stat and third sector organisations round the table, it was unheard of. You didn't get many organisations to take the time out and sit and take a holistic approach to mental health and addictions and all come round the table and agree to give their time once a month. They were all willing to do it. So that was the problem with the recovery café, we couldn't get the services. Then we got the services, but we couldn't get the people in to come and use it.*

*R: That's so frustrating. Why do you think that was?*

*G: I don't know, we opened and laid on a massive spread, had kid's entertainers, archery, loads of stuff. I think we had about 30 people. We had coffee mornings, barbeques, I'd worked with a company, we were gonna do foraging and outdoor cooking because I'd been on a course, and it was great fun. We'd been doing a cookbook with this girl. So, we worked with her and the Woodlands Project and did a risk assessment. We did advocacy, we did surveys to try and figure out what people wanted, whether it was, I don't know, a book club, music, education, computers, all that stuff. We had money there. And nobody.... One woman said, and this was the crux of it, 'well that's pointless. People need to be told what they're doing. You can't just expect them to come up with ideas off their own'. So, the volunteers got fed up. Nobody was coming. The food was free, we said if you're struggling just come in. we purposely opened on a Sunday because nowhere else was open, all the cafes, so you couldn't get a roll and sausage with a hangover! You'd think that would do it but nope, nope! Couldn't even feed starving hangover folk, so we just gave the money back?*

*We asked, and one of the reasons was we don't like the building. Another was we couldn't do three course meals because of health and safety. So, the old people just wanted somewhere to eat their three- course meal for a fiver, all the addicts, and crack is rife up there, nobody wanted to stop. Whatever trauma, whatever was going on in their lives was not going to be dealt with by coming to see us one day a week*

The persistence and indeed exacerbation of multidimensional trauma and poverty is illustrated in Gina's summary of her environment which suggests a concerning exacerbation in recent years:

*One of my exes committed suicide just two weeks ago. And the last three funerals I've went to are suicides, that's how bad it is in Scotland just now. She was only 34 and the girl that committed suicide before that was a little bit younger than I am, that was two years ago. And the other guy, he was an older gentleman, he threw himself in the canal last year, mental health. So, it's really bad and that's just wee villages. And there's the young folk, in a place I used to stay, three under 16-year- olds had committed suicide in two years. And then there's the drug deaths. Two died of something to do with ecstasy, another with Valium. There's a guy died just recently from Xanax. Scotland's the worst isn't it, the worst in Europe.*

Gina's description suggests chronic distress is endemic in deprived communities, implicating the amplification of inequality partly caused by neoliberal policies. Stevens (2019, p.444) suggests that government inaction regarding opioid overdoses is due to a disregard for impoverished populations whom he describes as being subject to a 'depersonalising class contempt'. This reflects the position of this thesis, that the economically and socially non-compliant are excluded from the same moralising considerations the state applies to other domains (Stevens, 2019).

Without redress of the inequalities discussed in the closing sections of this chapter, there can only continue to be an intensification of trauma and unmet needs, and,

correspondingly, PDU and SSW. This is without considering the very real human toll in terms of premature deaths through suicide, overdose and poverty.

## 8 Conclusion and Discussion

In the closing chapter I draw out the overarching themes from the findings to advance new contributions to the knowledge base and suggest alternative lenses through which to view and approach PDU and SSW in the post- industrial UK. I do this through three key discussion points: First, I illustrate the unsuitability of individualising models and challenge policy and practice based upon these. Second, I demonstrate the harmful consequences of neoliberal policies and related treatment models for marginalised women and the ways these exacerbate deprivation and multidimensional trauma. Thirdly, I propose the Scylla State, a concept I have developed as a gendered iteration of Wacquant's Centaur State (2009). This provides unique and much needed insight into the experiences of PDU and SSW women under the practice of austerity and policies of neoliberalism, and how these contrarily make recovery a more distant prospect.

I then offer reflections on the process and outcomes of the research before proposing future directions for research and concluding with a series of implications for policy and practice.

### 8.1 Discussion Points

Drawing upon my findings and interpreting these through my analytical framework, three overarching points emerge that comprise the main discussion points. Firstly, I raise the incongruence of individualising models with PDU and SSW women's lived experience, querying the suitability of current policy and practice. I suggest that PDU and SSW can alternatively be seen as criminalised coping strategies in response to multidimensional trauma emanating from intergenerational cycles of inequality. Secondly, I discuss the role of neoliberal policies in the UK and the consequent exacerbation of poverty and thus, multidimensional trauma. I then describe the



manifestation of this in New Recovery policy and practice and the resultant availability (or lack) of appropriate services and resources to combat addiction.

My final point considers the extent to which the specific experiences of women in the United Kingdom endorse Wacquant's (2009) conceptualisation of the 'Centaur State', and the ways in which this concept can be amended to depict the female experience. The Centaur State has been applied to discussions of the treatment of problematised populations in the UK by Povey (2017) and Fletcher (2011, 2013 and 2015) who describe the impact of retrenchment, punitivism and stigmatisation. These themes echo the experiences of the women in this research and so warrant particular attention. This was a previously neglected area and in doing so, I contribute to the expansion of the notion of the Centaur State to provide a gendered perspective. Rather than the Centaur, the findings suggest that a more appropriate model would be that of the Scylla, a multiheaded, feminised iteration of the combination of liberalism and punitivism described by Wacquant (2009).

#### 8.1.1 Discussion Point 1. The Inadequacy of Individualising, Responsibilising Models to Understand SSW and PDU

The theoretical constructions underpinning practical, political and societal treatment of PDU/SSW women are argued by this thesis to predominantly originate from a pathologising, moral/behavioural or blended approach (as described in Chapter 2). These models are suggested to feed into a narrative that marginalises these populations further, inappropriately treating them as deviant and consequently exacerbating their deprivation and trauma.

The responsabilisation of PDU and SSW is illustrated by the literature discussed in Chapters 1 and 3 and the Findings presented in Chapters 6 and 7: In the criminalisation of SSW, the disproportionate police attention paid to street (as opposed to indoor) sex work, and the focus in the desistance and recovery industries on behavioural correction, motivational interviewing and/or medical intervention. My findings suggest that PDU and SSW are instead coping and survival strategies in response to environmental and socioeconomic deprivation that do not originate from

the deficiencies of individuals but the pernicious impact of political strategies. I support the assertions of Alexander (2008), Kiker (1996) and Holmwood (2000) in identifying the role of neoliberal governance in the exacerbation of poverty and with that, trauma at individual, community and systemic levels.

As Reeve (2017), Tweedy (2018) and MacLeavy (2011) argue, neoliberal policies amplify exclusion via the retrenchment of appropriate support and increased conditionality and punitivism in response to perceived deviance. Furthermore, neoliberal policies such as austerity exacerbate the precarity, deprivation and psychological humiliation that are evidenced to contribute to male violence, child neglect and abuse and the incapacity of mainstream services to provide supportive responses to women who have these experiences (Baugher and Gazmararian, 2015; Bywaters et al, 2016; Ellis, 2019; Fahmy et al, 2016; Ishkanian, 2014; McGrath et al, 2015; Morrow et al, 2004).

This suggests the culpability of neoliberal policies in the amplification of multidimensional trauma and, consequently, the use of substances to manage the impact of this. Below, I demonstrate the presence of multidimensional traumas throughout women's histories and their contribution to entrenchment in and difficulties recovering from PDU and SSW. Women universally correlated these traumas with the onset and exacerbation of their addiction and, correspondingly (where relevant) survival sex working. This relationship connotes correlation between neoliberal policies, amplified deprivation, trauma and, as a consequent coping strategy in the absence of alternatives, PDU. This contradicts dominant models which locate responsibility for addiction and survival sex working in the individual, alternatively indicating the influence of politically exacerbated environmental factors.

As demonstrated in Chapter 3, neoliberal policies underpinned by individualising discourse have played a significant role in exacerbating inequality and poverty in the UK. This amplification and the associated policies are correlated with greater incidence of male violence, ACEs, alcoholism and mental and physical health problems (Ellis, 2019; Maryat and Frank, 2019; McGrath et al, 2015; Roy and Buchanan, 2018). As several women noted, their parents bore their own traumas, and it can be

theorised by extrapolating from the evidence discussed in Chapter 3 that this was connected to the impact of the rise of neoliberalism.

Many of the women described their childhood environments as being insecure and unsafe rather than the stable and protected surroundings essential to fostering the safety and belonging crucial to developmental years (Cloitre et al, 2009; Thompson, 2008). This developmental trauma included witnessing parental domestic abuse, parent's mental health problems and emotional dysregulation from caregivers. Cloitre et al (2009) illustrate how the lack of a stable caregiver in developmental years can impart childhood trauma that, alongside cumulative other adversities, increases the severity and likelihood of complex PTSD and of other symptoms in adulthood.

This relationship is supported by my Findings and in a wider review of the literature which concludes that the accretion of ACEs constitutes a significant risk for a plethora of health conditions, several of which are intergenerationally transmitted, including addiction (Hughes et al, 2017). This suggests that there is a link between poverty, transmitted trauma, adverse childhood experiences and social and health problems.

Research has begun to touch upon the relationship between poverty, ACEs and parental incapacitation and attachment difficulties with Steele et al (2016) noting far higher ACE and Parenting Stress Index among families with lower economic and social status Diener et al, 2003; Hughes et al, 2017; Maine et al, 2017; Steele et al, 2016). Hughes et al (2017, p. 365) describe the transmission and replication of ACEs and multiple disadvantage within families as *'indicative of the intergenerational effects that can lock families into cycles of adversity, deprivation and ill health'*. Similarly, Najavits et al, (1997) observe the prevalence of lifetime and developmental trauma among the families of PDU and SSW women. This is endorsed by my findings; the unavailability of caregivers, encompassing lack of emotional openness and fluency, inability to connect and respond compassionately to challenging behaviours, and exhibition of abusive behaviours and substance misuse suggest trauma responses throughout families. Indeed, many women now recognised that their parents' difficulties **were** rooted in their own experiences of deprivation and rejection in

childhood, and that this permeated communities and generations to transmit cycles of trauma.

In arguing that neoliberalism exacerbates poverty and inequality, we can further this accusation and propose that intergenerational and community addiction and trauma can also be linked to these political endeavours.

As we will see throughout the discussion points presented in this chapter, this is supported by the findings which suggest a more multifaceted reality than Maté's (2012) conceptualisation of addiction (See Chapter 3). This thesis suggests more: That women's traumas and coping strategies (and those of their predecessors and peers) were not individual dysfunction but a symptom of occupying a marginalised position in a dysfunctional society that accepts inequality and punishes the symptoms of it (Alexander, 2010; Holmwood, 2000; Kiker, 1966; Wacquant, 2009). To be explicit, it appears there is a correlation between the experience of trauma, neoliberal policies, increased poverty and stress among marginalised communities and families, and PDU as a self-soothing response.

Many women identified their developmental traumas as contributing to their feelings of dislocation and worthlessness. In order to soothe these feelings, women began using drugs and alcohol at an early age and soon found it to provide relief or a dearly needed alternate reality, with several women explicitly referring to 'oblivion'. The aforementioned incapacitation of parents, the availability of drugs in marginalised communities and the lack of accessible alternatives also contributed to an understandable early adoption of substances. This corresponds with the assertions detailed in Chapter 3, of Alexander (2008, 2009, 2010) and Wilkinson and Pickett (2010) that the experience of material poverty and social dislocation intensified by neoliberal governance (as described by Polanyi (1944) and Wacquant (2009)) experienced *alongside* inequality means that numbing attempts such as drug use often feel like the only tenable relief (Alexander, 2008; Bourdieu, 2003; Chandler et al, 2003; Gosline, 2007)

The findings suggests that these were not immoral young women who became trapped by physical addiction or behavioural compulsions, as the theories discussed

in Chapter 2 would hold. Rather, they had almost entirely grown up experiencing significant traumas from their most vulnerable years, for which intoxication was a logical coping strategy. These findings contradict both the behavioural and brain disease models which isolate addiction as a physiological sickness and/or an indication of social and moral dysfunction wherein one cannot prioritise the good of society over personal pleasure (Orford, 2001; West, 2001). Evidently, what the overwhelming majority of the participants in this research were seeking was oblivion from unbearable environmental circumstances and the impact of individual traumas that can be correlated with their community's ongoing deprivation and exclusion.

Alongside these experiences, trajectories of amplifying trauma and exclusion emerged as women's lives progressed, with women described being passed between family members, sent to correctional institutions such as boarding schools for 'naughty children', hostels and psychiatric institutions. Albeit referring to Australia, Kerry's (1993, p. 1) exploration of the trajectories of girls taken in by state services due to their upbringing and/or perceived delinquency describes how this often results in the exacerbation of criminalised behaviour and stigma through a 'complex web of governmental technologies' which conversely reproduce 'delinquency' rather than address it. This amplification of exclusion via state intervention is reflected in the experiences of several of the women, implicating neoliberal policies' individualising discourse in the creation and exacerbation of symptoms defined as problematic by the state.

These transitions were not just disruptive in terms of providing continuity and security, but also accompanied by messages from authority and care giving figures of the girls' low worth and deviance, endorsing their existing poor self-esteem. Lungu (2016) describes how the experience of labelling in developmental years can influence and embed individuals' self-image, behaviours and the expectations of those around them<sup>43</sup> of their behaviour and character. Several women spoke about exhibiting behavioural symptoms of trauma that were missed by authorities (and instead

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<sup>43</sup> Social networks and professionals  
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pathologised or interpreted as immorality or laziness) including taking pills at school, trichotillomania, truancy, and inability to focus on schoolwork. These untended symptoms and women's experience of lack of care from authority accelerated their trajectories as they became increasingly vulnerable. Often, these pathways pushed women further into the peripheries of society, to increasingly precarious and deprived environments, where they were not just systemically neglected but also more exposed to and unprotected from greater interpersonal traumas.

This included exposure and vulnerability to predatory, exploitative men. As we have seen in Chapters 5 and 6 several women suffered repeated incidences of sexual abuse and exploitation by multiple perpetrators. These encounters often had an environmental/systemic component where women met abusive partners and/or pimps during their time in youth hostels and care homes.

The relationship between interpersonal abuse and substance misuse is established in the literature and echoed by the experiences of the women who contributed to this research (Covington and Cohen, 1984; Ouimette et al, 2000; Swan et al, 2001). However, my findings suggest an extra dimension to this; that trajectories of exclusion that begin in childhood are typified by increasing experiences of trauma which then further amplify addiction.

For example, these encounters with men often corresponded with women becoming more entrenched in addiction (such as through being forcibly injected). The lack of systemic response to this led them to feel further neglected as they were considered by authorities to be 'in relationships' with pimps and abusers so also deviant and/or too chaotic through association. This left them vulnerable to introduction to street sex working, often to the financial and practical benefit of the men, either directly through pimping or indirectly, abetted by childhood sexual abuse having damaged the girls' identity. This had nothing to do with immorality, as suggested by the criminalisation of SSW, but misplaced efforts to feel love and validation because of the distorted conceptualisations of love and sex that are symptomatic of sexual and developmental trauma.

Though many of the SSW women were inducted by predatory men, the universal impetus behind sex working was to fund drug addiction, often theirs and a partner. This echoes the research base indicating that most women engaged in survival sex working do so solely because of addiction, and often due to pressure from partners (Cusick, 2006;

Gilchrist, 2005; Malloch and McIvor, 2010; McKeganey and Barnard, 1996; McKeganey, 2006b; Smith and Marshall, 2007). This thesis echoes the evidence arguing that entry into survival sex working ought to be understood in terms of need, not deviance or criminality. It also provides the additional perspective that SSW can originate from an exploited need for love and validation as well as a need to fund drug use to manage multidimensional trauma. Furthermore, though not in the remit of this thesis, the male experience of disempowerment, systemic humiliation and threat to identity that is correlated with austerity politics is argued to correspond with typically male expressions of pain through the infliction of abuse and control (Baugher et al, 2014; Turkoglu, 2013).

The impact of exacerbating deprivation can also be posited to contribute to a lack of opportunities that partly explain the cultural acceptance of PDU mentioned by several women (from their families and peers) as well as their barriers to recovery. This absence of opportunity and corresponding lack of hope was a common feature in women's childhoods; many were entirely excluded from the education or employment that might have helped them foster the resilience and assets needed to overcome early traumas. Many women were expelled from school; only one woman mentioned university during addiction, and one mentioned a 'Saturday job' and working in a pub. Otherwise, all women transitioned into chronic addiction and supported this through criminalised behaviour<sup>44</sup> or were not forthcoming regarding how they funded their habit, but work was not mentioned. This indicates that women's need for oblivion coupled with a lack of opportunities for escape further entrenched their transition from a deprived childhood into an adulthood of continued

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<sup>44</sup> Predominantly SSW but also shoplifting  
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trauma and deprivation. We can see that a proliferation of traumas, from the relational to the environmental and systemic, marked women's developmental years and contributed to their self-medication and, relatedly, SSW.

A useful metaphor I have expanded upon to encapsulate this is an adaptation of the tale of Androcles and the Lion<sup>45</sup>. The thorn in the lion's paw represents the traumas experienced by the lion due to an unstable environment wherein inhabitants must struggle to survive. Androcles represents service providers, a subsidiary of the state. Devoid of any support, the lion will continue to lick its paw to soothe the wound, just as the women in this research felt the only consistent balm to their wounds was the use of substances. However, both these strategies only provide temporary relief and over time, make the trauma worse. Androcles does not see the thorn for what it is, instead thinking the lion deficient and even deviant, not removing a simple little thorn for the pleasure of continuing to inappropriately attend to its wounds.

Corresponding to this metaphor, the misguided perception of Androcles means women's traumas are accompanied by a lack of appropriate systemic response and their symptoms of trauma and use of substances to medicate these are misunderstood as individual deficiency and immorality.

This is demonstrated in the findings by the multiple accounts of systemic neglect, where, reflecting individualising, responsibilising attitudes to poverty and trauma and to a lack of resources on a wider scale, there was a failure to identify and respond to the symptoms of unmet need. Instead, women felt there was a focus on responding punitively to their trauma.

Several of the women discussed services failing to pick up on the signs of their trauma and this lack of early intervention alongside action from purportedly protective services that felt punitive or neglectful increased their trauma and exclusion.

Relatedly, Holly (2017) discusses how a lack of trauma-informed practice and integrated care in services means women and girls' PTSD remains predominantly

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<sup>45</sup> The Blindboy Podcast, A Mental Health Plan for 2022, 05/01/22  
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unrecognised and falsely perceived as deviance. The relationship between *systemically unrecognised childhood trauma* and entrenchment in addiction has not previously been identified; however, drawing from the literature and the experiences of the women, it can be posited that this systemic trauma is another factor in women's addiction as it contributes to the distrust of authority.

Therefore, as we saw in Chapter 2, although policy and practice concerning PDU and SSW are underpinned by assumptions of deviance and deliberate alienation from 'prosocial society', the evidence presented here suggests an alternative. Instead, the relationship between multidimensional trauma in early years and the onset of addiction correlate with the exacerbation of deprivation via neoliberalism's retrenchment of resources and espousal of individualising, responsibilising discourse. This suggests an alternative understanding of women's addiction: that it is not a symptom of individual dysfunction, nor solely a coping strategy in response to the harms of another's dysfunction. Instead, addiction is interwoven with political practices, generations of poverty and stress in communities, and the medication of unrecognised consequent multidimensional trauma.

While political debate around sex work is largely occupied by debating the merits of criminalisation and decriminalisation, both approaches serve as short-term measures unless serious attention is paid to gendered inequality in opportunities, especially within marginalised communities (Tyler, 2021). Certainly, decriminalisation may afford sex workers greater rights and power to protect themselves under the law (Abel and Fitzgerald, 2010; Smith and Mac, 2018; Tyler, 2021). However, no woman interviewed was in favour of decriminalisation or felt criminalisation to be effective, and instead resolutely identified their sex work as a gendered response to need, to poverty, and to trauma. None of the women felt they would have sex worked without trauma and substances being involved, or need being the primary motivation. The resounding opinion was one that chimed with aspects of many feminist arguments around sex work as an issue related to patriarchal and capitalist hierarchy, involving both classist and sexist inequality and rooted in poverty and desperation (Kissil and Davey, 2010). Though women working in other areas of the sex industry may oppose this position, this is the reality for the women I interviewed, who were

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overwhelmingly motivated by survival. Therefore, the pertinence of acknowledging differing perspectives and simultaneous diverse approaches to sex work is critical.

Alternatives to debate around criminalisation, which was felt to focus on the symptom not the problem, suggest that in order to address SSW in a long- term way, the root causes of women's poverty and trauma need to be addressed. This entails traditional 'women's work' being suitably recompensed so women are not left dependent on men, which could empower women to make genuine choices about sex work by having

equitable access to alternative opportunities. The driver of fiscal survival and the role of drug abuse and consequently sex work as coping and numbing strategies contradict arguments that individualise and responsabilise PDU and SSW.

To conclude this discussion point, we can see that models which responsabilise and individualise addiction and 'criminality' as pathological flaws, behavioural dysfunction or immorality are countered by women's lived experience. Instead, we see extensive histories of trauma of every kind permeate generations of families and communities. The relationship between poverty, inequality and traumatic childhood experiences and the experience of violence and abuse has been established (Bywaters et al, 2016; Pickett and Pearl, 2001; Wilkinson and Pickett, 2009 and 2010) and such histories are rich in this research. While Maté (2008, 2012) is correct in correlating addiction with the experience of trauma, this research is unable to and does not aim to verify this with regards to distortion of brain function. It alternatively proposes that the experience of trauma correlates with poverty and inequality and the exacerbation of these by neoliberal policies. Accordingly, I advance that trauma can be experienced at individual, community and systemic levels. As we will see in the following two Discussion Points, neoliberal policies' retrenchment of support and systemic punitivism in response to PDU and SSW intersect to exacerbate addiction and withhold alternative sources of support.

### 8.1.2 Discussion Point 2. The Consequences of Neoliberal Policy and Complicit Treatment Models

We have discussed the harms done to individuals, communities and public services by austerity in Chapter 3 and, as explored in Discussion Point 1, I have proposed that neoliberal policies' exacerbation of deprivation contributes to multidimensional trauma and thus women's induction and entrenchment in PDU and SSW. I will now interrogate this further and propose a relationship between women's traumas, community and generational experiences of poverty and trauma and the rhetoric and measures of neoliberal governance in the UK. As discussed in Chapter 3, this includes the retrenchment of resources, advancement of individualising rhetoric, marketisation of public services and inappropriate systemic responses including conditionality, siloing of problems and approaches that are experienced punitively.

The relationship proposed can also be applied to models of recovery that have emerged during the neoliberal epochs' prioritisation of the individual, the economy and individualistic success (Hasenfeld and Garrow, 2012; Seddon, 2011; Thorsen and Lie, 2006). New Recovery reflects these mores; partly, it may be proposed, due to the individuals who created them having grown and thrived among these narratives. This thesis proposes a new arm to the critique of New Recovery described in Chapter 3; that in reflecting the dominant political mores of the era, it ignores the role of the state in undermining recovery assets, informs inappropriate service responses, justifies lack of resources and the criminalisation of survival behaviours. This is due to its perpetuation of individual responsabilisation and the myth of pulling oneself up by the bootstraps, a task as impossible as it sounds!

New Recovery can be argued to replicate the misplaced assumption of neoliberalism that success is a matter of effort, regardless of one's starting place. New Recovery and Neoliberal policies look at symptoms not causes and both fail to recognise the correlation between PDU and medication of multidimensional trauma, which are contributed to by the exacerbation of deprivation and exclusion inflicted by those same models.

The women in this study described growing up in communities that lacked resources and opportunities and whose inhabitants were struggling with their own traumas. Regardless, New Recovery rhetoric advocates self-motivated help and community asset realisation and is, perversely, espoused by a state whose measures have contributed to the attrition of community assets and opportunities.

This manifests in the pre-eminence of policy and practice that places the onus on communities and individuals for recovery and redemption via active citizenship and asset realisation. In doing so, the responsibility of the state for addiction and recovery is reduced, while outcomes are guaranteed to be value for money, timely and measurable (Fomiatti, 2020; Fomiatti et al, 2019; Thomas et al, 2019).

The 2021 Drug Strategy 'From Harm to Hope' introduces more stringent commissioning standards which comprise a national and local set of outcomes concerned with numbers in recovery and demonstration of a range of success factors including 'meaningful activity', long term recovery and mental health (HM Government, 2021). This places even more pressure upon services to demonstrate outcomes without the investment needed being put into communities themselves. Instead, money is to be funnelled into the treatment industry with the expectation that recovery can be delivered in isolation from the environment and the socioeconomic deprivation that can be implicated in the increase in, and entrenchment of, addiction in the first place. This is argued to be a misallocation of resources that expands the political industrial complex of New Recovery, feeding the industry at both ends and further amplifying performance expectations, conditionality, and siloing while restricting the capacity of frontline professionals to exercise crucial creativity and discretion. This also fails to address the evidence suggested by this research and partly endorsing Mate's work (2018) that conceives of addiction as a trauma response. However, this thesis adopts a socioeconomic, as opposed to a developmental lens, proposing that trauma correlates with inequality, poverty and the responsabilising and retrenching aspects of neoliberal policies.

As illustrated in Discussion Point 1, Neoliberalism's emphasis of the power of individual choice and the responsibility of the individual for their actions fails to

understand the impact of trauma histories and lives spent in survival mode. This results in pejorative judgements being made about women's choices, for example regarding partners, risky sexual behaviour, and sex working. The accounts in this research demonstrate how seemingly inconceivable 'choices' made by women were distorted by their traumas and low self-esteem, lack of genuine alternatives and the desire for connection. 'Choice' also ought to be understood in the context of the subversion of the hierarchy of needs that is caused by addiction and as an unintended by-product of the numbing effects of substance misuse.

By adopting a broader, more compassionate lens to view individual action in the context of environment, history, and access to basic resources, seemingly deviant behaviours can be understood and responded to appropriately, without responsibilising women for the consequences of the harm done to them.

Below, I discuss examples of how the shared principles of New Recovery and Neoliberal policies manifest to obstruct the adoption of a broader, more informed lens, making recovery a more distant possibility. These principles comprise the justification of retrenchment of resources and the ensuing undermining of professionals' capacity for appropriate response. Additionally, we have conditionality of access, siloed treatment, competitive contracting practices and, governing and guiding this, a business-practice led focus on 'hard' outcomes. Resultantly, we see how women's experiences of deprivation and the conditionality of female citizenship has become more complex. Instead of overt declarations of deserving or undeserving, women's experiences suggest they are more subject to the unpredictable assault or neglect of the state's multifarious heads.

As a result of this, a further original contribution of this research is the expansion of the hypothesis of the deserving and undeserving poor to one permeating public services and political discourse to define the deserving addict, victim and sick. Consequently, women are often met by eligibility clauses underpinned by flawed understandings, where, in the event of failure, they face a denial of support that appears to be informed by assumptions of their wilful deviance. This point is further

developed in Discussion Point 3 which proposes the model of the Scylla State as a feminised alternative to Wacquant's Centaur State.

### *Community Poverty*

Indicating the impact of austerity measures detailed in Chapter 3 on already marginalised populations, several women described communities that had been abandoned, with particularly gendered implications (UK Women's Budget Group, 2012). Parenting and family resources that had previously helped women who had, as many of the women in this research, experienced an absent or incapacitated caregiver, seemed to have vanished. The assumption of women's innate maternal instincts and, it seems, ability to conjure food, shelter, and safety from nothing, underpins the justification of the retrenchment of these assets. Where they had existed, community centres, groups and activities were disappearing, and women bemoaned this lack of support for vulnerable mothers and lack of occupation and stimulation for children.

The unsuitability of New Recovery ethos which advocates community asset realisation to build 'recovery capital' was implied in the women's experiences of environmental poverty. Many women's communities during addiction were devoid of the assets associated with recovery including safe, comfortable housing and accessible, appropriate public service support.

### *The Consequences of New Recovery Ideology and Free Market Practices in Public Services: Lack of Resources and Responsivity*

The inappropriate expectations, lack of resources and gender awareness within mainstream services was universally mentioned by those women who now professionally strove to improve the landscape they had battled through. There is an untenable conflict between capacity and demand in the sectors that work with SSW and PDU women as austerity measures and neoliberal expectations undermine the sector's ability to sufficiently meet needs and provide appropriate support. Indeed, in addition to undermining service's capacity, these expectations and practices were felt to add to women's difficulties, conferring another layer of systemic trauma.

Women's stories can be contextualised against what we know about the impact of austerity, discussed in Chapter 3, and the tenets of New Recovery (in Chapter 2) to suggest that the retrenchment of resources, justification of this and dominance of ideology that champions community treatment and self-motivated asset realisation is rendering the landscape of services increasingly desolate.

Rosie referred to her previous career as a 'golden age' in which commissioners were responsive to understanding and addressing the needs of women. There are several examples given by women that suggest the rarity of this intent and effort. For example, in community treatment orders, rigid engagement criteria and lofty expectations that suggest a political aversion to long-term, compassionate investment. Instead, the landscape is dominated by a burgeoning focus on reducing costs and thus removing resources and inadvertently perhaps, but according to women's experiences, increasing responses that feel punitive and exclusionary.

There is increasing recognition of the futility of custodial sentences for women, whose crimes are often 'petty' and motivated by poverty and survival needs, and that the conditions of women's prisons and the lack of aftercare can exacerbate poverty and trauma (Carlen and Worrall, 2013; Corston, 2007; Malloch, 2016; Worrall and Gelsthorpe, 2009). As a result of this, and in no small part the focus on the purported economic benefits of community treatment, there has been a significant increase in conditional community orders. Many of the women reported experiencing this and certainly not in the positive sense intended.

The impact of neoliberal policies' focus on business practices such as competitive, quantitative outcome demonstration upon the services that were available in the community are discussed further below. This includes competitive contracting, which we discuss now in more detail.

The prominence of competitive contracting practices meant often services were bound to focus on a single problem, and so ownership of specific remits threatened joined up working as other services are excluded as sources of authority. This was attested to by Rosie who described how her service were not authorised to verify

homelessness with the council and so swathes of the homeless populations were unseen.

The fragmented practice that resulted from competitive contracting meant services were inhibited from working alongside one another to share information, expertise, and workload to meet the needs of a shared client base. This is illustrated in the experiences of women with concurrent mental health and addiction issues but is a finding that applies universally to women's experiences of seeking help for multiple needs.

This thesis also provides evidence to advance the assertion that hard outcome demands do not fit recovery patterns and especially the needs of women, where lifetimes of trauma and exclusion make meeting demands untenable. The measurements preferred by New Recovery (detailed in 3.4) are incompatible with what many women cited as being transformational for them; namely relational and emotional needs such as the demonstration of care, building trusting relationships and an open-door policy. Instead, New Recovery tools measure contribution, self-discipline and activity which demonstrably benefits the state rather than measuring how much a service is providing for women. This fails to recognise the two-way process of recovery wherein contribution and support goes both ways; namely, if the state desires citizens to live socially and economically productive and fulfilling lives it must provide the assets and support to do so.

Approaches in which inappropriate expectations guarded access to support were also felt to exacerbate trauma, undermining the capital women did possess and further excluding them. This is reflected in women's assertions that community treatment and other public services' responses to them felt punitive, coercive and exploitative. This can be explained against the backdrop of the impact of the neoliberal policies and models discussed in Chapters 2 and 3.

An iteration of this includes payment-by-results and outcome-based tendering that has been suggested to incentivise 'cherry picking' or 'gaming the system' by selecting service users with the 'best chances' of recovery for treatment (Christopher and Hood, 2006; Duke, 2013; McDonald et al, 2010; Thomas et al, 2019; Vacchelli et al,



2015). Alongside funding cuts and tendering according to siloed problems, this intersects to further contribute to the imposition of eligibility criteria and inhibit frontline practitioners from exercising 'street level' jurisdiction and professional creativity and curiosity (Boyle, 2011; Brodtkin, 2012; Clist, 2019; Lipsky, 2010; Whitehead, 2015; Whitfield, 2014). In the Findings, the impact of these pressures manifested in women's experiences of stringent eligibility criteria and perceived coercion, indicative of attempts to ensure support was only accorded to those most likely to succeed.

### *Compelling behaviour*

Conditionality permeated women's experiences of support seeking, with help contingent upon meeting often unattainable criteria to demonstrate worth and capability. Underpinning this conditionality, as suggested by Chapters 2 and 3, is the retrenchment of resources and advancement of the ideological expectation of the individual's ability to self-discipline and conform. This often tallied with interventions felt to be coercive in order to encourage women to submit to and accept what would be offered.

Social services, drug treatment and the criminal justice system were all felt by women to have used control and coercion to inhibit behaviour or compel self-discipline. Given many of these women were also in abusive relationships, their vigilance to feeling manipulated and coerced may have been enhanced by this perceived lack of transparency and rejection. This included withholding access to resources and services, demanding engagement with health services, providing ultimatums and using surveillance and cross sector alliances to mandate engagement or monitor behaviour.

Several women entered court-ordered counselling and/or treatment instead of receiving carceral sentences. However, this was felt inappropriate as it was symptom focused, not cause focused, and aimed to quash behaviours rather than address traumas at their root. This coerced treatment was perceived by women as a cynical tick box exercise, and they often responded duly, by giving the appearance of

compliance to get through the sentence, continuing to rely on drug and drink to self-medicate.

The lack of provision to allow incarcerated women to keep in contact with their children, with 17,500 children affected nationwide, was another point where women felt manipulated into treatment they did not want (Corston, 2006; Working Chance, 2021). This reflects the literature suggesting motherhood is perceived as a powerful leverage point for change by services who work in tandem to try and enact this (Corston, 2006, Working Chance, 2021). However, the reality of the experience of this was counterproductive for women. Several women spoke of the ineffectuality of coercive treatment, describing being pressured into treatment as an alternative to sentences and/or as conduits to being awarded custody of children, regardless of personal readiness. The unsuitability of the treatment proscribed only served to work against the women as they were deemed non-compliant for being unable to meet demands, such as attending appointments at clashing or unsuitable times. Women often felt compelled to accept unsuitable support that they did not want and as a result were more likely to relapse.

This suggests the flaws in conditional, coercive treatment but also that the assumption that motherhood is a positive leverage point for change may be mistaken or more complex. This echoes (Stone, 2016) and adds a new perspective that it can inadvertently feel like manipulation and control as many women may be or have experienced this in relationships. As a result, engagement is cursory at best and trust in the system reduced.

This illustrates the expectation of services that vulnerable people whose lifestyles may be survival-focused and chaotic meet the requirements of the service or be dismissed. Contradicting a 2009 Government Audit, McPhee, and Sheridan (2020) have found that these practices and others connected to funding processes are implicated in the high rates of drug deaths in Scotland as they exclude those most in need. Considering that similar processes are at play in England, as referred to in the Findings, the extrapolation is an unhappy one (Iacobucci, 2019; Mahase, 2019; Parsons, 2019). Certainly, many women were unable to access support in the first place, whether due

to trauma related behaviours being misinterpreted or their being unable to prioritise day treatment attendance over all their other needs.

It is also worth re-acknowledging that although in narrative terms, drug and alcohol addiction is purported to have shifted from a criminal issue to one of health, (though could be argued to occupy a liminal position, hence coerced treatment), as Gina and Rosie remarked, women continue to be arrested and sentenced for drug related crimes. As a result of this, they are still treated as criminals and with that, suffer the exclusionary and harmful impact of criminalisation including loss of child custody, housing, benefits, and the indelible stain of a conviction (Roy, 2015).

This highlights the contradictions between the punitivist essence of the criminal justice system (and the realities of drug treatment interventions) and the increasingly heralded recovery aspect. Both prison and community- based treatment were experienced primarily as punitive rather than rehabilitative. This was due to several factors including conditionality, problem-focused interventions, coercion and the impact receiving this 'support' had on women's lives, for example exclusion from employment opportunities, benefits and housing.

### *Siloed Issues*

Several women spoke of siloed mental health and drug treatment provision trapping them in a revolving door, with the exit further obscured by prohibitive waiting lists. This was felt to perpetuate cycles of relapse and exacerbate futility and exclusion, and is another issue related to the business practices and reduced capacity correlated with neoliberal policy's impact on the public sector (as per 3.5, Fomiatti et al, 2019; Smith and Marshall, 2007 and Stephenson, 2012)

Despite recognition of the duality of mental health problems and substance misuse and the importance of an integrated treatment model, the realisation of this appeared constrained by tendering practices and resource limitations restricting

provision of services to respond only to psychosis, if that<sup>46</sup>. This endorses Houghton et al's (2021) findings that only 4% of respondents felt they received integrated treatment. Several of the women mentioned being expected to demonstrate a period of sobriety before being assessed by mental health services and found that if they were able to achieve this, the waiting list was such that the window of opportunity or 'gift of desperation' was gone, and they relapsed. Furthermore, evidence shows that, especially for SSW, without trauma focused interventions, when drug use is decreased, PTSD symptoms tend to increase and so this is an untenable expectation (Patel et al, 2020). Therefore, while there is recognition of the need for dual diagnosis treatment it can be posited that due to lack of resources and siloed commissioning, services are unable to respond in a timely manner even when eligibility requirements are met. It is important to note that this didn't merely occur on the frontline; we saw in 6.5.3 that Keira had met with the minister responsible for mental health and raised the issue of addiction, only to be told 'oh that's another minister'. While there continues to be another minister or another service and integrated working is inhibited, the consequences of untreated dual diagnosis will continue to blight the lives of women, who disproportionately experience mental health problems and depressive disorders, often related to abuse (Arpa, 2017; WHO, 2002).

We will now turn to a more detailed exploration of how contemporary neoliberal policies can be argued to have expanded upon the notion of the deserving poor and embedded this concept throughout services.

### *The Deserving Addict*

Access to support was dependent on meeting conditionality clauses concerning both behaviour and potential for success, even where limited intervention was concerned.

One iteration of this conditionality was a catch 22 wherein women were required to demonstrate an ability to stay clean for a period of time 'in the community', namely

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<sup>46</sup> As we saw with Keira who repeatedly asked services for help with her partner who was exhibiting signs of psychosis. They were rejected and he ultimately committed suicide.

with minimal support and a prescription before they would be considered for residential rehabilitation. Ironically, those most in need of residential rehab are the most in need overall, so demanding that women jump through hoops only withholds resources from those who ought to be prioritised. Rosie described being refused rehab funding for a woman she was supporting, despite the woman deteriorating rapidly after a decade of failed community treatment. Other women described being expected to prove sobriety or attend groups before even given access to support. This may be indicative of the New Recoverist insistence on low cost, brief psychosocial interventions delivered en masse, sold as an effective way to instil recovery in communities. Regardless, this incentivises gaming of the system so that only the most manageable of addicts are seen, again failing to act upon the 'gift of desperation' and excluding those most in need.

Several women were excluded from services because of behaviour related to their traumas, especially aggression, where anger was received at face value and not explored and understood as misplaced anger in response to horrific past abuses. We saw in 6.4.4. that Gina was repeatedly banned from treatment services, psychiatrists, and hostels for being aggressive and even for overdosing while Anna had become used to being labelled as 'psycho' by services (6.4.4). The expectation of passivity and compliance by services purporting to support society's most vulnerable and traumatised women runs contrary to the reality of the histories and needs of those they claim to be serving. Rather than expecting women to quell their symptoms (which many are often doing in their own way, through substances) to gain access to services, behaviour that seems adversarial ought to be understood as part of the population profile, and ways found to respond compassionately and inclusively. By admitting only women who have mild need or who can mask their traumas, services may ensure their client base is more likely to reflect success upon them. However, by encouraging the suppression of traumas, even in those who are able, they are providing only surface level or 'fingernail' recovery. Kim now works in services and was able to 'see through' the (valid) anger of SSW and to engage with them whereas previously they would have been banned. This illustrates how peer insight can provide advocacy and insight that increases services' ability to appropriately recognise and

respond to the symptoms of trauma which are prevalent among the populations they support. Behaviour, or rather trauma symptoms, were viewed through a risk averse lens, contributing to the perception of women as unlikely or unable to recover, whether through being too complex or otherwise challenging to work with.

Most women acknowledged the role of trauma in their addiction and reflected that this had also impacted on their struggles with community treatment. Dissociation is a trauma symptom worth particular attention; it can be interpreted by services as disinterest in change, especially within services who are informed by a motivational interviewing framework that places individual volition in tandem with effort at the heart of recovery, as is common in community drug treatment (Heather, 2005). The expectation of self-led transformation in response to motivational cues from professionals fails to acknowledge the obstacle that trauma poses in the development of trusting relationships and thus women's abilities to engage with interventions. Motivational interviewing also neglects the overwhelming counterinfluence of ongoing trauma and deprivation that, unaddressed, undermine a therapeutic relationship.

### *The Deserving Sick*

Where women did mention the welfare state, it was regarding eligibility for disability or sick pay. Their experiences reflect the evidence base describing the increasing stringency and dubious practices of disability reassessments (Grover, 2017; Lindsay and Houghton, 2013). Attesting to the disproportionate impact of this upon women (Beatty and Fothergill, 2015), illnesses typically associated with the bodily manifestation of women's trauma, such as chronic fatigue and autoimmune disorders, were disregarded by assessors (as we saw with Abi in 6.4.2). This indicates a bias and ruthlessness at the heart of welfare eligibility processes and how increasingly stringent conditionality clauses suggest a patriarchal disregard of 'hidden' illnesses experienced by women that correspond with trauma (Ciccone et al, 2005; Speake, 2020; Van Der Kolk, 2015).

Echoing Esping-Anderson's (1990) definition of the liberal welfare state as one which deters reliance upon government support, women found various systems and the

web of associated services un navigable, and this served to deter them from attempting to access resources. For example, Brenda was unable to access support until supported to engage with and address her debts, welfare entitlements and burgeoning health problems. This was eventually done by a specialist service who accompanied her to appointments and advocated for her. This contradicts the presumptions of neoliberalism and New Recovery that individuals can access and realise assets and convert this into capital. Instead, I suggest that, in placing obstacles to access and expecting disadvantaged individuals to overcome them without assistance, women's Human Rights may be infringed by these barriers to public services (Reeves, 2019; HM Government, 1998).

Where women did have the capital, as illustrated in 6.2., they were able to self-advocate and defend themselves. These characteristics and resources seem critical in the successful navigation of the welfare state and in women's capacity to assert the validity of their needs and entitlement. However, such assets had been undermined by lifetimes of trauma and deprivation, and most women were overwhelmingly trapped, unable to meet the requirements and navigate the systems needed to access support, financial and medical.

### *The Deserving Victim*

Several women could be perceived as having been indirectly punished for their experience of violence at the hands of a partner. Seemingly, motherhood and victimisation are hard to dually accommodate in risk averse services where the focus does not include the mother. Several women described being expected or demanded to leave controlling and violent partners without being given external support to do so. This ignored the realities of women's lives, typified by Kylie who had experienced a lifetime of trauma, was isolated from her family and under the control of a man who was known by professionals to be violent. However, she was expected to exhibit agency and autonomy in these circumstances and to meet the criteria of social services. Failure, she felt, resulted in punishment dually; firstly, by being treated as *a risk* rather than appreciated as *at risk* and secondly, by having her validity as a victim

of trauma and the impact of her multiple unmet needs upon her parenting capacity ignored (Featherstone et al, 2018; Featherstone and Gupta, 2018).

Women also felt patronised and disregarded by healthcare providers when they were known as addicts. The expectation to control themselves before help would be provided also seems to conflict with the tenets of the Hippocratic Oath including to 'first, do no harm'. Several women were told by practitioners they were either over exaggerating pain or confusing their symptoms with the effects of addiction. These assumptions were countered by the women's diagnoses in recovery of legitimate physical ailments, and of personality disorders being replaced with trauma diagnoses. Upon being admitted to hospital after being pushed down the stairs, Emma was chastised by a doctor for her addiction and told she needed to get it under control as her behaviour was costing the NHS. This is indicative of the impact of fiscal pressures on healthcare services but also how the responsibilisation of certain problems can obscure the realisation of and response to women's abuse.

An especially galling iteration of conditionality was the denial of women's validity as victims by the criminal justice system. Several women, especially street sex workers, approached police for help when they had been seriously assaulted (including broken bones, teeth being knocked out, blood being drawn, torture and kidnap). However, when they did so, even in one case, when covered in blood, with torn clothes and having remembered the license plate and a description of the attacker, they were dismissed. Lily, the woman who experienced the assault previously mentioned was told by the police 'you choose to come out here don't you', exemplifying the appalling victim blaming that stigmatised women can be subject to. It also attests to the systemic persistence of rape myths wherein women are blamed for their clothing, intoxication, and behaviour. Embodying the divergence in treatment of deserving and undeserving victims, several women found themselves called upon (also emotionally manipulated and fiscally bribed) as witnesses in a case against their attacker when a non-marginalised woman was attacked, or attacks reached a significant severity to provoke police action on behalf of otherwise 'undeserving women'. This encapsulates the conditional citizenship of deviant women under the neoliberal state. When



women do meet societal expectations, they are granted victim status <sup>47</sup> but ‘undeserving victims’ are accorded partial validity only if being used to protect the former and still do not receive justice or support in recognition of their own experiences.

A lack of trauma cognisance also impedes upon the perception of women’s validity as victims; trauma awareness can be argued to be contradictory of neoliberal policies as it requires acknowledging the influence of women’s histories and environments and the need for external support.

In women’s experiences of assault, lack of trauma fluency appeared to converge with their marginalised status to deny them support. Women reported dissociation as a subconscious protective strategy in response to triggers, such as experiences with the police with whom they had a history of negative experiences. However, this strategy served to reinforce negative assumptions that were used to deny their victimhood. Detachment and lack of emotion when recounting sexual assault has also been identified as a trauma symptom that is misinterpreted by the criminal justice system and juries as evidence of untrustworthiness and fabrication (Ellison and Munro, 2017). Defence counsels and juries expect evidence to be recounted precisely and consistently, and so misremembering or patches of amnesia are used to invalidate survivor testimonies. Consequently, the misunderstanding of the impact of trauma, including dissociation, can present barriers to women receiving the justice and support they need and deserve.

### 8.1.3 Discussion Point 3- The Gendered Iteration of The Centaur State: The Scylla State

By contextualising the empirical data against the Analytical Framework, we can see how neoliberal governance can be posited to have a distinct, harmful impact upon PDU and SSW women.

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<sup>47</sup> Although this is a somewhat flimsy status, as the dire records for prosecution of rape and sexual assault in the UK indicate (Hohl and Stanko, 2015).

As the concept of multidimensional trauma delineated throughout the Findings Chapters (5-7) illustrates, this thesis expands upon the attestations of Polanyi (1944) and Wacquant (2009) regarding the exacerbation of marginalisation inflicted by neoliberal governance. Furthermore, multidimensional trauma and the relationship with poverty and inequality also supplement and fortify Alexander's assertions (2008 and 2009) that poverty of spirit as well as material poverty are consequences of neoliberal policies. In this thesis we have seen how generational cycles of deprivation coincide with eras of exacerbated neoliberalism and translate to the transmission and amplification of trauma throughout communities.

Therefore, multidimensional trauma correlates with marginalised population's experiences of *further* exclusion and trauma through systemic responses, and lack of. This constellation of trauma is proposed to underpin women's resort to PDU and SSW and their barriers to recovery. Indeed, systemic trauma described includes equally what *is* done and what *is not done*, or absent.

An alternative model that refers to this combination of neglect and action in greater detail, its correlation with neoliberal policies and its impact upon marginalised populations, is Wacquant's Centaur State (Fletcher, 2013; Povey, 2017; Wacquant, 2009). Martin and Wilcox (2012) have touched upon the concept of the penal state in women's experiences in prison in the UK and conclude that responsabilisation remains even within efforts to try and mitigate the destructive impact of prison upon female populations. I expand the exploration of the applicability of this to the experiences of women in the United Kingdom, identifying several key themes that typify the gendered manifestation of the Centaur State: Womanfare, dual punishment, the retrenchment of rights to health and safety and branding vs blacklisting.

Drawing upon Wacquant's description of the Centaur State<sup>48</sup>, while working class men's rights under the Centaur State are argued to be contingent on submitting to workfare (Fletcher, 2013), women's rights appear dependent upon social compliance, or 'womanfare'. This is predominantly in accordance with normative capitalist ideals of femininity the production and sustenance of economically productive citizens requiring minimal state support. Recalling Maruna's (2001) assertion that the role of the probation officer is to get the offender 'marriable and employable!' (See Chapter 2.12), we can see the correlation between the neoliberal State's expectations of masculinity as described by Wacquant (2009) and the expectations of femininity suggested by women's experiences. Namely, that success equals economic productivity or familial/social productivity.

These are suggestive of a form of neo-Victorian expectations whereby the working-class woman's remit is to produce and manage obedient and self-sufficient members who either contribute by submitting to workfare or perpetuate the production line of compliant families. This social contract operates less as a Centaur, with a penal body beneath a liberal head, but as the Scylla, with many, sometimes concealed heads employing various strategies to compel desired behaviour from women. Certainly, as demonstrated, the women experienced these blows as punitive, coercive, and exploitative, echoing the punitivism cited by Wacquant (2009) but speaking to a greater diversity of strategy and impact. Below, I discuss the manifestations of these different heads and their strategies.

Women referenced feeling subject to stringent regulation, surveillance and manipulation, primarily from services concerned with their motherhood. As per Wacquant (2009), these were conducted through alliances between public and protective services, with drug treatment and the police working with social services. Women described the intent and impact of these alliances as to monitor, gather evidence upon and collaborate to demonstrate their incapacity. The punitivism

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<sup>48</sup> Defined in 3.4

experienced by mothers was more covert and indirect than Wacquant's (2009) descriptions, for example through the imposition of strict conditions without the requisite support to meet these. The Centaur State's individualisation and responsibilisation of 'social problems' certainly persist, albeit with a focus on the concept of choice. For example, women felt condemned for 'choosing' not to meet the standards of the state, rather than being understood as unable to. Similarly, as Wacquant's men (2009) are punished and incarcerated for 'choosing' survival crime, so women are punished for 'choosing' violent, controlling relationships and addiction, (despite these being survival behaviours or victimisation) over being a 'good mother' and 'putting children first.' This was a prominent finding so is given further attention in the following section.

Furthermore, while research has demonstrated the prevalence of exploitation from male partners involved in women's PDU and SSW, the approach of the state towards both parties has not been contrasted (Chase and Statham, 2005). Legal measures around coercion and control in sex working commonly focus on brothel keeping, modern day slavery and trafficking. However, they fail to capture the nuances of relationship-based coercion and it can be posited that women *lack* legal protection against abusive and exploitative partners where coercion, PDU and SSW converge.

Consequently, it can be argued that women are *punished for* their partner's abuses. There was no mention of action taken against men who coerced women into survival sex work; only the woman was targeted by police. Furthermore, while it was raised that women are reluctant to disclose their sex working history in treatment, it was also mentioned that men in mixed treatment would seek out, groom and manipulate sex workers (as attested to by Rosie, Lily, and Kim, among others). This indicates the difference in the stigmatisation of women who sex work and men who exploit and pressure women to do so, with women in receipt of blacklisting and judgement while men continue to evade attention.

The evidence discussed in 3.5 and in the Findings chapters implies that the interventions women experience as punitive by the state are more multifaceted than the penalism Wacquant describes and can also be experienced as a replication of

traumatic interpersonal experiences. Women found the approaches taken by services to betray their confidence and trust and amplify their feelings of persecution; for example, through covert monitoring of their behaviour, and gaslighting where women felt blamed for the symptoms of their abuse or coaxed into situations then punished for being there. Consequently, they lost any remaining faith in public services and felt that they were deemed unworthy of the support and respect accorded to other women.

### *Dual Punishment and Duality*

We have briefly touched upon and have seen several instances (in 6.7.3.) of how mothers in abusive and violent relationships feel blamed for their inability to protect their children from harm, rather than being appreciated equally as victims. This approach fails to consider other variables (such as the impact of trauma or coercion) upon women's abilities at the time. Women felt labelled as unfit mothers and targeted by mandates that paid no heed to external barriers. Indeed, no support was offered to mitigate these barriers and contrarily women were responded to in ways that exacerbated deprivation and trauma. Regardless of their mutual victimhood, the child- focused lens of social services meant only the child was recognised, and so mothers felt further disadvantaged by systemic mechanisms designed to protect the vulnerable and marginalised. Several women experienced this, which echoed their life histories of neglect, and the result was greater entrenchment in abusive relationships, substance misuse and other harms. This was often compounded by their fiscal vulnerability, due variously to financial control by partners, the burgeoning costs of a drug habit and the unnavigability of the welfare state.

The direct penalism of women's responses to poverty and trauma is applicable to a significant number of women in prison. As detailed in 7.2, women were most often in prison for drug related crimes, including possession of substances that 'belonged to their boyfriend or girlfriend.' This criminalisation by proxy ignores the prevalence among women who have experienced developmental or historical trauma to be 'people pleasers'; where the desire to feel safe and wanted manifests in a tendency to put others first, making them vulnerable to exploitation.

Policing strategies were also dualistic; even when described as having shifted to a supportive approach, police intervention continued to be experienced negatively. As identified by Brenda and Rosie, strategies vary by borough but tend to diverge between punitivist or victim focused. However, even where less punitive policing was observed, these seemed to reflect the moral- behavioural models discussed in Chapter 2, including court ordered community drug treatment, directed by an assumption that medical stabilisation and/or motivational/behavioural interventions would be curative. As we have seen, these forms of treatment were found unsuitable by women and could expose them to predatory service users. Women also remarked that court ordered interventions tended to be symptom focused, neglecting to acknowledge the role of deprivation and trauma.

Conditional drug treatment, although presented by the state as a shift from punitivism to a health-based perspective, seems to continue to perpetuate the responsabilising, individualisation of social problems that is espoused in neoliberal discourses. We have seen this persistent penalism, where women were ordered to take part in treatment or face incarceration and lose benefits, housing and even custody of children. The lack of support upon release also indicates that although women had 'paid their dues' in terms of their sentence, they were still treated as lesser; still denied access to shelter, safety and support and yet expected to be rehabilitated through deterrence alone. This is suggestive of a form of banishment wherein previous 'crimes' cannot really be atoned for; though the efforts are expected, they are not rewarded.

While social services were felt to often ignore women's victimhood, other systemic mechanisms were stymied by a conflicting recognition of women's risk and victimhood that seemed unable to acknowledge that women can hold dual positions. This is exemplified by the ironic behavioural clauses of psychiatric, rehabilitative, and other sectors whose remit is supposed to be to support people struggling with complex need, not rejecting them for meeting those criteria. The tensions in the treatment of women in PDU and SSW policy and practice indicates a previously unidentified iteration of the feminised Centaur State, The Scylla State, whereby women are treated dually as victims and criminals, as helpless and deviant. Consequently, women were both regulated and disregarded depending on the lens

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they were viewed through in that instance; there were several examples given where women were temporarily afforded victim status when being used by the police to give evidence to gain justice for ‘normal’ (interviewee’s own words) women. However, the women themselves were frequently denied protection and had their own experiences of violence dismissed and minimised.

Penalism and expectations of productivity also operate in tandem in the Scylla State. Wacquant spoke of the labour camps of the American penal system. In this research, we see accounts of female prisoners being expected to serve as uncompensated maids for male prisoners (in 6.5.2). This suggests a neo-Victorian underpinning to the purported rehabilitative aspect of women’s prisons and an emphasis on ‘improving work’ based on patriarchal assumptions about women’s capacity and role (Carlen and Worrall, 2013;

Worrall and Gelsthorpe, 2009). This also attests to Rafter’s (1990) description of women’s imprisonment as a means to instil and enforce middle class, normative standards of femininity, including homemaking duties. This certainly speaks to an idealisation of gender roles in the family, whereby women ‘keep the house’ and take care of the man and his home while he is out working (Bosworth, 2017). This conceptualisation of household roles fails to acknowledge the impact of unemployment, precarious work, poor working conditions and flimsy labour rights upon working-class homes’ ability to survive under this model<sup>49</sup>.

Research on penalism and femininity suggests that this gendered approach is generalisable to the female prison population, reflecting the scarcity of women’s prisons and the emphasis placed on regulation and reform through discipline (Howe, 1994, Coyle,

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<sup>49</sup> This is without even broaching the issue of whether women might desire to conform at all!

By breaching the neoliberal state's unspoken social contract, it is argued that women were denied equal rights to citizenship and also their Human Rights regarding health<sup>50</sup>.

In its definition of human rights, The World Health Organisation (1946) mandates that access to health is an unconditional right that must be met by all states. This is defined as;

*Access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health- related information and education, and gender equality. (World Health Organisation Constitution, 1946).*

Determinants of health can be expanded to incorporate recognition of and response to addiction and C/PTSD, as both have direct impact on psychological and physical health. However, manifestations of neoliberal policy in services, as detailed in Point 2, meant that women were excluded from equitable access to resources and support.

This retrenchment of rights was particularly stark in women's experience of the criminal justice system which, as we have seen in Chapter 6 and 8.1.2 was felt to deny them the legal rights and protections afforded to others. As discussed earlier, the Human Rights Act (HM Government, 1998) entitles everyone to equal access to public services and facilities, but several women were disbelieved and otherwise denied the protection from public services against violent offenders.

While in the UK successful conviction rates for **all** victims of rape and sexual assault are markedly low and support for victims is provided almost solely **during**

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<sup>50</sup> The 1998 Human Rights Act (HM Government) sets out the civil rights that are held by everyone UK and these cannot be rescinded due to gender, race or any other discriminatory criteria. One such right is for staff in public service to respect and protect other's human rights, and this covers NHS staff, the police, and social services. Everybody also has the right to use public services and facilities; by being rejected or subject to conditional access, women are being denied equitable access to public services and amenities.



proceedings, as per the Stern review (Cook, 2011), police attitudes to victim credibility mean SSW and other 'deviant' women receive even less support.

This indicates a retrenchment of SSW/PDU's rights to protection as they are accorded a lesser status as victims and the retrenchment of equal rights to public resources in terms of appropriate support. Illustrating how systemic trauma comprises what is done *and* not done, while women do not appear to receive equal protection and justice, they *are* accorded blame for the symptoms of their traumas.

Furthermore, being assaulted and then disbelieved amplifies women's' trauma, exacerbating their feelings of being unworthy and systemically replicating abusive experiences (DeCou et al, 2019). Therefore, it can be argued that these failures to protect women may have the effect of worsening their health; therefore, not only are women not receiving support they are entitled to, but their ill health is being aggravated by the same system.

#### *Blacklisting: Opportunities for Redemption or An Indelible Stain?*

My findings conform with Wacquant's assertion that the Centaur State ensures deviant individuals are 'durably blacklisted' (Wacquant, 2009), although for women it would be more appropriate to describe them as 'durably branded'. Women's exclusion seemed more social and bureaucratic as opposed to through the spatial exclusion of the penal state.

This was not, as per Wacquant (2009), for refusing to enter unstable wage labour but for the inability to provide nurturing and secure environments where needs are met and morality reproduced, in homes and communities.

Women were expected to redeem themselves via partial reintegration through a form of penance as volunteers, advocates and underpaid and under-supported 'peer workers'. We saw how women's particular expertise, for example regarding SSW, was relied upon by services to the extent that they became solely responsible for and overburdened by their caseloads. As Jo and Rosie pointed out (6.8.), echoing the literature on the impact of austerity (Chapter 3), services are overworked,

underfunded and problem, not person-centred. As Pearson (2019, p. 29) asserts, neoliberal policies in the UK are heavily reliant on women's unpaid labour which is treated as an *'expendable and costless resources that can absorb all the extra work from these cuts'*. Peer worker's employment can be seen as a subsidiary of this approach as they are often treated as secondary employees, subject to precarious, casual employment arrangements, lower rates of pay and fewer employee rights (Greer et al, 2020). This could be due to a view of peer workers as inherently less qualified and valuable than professionally trained workers or a calculated fiscal decision that nonetheless still devalues peers. Regardless, we saw in the Findings that even in employment and 'giving back' (in desistance terminology), ex addicts remain branded and marginalised due to their experiences. This is a contradictory position; peer workers are lauded as critical to systems change and considered essential in services, yet their inclusion appears tokenistic and occasionally risky. It appears that the eagerness to tick boxes and build a workforce at less cost overtakes considerations of the readiness and capacity of the worker and of the service to support them.

Lily (6.7.1) referred to the indelibility of the stigmatisation of SSW, both in legal and less direct terms. Women's criminal records would label them 'sex offenders', a tarnish that is both practically and psychologically injurious for women who have frequently been victims of genuine sex offenders. The marring of women's records excludes them from volunteering and employment opportunities, despite these being one of the main tenets of New Recovery and Desistance's conceptualisation of recovery and success.

'Redemption of self/identity' as espoused in desistance theory was further thwarted informally, ironically **by** the criminal justice system, who are ostensibly invested in the rehabilitation of 'offenders'. Lily (6.6.1) was stopped in her car and humiliated by police officers who recognised her as an ex-street sex worker, while Maria was demanded to refer to police in training **she was providing** by their titles; she resisted this heavy handed and insensitive power play and asserted that they were now here to listen to her and weren't her 'Sergeant'!

## 8.2 Original Contributions to Knowledge

The points previously discussed detail my original contribution to knowledge and below I explicate this further by summarising the essence of these concepts and arguments and what they can provide.

### 8.2.1 The Relationship Between Women's Multi-Dimensional Trauma, Addiction, and the Culpability of Neoliberalism

My findings clearly indicate the roots of women's addiction in trauma; this reinforces the more nuanced, compassionate understanding advanced among some academics, but is unique in proposing that addiction can be understood as a response to multidimensional trauma. Most women's early years were marked by repeated developmental and other traumas that are exacerbated by poverty, transmitted intergenerationally and occur and intersect on individual, community and systemic levels. Women were explicit about the role of their PDU as a form of self-medication in response to this, numbing the pain of their traumas and providing oblivion from their deprived environments. This almost universal attestation stands in opposition to theories that rest on the medicalisation or moralisation of addiction, suggesting that instead PDU is a direct response to unbearable surroundings and experiences. Regarding PDU as a response to traumatising environments, the lack of appropriate support and opportunities in the women's worlds constitute a form of community trauma. This relationship between PDU and trauma and its multidimensional nature is further attested to by the worsening of their drug use in response to systemic traumas such as negligent or punitive responses from services, such as to relapse in response to further traumas such as bereavement.

Furthermore, women's SSW almost entirely accompanied their PDU along with the impact of their traumas and their deprivation. Again, this suggests that SSW, as with PDU, is a response, a survival strategy to environmental and socioeconomic hardship. Therefore, PDU and SSW are not symptoms of individual deviance but of the impact of developing and existing as a human in deprived and traumatic surroundings.

Several women recognised that their developmental traumas were rooted in intergenerational cycles of trauma: historically, this corresponded with the exacerbation of inequality experienced as the post-war UK welfare state began to be both ideologically and practically dismantled, taking on new fervour in the mid-1980s. The women's parents grew up in their own epoch of neoliberalism and economic upheaval and consequently experienced their own traumas. The traumas of the women and their families were not isolated to the individual/interpersonal experiences described by Maté (2008), Herman (2015) and Van der Kolk (2015). Instead, the evidence on the relationship between deprivation and increased violence suggests that this can be multiplied and amplified by the neoliberal ideals and practices that have increasingly shaped policy, culture, and practice (Cunradi et al, 2000; Gilroy et al, 2015a; Jewkes, 2002; Khalifeh et al, 2013; Sutherland et al, 2001; Vest et al, 2002). Accordingly, trauma can be conceived of as a symptom of the inequality that results from the discourse and practice of the neoliberal state. There is also evidence of women experiencing systemic trauma as a result of neoliberal policies, including in the ongoing retrenchment and conditionality of support, expectation of self-sufficiency regardless of environmental deprivation and the dominance of models that are experienced punitively. Therefore, the absence of appropriate responses and resources also contribute to women's experiences of trauma.

In summary, trauma is multidimensional, and correlates with the exacerbation of inequality and poverty effected by neoliberal policies. This occurs through inappropriate responses of the state that stem from the dominance of business practices in public service, of responsibilising, individualising discourse and neo-Victorian expectations of womanhood ('Womanfare'). Therefore, in addition to fortifying and diversifying the academic knowledge base concerning trauma and women's addiction by introducing the concept of multidimensional trauma, I also illustrate the incompatibility of dominant PDU and SSW policy and practice with the realities of women's experiences and needs. This offers an alternative mode to develop addiction policy and strategy that would work *with* marginalised communities. By understanding that trauma can be multidimensional and that the

experience of trauma can be exacerbated and amplified systemically, we can alter the way we approach work with traumatised people. Policy and practice informed by multidimensional trauma would incorporate the understanding that recovery support must address unmet need on multiple levels and that services and systems must be trauma-informed and compassionate in their responses.

### 8.2.2 The Feminised Centaur State: The Scylla State

While the Centaur State (Wacquant, 2009) serves as a useful concept to understand the intentions and actions of the post-industrial neoliberal state towards marginalised men, the women who share these spaces had not been afforded the same consideration. My research illustrates how, at the heart of the multi-dimensional traumas experienced by the women is political and economic theory and practice that demands compliance and productivity of communities according to gender-specific normative expectations of the state. As opposed to the overt 'warfare' between the so-called welfare state and working-class men described by Redman (2020), we see a more subtle array of strategies experienced by women who come to the attention of the state. Certainly, there seems to be a neo-Victorian renewal of concerns about the productivity of the working class, coupled with and intensified by the focus since Thatcher's government on public services replicating business models. However, the expectations that women are behove to are more concerned with social productivity and moral and behavioural hygiene, of the creation and sustenance of economically productive, socially compliant, and self-sufficient families. The goal is to keep the wheels of the post-industrial system turning, regardless of the increasingly dire conditions of marginalised communities. However, women's role in this deviates significantly from men's and we see this in the strategies used by the state. Under the Scylla State, the state employs a multi-headed and covert approach where multiple strategies, often couched in conditionality, attempt to warehouse deviant women and compel them into submission or change. Failure to adhere to this unspoken social contract results in further ostracisation, deprivation and punitivism. Rather than direct punitivism, women often described their experiences in terms of coercion and manipulation and underpinned by the retrenchment or denial of support based upon

moral judgements. This replicated the abusive relationships that most women had suffered and so suggests an inadvertently self-sabotaging component to systemic responses to supposedly 'deviant' women. Furthermore, the experiences of women that occurred due to their perceived deviance actually excluded them *further* from the rights and status accorded to those who are able to conform, amplifying their exclusion from the mainstream.

We see in the modern treatment of 'deviant' women a neo-Victorian revival of the notions of the 'angel in the house'. Just as Dickens' Urania Cottage was designed to rehabilitate and reform homeless and sex working women, modern approaches reflect similar ideals. Urania Cottage implemented a strict regime, instilling religious and moral virtues as well as 'feminine skills' such as cooking and laundry to prepare women for their new lives of domesticity (Kennedy, 1978). Modern iterations still focus on demanding that the labours of the individual are applied to realise improvement according to the moral-behavioural mores of a patriarchal state. These expectations are accompanied by the increasing retrenchment of resources and the evasion of the state's responsibility to create and sustain environments in which compliance and productivity is possible. This approach treats survival and coping behaviours such as PDU and SSW as chosen deviance rather than symptomatic of the historic and ongoing actions of other arms of the state.

The concept of the Scylla State adds a much-neglected gendered dimension to understandings of the experiences of marginalised populations in the era of post-industrial neoliberalism. This essential advancement of the concept of the Centaur State enables it to be inclusive of sex and the expectations of gender that differentiate these experiences, expanding and diversifying our ability to interrogate neoliberal society.

### *Neoliberal Policies and New Recovery Contradict the Development of Recovery*

My empirical data contradicts the dominant models of recovery and within that, the neoliberal policies from and under which New Recovery has flourished. Although attention has been paid in the Swedish context to the impact of marketisation on addiction treatment, my position takes a UK- specific lens and incorporates the

theories and ideals of neoliberal policies and particular theories of addiction that accompany free market practices (Storbjörk and Stenius, 2019). I argue that the individualising, responsabilising and male-centric models that inform policy and practice are not only unsuitable for women but can inflict greater harm. My research presents an alternative explanation and depiction of recovery that can inform better responses to women and provide them with treatment they can engage with and benefit from.

We have seen that formal treatment as it stands was felt by women to neglect their specific recovery needs, especially if women were survival sex workers. The models underpinning these interventions fail to recognise cause, instead individualising and responsabilising symptom/s. Coupled with a lack of gender and trauma fluency and the stifling impact of neoliberal practices upon public services, this creates an unsuitable and arguably traumatising landscape. My challenge to these models opens up the opportunity for a broader discussion that acknowledges the roots of addiction in systemic and environmental traumas, and the need for treatment to redress this. Women who did recover through treatment did so in residential rehab after prolonged periods of relationship building and were also provided with ongoing support outside rehab. These experiences encapsulate the true process of recovery: through providing environmental escape, restitution of purpose and spirit, access to opportunities, support to realise them and a sense of belonging and social connection. This perhaps explains why community treatment is so unsuccessful in the long-term beyond providing 'fingernail' sobriety that may feel coerced; true recovery entails addressing causes not symptoms, and the causes are deprivation, inequality, and trauma. Therefore, the alternative model I advance understands that the process of recovery requires a holistic restitution of the harm that has been experienced at individual, community, and systemic level. Recovery is also bidirectional and the state must offer what it expects people to achieve in their recovery: namely, by offering the investment of resources and inclusion of citizens, not continuing the abandonment of communities to perpetual struggle; meaningful, secure, well compensated and

recognised employment and fiscal security and recognition for all citizens<sup>51</sup>, not precarious zero-hours contracts and increasingly curtailed employment rights; finally, a sense of value and belonging, rather than a proliferation of experiences and messages of rejection. This echoes Alexander's (2008) assertions discussed in 3.4 and provides greater insight into how and why this is so, particularly for women. Those who recovered in (residential, specialist) treatment described it providing them with self-knowledge, empathy, connection, value, and a sense of purpose. This was often accompanied by employment opportunities in organisations where a shared purpose united them with likeminded professionals, albeit one constrained by untenable outcome expectations.

### 8.2.3 Reflection

I was initially a little disappointed that there was scant mention of the welfare state, benefits or work programmes and wondered if my inclusion of Wacquant was misguided. However, when I returned to the broader concepts at the heart of the Centaur State, namely the penalisation and criminalisation of poverty and responses to it, I found a strong framework with which to interrogate my findings. The themes of retrenchment, punitivism and the marginalisation of the poor were rife, yet manifesting in different but still pertinent gendered iterations.

A significant point regarding potential critique of this research is the selectivity of sampling that was necessitated by the very real fact that women *currently* experiencing PDU/SSW could not be spoken to. Partly this was due to COVID-19 prohibiting travel and paralysing services. But crucially, it must be acknowledged that women currently living in a maelstrom of traumas are often unable to be interviewed for tragic reasons. Many are in prison for crimes that can be conceived as falling under the auspices of the experience of poverty and neoliberal policies. Others are unreachable, deliberately hidden from sight for fear of persecution and deterred from seeking help because of life course experiences of rejection and punitivism. There are

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<sup>51</sup> Including social and familial contribution as well as economic  
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also those increasing numbers of women who have not survived the maelstrom, and at the time of writing Scotland and England have the highest rate of drug related deaths in the world and this still excludes suicides, addiction- and poverty-related health problems, and murders. These women must not be forgotten, especially when looking to research such as this for answers. Alongside the stories of the women who did recover recorded here, there are thousands who did not and must still be recognised when contextualising ‘the problem’ of the consequences of deprivation and inequality upon women.

I was compelled to interview remotely due to COVID-19, but I am aware that this is not considered ideal practice for qualitative interviews. I was especially concerned about using remote methods when discussing sensitive topics. However, I did find that this did not seem to be an issue in reality, although I wonder if this is a reflection of the readiness of the women with whom I spoke to talk, and the rapport we formed despite the distance. It may suggest that for some populations, face-to-face research is not the gold standard of qualitative practice. It also raises the question as to whether the preference for face to-face research most benefits the researcher, who can draw upon tone and visual cues, to the detriment of the participant’s comfort.

### 8.3 Future Directions

By speaking to women in recovery *and* those actively in PDU and SSW about their motivations, the role of drug use and their view of self, I could further explore the impact of the messages received in multidimensional traumas and of the potentially mitigating role that trauma-informed support can play. This could provide new perspectives on the role of trauma-cognisant and emotional resilience-building support in shifting women’s perceptions of their PDU and SSW, for example from deviant to survivor.

I would like to further explore the concept of multidimensional trauma, in particular the correlation between periods of economic upheaval, the intensification of neoliberal discourse and politics, and the experience of trauma.

Many women experienced community treatment and statutory services negatively, variously citing them to be coercive, exploitative, corrupt and punishing. Contextualising this against what we know about the impact of neoliberal policies and expectations upon services, this could be in part due to pressure and restrictions from the demand for timely hard outcomes and services simply being overwhelmed and under-resourced. It would be valuable to interview professionals from social care, community treatment, healthcare, and the criminal justice system to explore their perspective and experiences to further develop an understanding of how and why women experience services in this way. Whether pernicious intention is there or not, the fact women have these experiences and describe interventions in this way is significant, in terms of engaging hard to reach populations, providing effective support and avoiding replicating and inflicting trauma.

## 8.4 Implications for Policy and Practice

Here, I delineate the main implications for professionals and policymakers drawn from the arguments laid out in this chapter, as supported by the Findings and literature in Chapter 3.

A twofold approach is needed to redress the various deprivations detailed in this research. This must be underpinned by an understanding of PDU and SSW as coping strategies in response to poverty and trauma, and recognition of the role of the state in exacerbating and creating new iterations of these. This incorporates accepting that punitive, aggressive approaches to drug use, through wars on drugs, the penalisation of users and efforts to ‘chase out’ supply and demand is misguided and futile. With the persistence of penalism, users will continue to be ostracised and have their traumas, deprivation and exclusion exacerbated, increasing their criminalised responses.

The individualising, responsibilising models underpinning PDU and SSW policy and statutory practice fail to tackle the root of the problem, inflict systemic trauma, and further exclude marginalised individuals. An alternative to the New Recovery Industry is the recognition that traumas experienced over a lifetime require intensive and

consistently available support, regardless of abstinence. To implement such a system would involve network-wide change and acceptance that the practices of industry (including prioritising value for money and stakeholder not beneficiaries' interests) are incongruent.

Secondly, an appropriate response to drug use would involve adopting a truly health- and rights-based focus and recognising that marginalised communities are currently systemically excluded. Focus on redressing these inequities in society would offer a genuine strategy for reducing demand. For those who continue to use drugs, and this must be accepted as a reality and a right, a parallel harm reduction approach is crucial. This would respect the rights of users by operating in their best interests and without conditionality or punitivism. The dualism of harm reduction and recovery support would optimise safety alongside readily available holistic interventions to meet user's self-defined goals, when and if they are ready.

This would reduce systemic traumas among those seeking help and offer a more appropriate way of minimizing the harms of drug use immediately. It would also engage users on their own terms in treatment that would tackle the causes of their symptoms.

The next part of the 'puzzle' entails addressing the upcoming generations who will undoubtedly replace those who either recover, remain addicted, or die. I have delineated the relationship between addiction, trauma, and deprivation; rectifying this entails redressing socioeconomic inequality and the marginalisation of communities.

This would entail significant investment over time but bolstered by the recognition that in the long term, the benefit for individuals, society and the government could be transformative. This includes the redress of environmental neglect, of precarious and underpaid labour, of the retrenchment of benefits. This would also entail recognition of the validity of traditional 'women's work,' from child-raising to often underpaid careers such as care work. This would necessitate applying a truly democratic approach to the allocation of resources and opportunities across class and gender, which would significantly reduce the stresses and deprivation placed upon

marginalised communities. In reducing deprivation, we may reduce traumas including the experience of violence and neglect in families and relationships. Consequently, this mitigation of the roots of many traumas may help stem the tides of addiction.

Where communities have embedded histories of deprivation, it is critical to dually intervene early and tackle root issues by investing immediately and in the long term to improve the experiences and opportunities of the young and change the futures of communities. While this is purportedly being done by the current 'Levelling Up' strategy under Boris Johnson, there has been widespread and vocal condemnation of this for various reasons; among them the paucity of resources being allocated to communities that most need it and the redirection of funds to Tory seats in the South-West (Westwood et al, 2021). Nonetheless, the 'Levelling Up' initiative has great potential and provides an opportunity for discourse and consequently action to occur to develop a plan of action to tackle regional inequality and the impact of post-industrialization upon previously industrial communities. An invaluable template to guide efforts to truly level up and alleviate poverty in the UK is provided by the Joseph Rowntree Foundation who are consistently producing up to date research and guidance on specifically how the government can redress inequality while boosting the economy.

While the impact of austerity has been significant, there were recent signs that the government was willing to loosen its grip on the purse strings for vulnerable populations. Increasing attention is being paid to the value of housing, for example, the 'Everybody In' initiative during the lockdowns of COVID-19 demonstrated the government can provide accommodation and support for homeless people. Furthermore, professionals have attested to the transformative impact this has had on recipients, including their drug use (advised by Rosie). However, as Gore et al (2021) surmise, regional inequality, temporary investment, and the impact of decades of retrenchment in communities, public spaces and services persist and need addressing on a long-term basis.

In addition to addressing deprivation on a macro level, housing alone is not enough and needs to be part of a package of care that is founded on the establishment of

stability and safety and takes a comprehensive approach to unmet need that is truly personalized.

Trauma is near ubiquitous among women involved in PDU and SSW, so to engage these populations and respond to their needs appropriately and successfully, it is vital to develop trauma fluency throughout systems and services they encounter. This necessitates the prioritisation of a systems-wide, united approach to recognising and responding to women's trauma. Unified by the shared goal of addressing women's multidimensional traumas via a union of expertise, we can facilitate collaborative working where each service is secure in its role and remit. Most importantly, it can develop ways for women's experiences of services and help-seeking to entail compassion and appropriate response, rather than experiences of punitivism and exclusion.

#### 8.4.1 The Next Zeitgeist of Neoliberal Policy?

Sadly, the very opposite of this appears to be underway, suggesting the crisis investments to manage COVID-19 and the 2022 £15bn cost of living investment to be anomalies rather than new directions. Overall, the government's response is at best one of antipathy and is predictably sparse in its long-term vision. Despite warnings that 40% may soon be in fuel poverty and with reports of the choice between heating or eating becoming more prevalent, the Prime Minister's response is reported to be to recommend work as the route out of destitution (Stewart and Topham, 2022). This is despite the fact that 41% of Universal Credit claimants are already in work and the estimate that 68% of families in poverty have at least one working adult in them (Stewart and Topham, 2022). This is a deeply concerning indication of the forthcoming intensification of poverty and the state's neglect and individualization of it. This is further attested to by the 2021 Drug Strategy, discussed below.

#### 8.4.2 Punishing Poverty and Trauma: HM Government 2021 Drug Strategy

In December 2021, the UK Government announced a three-year drug strategy plan to invest £3m into reducing demand and supply, retaining its emphasis on crime reduction, problem-focused community treatment and coercing addicts into abstinence and employment (HM Government, 2021). This pledges significant investment into community drug treatment services including employment programs, and an increase in policing efforts to disrupt county lines. The 'Tough Consequences' out of court disposal scheme purports to act as a deterrent to drug use by inflicting 'civic penalties' such as fines, curfews and even removal of passports and driving licenses (HM Gov, 2021). This is the most explicit evocation by the state of the contractual nature of civic rights, and a significant departure from previous strategy's rhetoric that was shifting towards viewing addiction as a health problem, not a criminal justice matter (HM Government 2010 and 2017). Understood contextualised against the literature on individualising and responsibilising theories of addiction, the impact of neoliberal policies discussed in Chapter 3 and the Findings Chapters where women report feeling coerced into inappropriate 'treatment' and punished when unable to comply with impossible demands, this is a worrying development. The 2021 strategy indicates an even greater retrenchment of appropriate support to tackle addiction and a further swing towards responsibilising individuals. Viewed alongside the experiences of the women interviewed and the literature discussed in Chapter 3, 2021's strategy can be critiqued as embodying a reductive understanding of addiction which focuses on treatment as the solution and physiological dependence and behavioural dysfunction as the problem. This strategy marks the greatest step yet towards an overt criminalisation of poverty, as described by Wacquant (2009) that the UK government has taken. It is especially inappropriate for women, whose addiction is often rooted in multidimensional trauma and for whom community treatment is particularly unsuitable, as attested to by this research and supported by the wider evidence base (Malloch and McIvor, 2010 and 2011).

To conclude, these recommendations do not purport to offer a panacea to the stories of constellations of adversity and trauma shared by the women who have shaped this

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thesis. Neither do they attempt to insist that human nature is devoid of selfishness, aggression, or greed or that these traits exist only at systematic level. However, they do propose a way for the state to address its role in exacerbating these tendencies or flaws by promoting security and opportunity throughout communities. This would significantly reduce the external pressures and traumas that marginalised women medicate with drug use, and it would address the destitution that is commonly behind street sex working.

## References

- Aaron LA, Bradley LA, Alarcón GS, Triana-Alexander M, Alexander RW, Martin MY, Alberts KR. Perceived physical and emotional trauma as precipitating events in fibromyalgia. Associations with health care seeking and disability status but not pain severity. *Arthritis Rheum.* 1997 Mar;40(3):453-60. doi: 10.1002/art.1780400311. PMID: 9082933.
- Abel, G. M. (2011). Different stage, different performance: The protective strategy of role play on emotional health in sex work. *Social Science & Medicine*, 72(7), 1177-1184.
- Abel, G., & Fitzgerald, L. (2010). Taking the crime out of sex work: New Zealand sex workers' fight for decriminalisation. Policy Press.
- Abramovitz, M. (2012). *The feminization of austerity*. Paper presented at the New Labour Forum.21(1). 30-39.
- Acker, C. J. (2002). Creating the American junkie: Addiction research in the classic era of narcotic control. JHU Press.
- Alexander, B. (2010). The globalization of addiction: A study in poverty of the spirit. Oxford University Press.
- Alexander, B. K. (1990). The empirical and theoretical bases for an adaptive model of addiction. *Journal of Drug Issues*, 20(1), 37-65.
- Alexander, B. K. (2001). *The myth of drug-induced addiction*. A Paper Delivered to the Canadian Senate, 37<sup>th</sup> Session.
- Alexander, B. K. (2012). Addiction: The urgent need for a paradigm shift. *Substance use & Misuse*, 47(13-14), 1475-1482.
- Alexander, B. K. (2015). *Healing addiction through community: A much longer road than it seems*. Paper presented at the Creating Caring Communities Conference.



- Alexander, B. K. (2016). Replacing the official view of addiction. To fix or to heal . New York University Press.
- Allen, J., & Balfour, R. (2014). *Natural solutions for tackling health inequalities*. London: UCL Institute of Health Equity.
- Alschech, J., Regehr, C., Logie, C. H., & Seto, M. C. (2020). Contributors to posttraumatic stress symptoms in women sex workers. *American Journal of Orthopsychiatry*, 90(5), 567.
- Anakwenze, U., & Zuberi, D. (2013). Mental health and poverty in the inner city. *Health & Social Work*, 38(3), 147-157.
- Anderson, T. L. (Ed.). (2008). Neither Villain nor Victim: Empowerment and Agency among Women Substance Abusers. Rutgers University Press.
- Anderson, T. L. (2005). Dimensions of women's power in the illicit drug economy. *Theoretical Criminology*, 9(4), 371-400.
- Annesley, C. (2012). Campaigning against the cuts: Gender equality movements in tough times. *The Political Quarterly*, 83(1), 19-23.
- Annesley, C., & Himmelweit, S. (2010). The impact on women of the coalition spending *review 2010*. UK Women's Budget Group, London.
- Annison, J., & Brayford, J. Eds. (2015). Women and criminal justice: From the Corston report to transforming rehabilitation. Policy Press.
- Armstrong, E. G. (1981). The sociology of prostitution. *Sociological Spectrum*, 1(1), 91-102.
- Arpa, S. (2017). *Women who use drugs: Issues, needs, responses, challenges and implications for policy and practice*. Background Paper Commissioned by the European Monitoring Centre for Drugs and Drug Addiction for Health and Social Responses to Drug Problems.

Ashbee, E. (2015). Neoliberalism, conservative politics, and 'social recapitalization'. *Global Discourse*, 5(1), 96-113.

Ashery, R. S., Carlson, R. G., Falck, R. S., & Siegal, H. A. (1995). Injection drug users, crack-cocaine users, and human services utilization: An exploratory study. *Social Work*, 40(1), 75-82.

Ashley, O. S., Marsden, M. E., & Brady, T. M. (2003). Effectiveness of substance abuse treatment programming for women: A review. *The American Journal of Drug and Alcohol Abuse*, 29(1), 19-53.

Ashton, M. (2008). Potholed road to recovery-Where is it coming from, where might it lead? Mike Ashton plots a course through the credit crunch, good intentions, and hitchhiking agendas. Druglink, 19.

Atkinson, J., Nelson, J., Brooks, R., Atkinson, C., & Ryan, K. (2014). Addressing individual and community transgenerational trauma. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*, 2, 289-307.

AVA and Agenda. (2019). Breaking down the Barriers: Findings of the National Commission on Domestic and Sexual Violence and Multiple Disadvantage. AVA, London.

Babor, T. F., Caulkins, J. P., Edwards, G., Fischer, B., Foxcroft, D. R., Humphreys, K., Obot, I. S., Rehm, J., & Reuter, P. (2010). *Drug policy and the public good*. Bacchi, C. (2005). Discourse, discourse everywhere: Subject "agency" in feminist discourse methodology. *Nordic Journal of Women's Studies*, 13(03), 198-209.

Bacchi, C. (2012). Why study problematizations? making politics visible. *Open Journal of Political Science*, 2(01), 1.

Back, S., Dansky, B. S., Coffey, S. F., Saladin, M. E., Sonne, S., & Brady, K. T. (2000). Cocaine dependence with and without post-traumatic stress disorder: A comparison

of substance use, trauma history and psychiatric comorbidity. *American Journal on Addictions*, 9(1), 51-62.

Bacon, M., & Seddon, T. (2020). Controlling drug users: Forms of power and behavioural regulation in drug treatment services. *The British Journal of Criminology*, 60(2), 403-421.

Bailey, T. D., & Brown, L. S. (2020). Complex trauma: Missed and misdiagnosis in forensic evaluations. *Psychological Injury and Law*, 13(2), 109-123.

Baker, L. M., Dalla, R. L., & Williamson, C. (2010). Exiting prostitution: An integrated model. *Violence against women*, 16(5), 579-600.

Barnard, M. A. (1993). Violence and vulnerability: Conditions of work for street-working prostitutes. *Sociology of Health & Illness*, 15(5), 683-705.

Barr, B., Taylor-Robinson, D., Stuckler, D., Loopstra, R., Reeves, A., & Whitehead, M. (2016). 'First, do no harm': Are disability assessments associated with adverse trends in mental health? A longitudinal ecological study. *Journal of Epidemiological Community Health*, 70(4), 339-345.

Barr, Ú. (2019). Explaining Desistance: Traditional Perspectives. In *Desisting Sisters* (pp. 25-53). Palgrave Macmillan, Cham.

Barr, U. M. (2018). Gendered assisted desistance: a decade from Corston. *Safer Communities*.

Barr, Ú. M. (2017). *Voicing desistance: Female perspective on giving up crime* (Doctoral dissertation, University of Central Lancashire).

Barter, C. A., Bracewell, K., Stanley, N., & Chantler, K. (2018). Scoping study: Violence against women and girls services.

Bartley, P. (2012). Prostitution: Prevention and reform in England, 1860-1914. Routledge.

- Batiste, C. G., & Yablonsky, L. (1971). Synanon: a therapeutic lifestyle. *California Medicine*, *114*(5), 90.
- Baughner, A. R., & Gazmararian, J. A. (2015). Masculine gender role stress and violence: A literature review and future directions. *Aggression and Violent Behavior*, *24*, 107-112.
- Bauld, L., McKell, J., Carroll, C., Hay, G., & Smith, K. (2012). Benefits and employment: How problem drug users experience welfare and routes into work. *Journal of Social Policy*, *41*(4), 751-768.
- Baumberg, B. (2016). The stigma of claiming benefits: A quantitative study. *Journal of Social Policy*, *45*(2), 181-199.
- Beatty, C., Foden, M., McCarthy, L., & Reeve, K. (2015). *Benefit sanctions and homelessness: A scoping report*. Crisis.
- Beatty, C., & Fothergill, S. (2015). Disability benefits in an age of austerity. *Social Policy & Administration*, *49*(2), 161-181.
- Belcher, J. R., Greene, J. A., McAlpine, C., & Ball, K. (2001). Considering pathways into homelessness: Mothers, addictions, and trauma. *Journal of Addictions Nursing*, *13*(3-4), 199-208.
- Benn, P. (2007). Disease, addiction and the freedom to resist. *Philosophical Papers*, *36*(3), 465-481.
- Benoit, C., McCarthy, B., & Jansson, M. (2015). Stigma, sex work, and substance use: A comparative analysis. *Sociology of Health & Illness*, *37*(3), 437-451.
- Benoit, C., Smith, M., Jansson, M., Magnus, S., Flagg, J., & Maurice, R. (2018). Sex work and three dimensions of self-esteem: Self-worth, authenticity and self-efficacy. *Culture, Health & Sexuality*, *20*(1), 69-83.
- Berends, L. (2011). Embracing the visual: Using timelines with in-depth interviews on substance use and treatment. *Qualitative Report*, *16*(1), 1-9.

- Berridge, V. (2012). The rise, fall, and revival of recovery in drug policy. *The Lancet*, 379(9810), 22-23.
- Bertrand, M. A. (1994). 1893–1993: From La Donna Delinquente to a postmodern deconstruction of the ‘Woman question’ in social control theory. *The Journal of Human Justice*, 5(2), 43-57.
- Bevan, M. (2015). Desistance from crime: A review of the literature. *Practice: The New Zealand Corrections Journal*, 3(1), 5-9.
- Birkett, G. (2019). Transforming women’s rehabilitation? an early assessment of gender- specific provision in three community rehabilitation companies. *Criminology & Criminal Justice*, 19(1), 98-114.
- Bjønness, J. (2015). Narratives about necessity—constructions of motherhood among drug using sex-sellers in Denmark. *Substance use & Misuse*, 50(6), 783-793.
- Blair, A., Marryat, L., & Frank, J. (2019). How community resources mitigate the association between household poverty and the incidence of adverse childhood experiences. *International Journal of Public Health*, 64(7), 1059-1068.
- Blaxland, M., Skattebol, J., Hamilton, M., van Toorn, G., Thomson, C., & Valentine, K. (2021). From being ‘at risk’ to being ‘a risk’: Journeys into parenthood among young women experiencing adversity. *Families, Relationships and Societies*. 1-20.
- Bloom, B., & Covington, S. (1998, November). Gender-specific programming for female offenders: What is it and why is it important. In *50th annual meeting of the American Society of Criminology, Washington, DC*.
- Bloom, B., Owen, B. A., & Covington, S. (2003). Gender-responsive strategies: Research, practice, and guiding principles for women offenders.
- Bloom, S. L. (2010). Organizational stress and trauma-informed services. In *A public health perspective of women's mental health* (pp. 295-311). Springer, New York, NY.
- Bone, J. (2012). The deregulation ethic and the conscience of capitalism: How the

neoliberal 'free market' model undermines rationality and moral conduct. *Globalizations*, 9(5), 651-665.

Borkman, T., Kaskutas, L. A., & Owen, P. (2007). Contrasting and converging philosophies of three models of alcohol/other drugs treatment: Minnesota model, social model, and addiction therapeutic communities. *Alcoholism Treatment Quarterly*, 25(3), 21-38.

Bosworth, M. (2017). Engendering resistance: Agency and power in women's prisons. Routledge.

Bourdieu, P. (1985). The social space and the genesis of groups. *Theory and Society*, 14(6), 723-744.

Bourdieu, P. (2003). Firing back: Against the tyranny of the market Vol. 2. Verso.

Bourdieu, P. (2011). The forms of capital. (1986). *Cultural Theory: An Anthology*, 1, 81- 93.

Bowen, R. R. (2013). *They walk among us: sex work exiting, re-entry and duality* (Doctoral dissertation, Arts & Social Sciences: School of Criminology).

Boyle, D. (2011). The pitfalls and perils of payment by results. *Local Economy*, 26(8), 627-634.

Brady, K. T., & Lydiard, J. B. (2021). Women and addiction. In *Textbook of Addiction Treatment* (pp. 1395-1405). Springer, Cham.

Brady, K. T., & Randall, C. L. (1999). Gender differences in substance use disorders. *Psychiatric Clinics of North America*, 22(2), 241-252.

Bramall, R., Gilbert, J., & Meadway, J. (2016). What is austerity? *New Formations*, 87(87), 119-140.

Bressler, R., Erford, B. T., & Dean, S. (2018). A systematic review of the posttraumatic stress disorder checklist (PCL). *Journal of Counselling & Development*, 96(2), 167-186.

- Bretherton, J., & Pleace, N. (2015). Housing first in England: An evaluation of nine services.
- Brewis, J., & Linstead, S. (1998). Time after time: The temporal organization of red-collar work. *Time & Society*, 7(2-3), 223-248.
- Briggs, A. (1961). The welfare state in historical perspective. *European Journal of Sociology/Archives europeennes de sociologie*, 2(2), 221-258.
- Brinkmann, S., & Kvale, S. (2018). Epistemological issues of interviewing. In *Doing Interviews* (pp. 13-26). SAGE Publications Ltd, <https://dx.doi.org/10.4135/9781529716665.n2>
- Broadhurst, K., Hall, C., Wastell, D., White, S., & Pithouse, A. (2010). Risk, instrumentalism and the humane project in social work: Identifying the informal logics of risk management in children's statutory services. *British Journal of Social Work*, 40(4), 1046-1064.
- Brodkin, E. Z. (2012). Reflections on street-level bureaucracy: past, present, and future.
- Brown, K., & Sanders, T. (2017). Pragmatic, progressive, problematic: Addressing vulnerability through a local street sex work partnership initiative. *Social Policy and Society*, 16(3), 429-441.
- Brown, K., & Wincup, E. (2020). Producing the vulnerable subject in English drug policy. *International Journal of Drug Policy*, 80, 102525.
- Brown, V. B., Melchior, L. A., Panter, A. T., Slaughter, R., & Huba, G. J. (2000). Women's steps of change and entry into drug abuse treatment: A multidimensional stages of change model. *Journal of Substance Abuse Treatment*, 18(3), 231-240.
- Brunschot, E. G. V. (2003). Community policing and "john schools". *Canadian Review of Sociology and Anthropology*, 40(2), 215-232.

- Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, 6(1), 97-113.
- Bryman, A. (2016). *Social research methods*. Oxford university press.
- Bryman, A. (2017). Quantitative and qualitative research: further reflections on their integration. In *Mixing methods: Qualitative and quantitative research* (pp. 57-78). Routledge.
- Bufacchi, V. (2005). Two concepts of violence. *Political Studies Review*, 3(2), 193-204.
- Bullock, R., & Parker, R. (2014). A historical review of the concept of severe and multiple disadvantage and of responses to it. A discussion paper for Lankelly Chase. Dartington: Centre for Social Policy.
- Bullough, B., & Bullough, V. L. (1996). Female prostitution: Current research and changing interpretations. *Annual Review of Sex Research*, 7(1), 158-180.
- Bungay, V. (2013). Health care among street-involved women: The perpetuation of health inequity. *Qualitative Health Research*, 23(8), 1016-1026.
- Bush, I. R., & Kraft, M. K. (2001). Self-sufficiency and sobriety: Substance-abusing women and welfare reform. *Journal of Social Work Practice in the Addictions*, 1(1), 41- 64.
- Bushway, D., & Heiland, L. (1996). Women in treatment for addiction: What's new in the literature? *Alcoholism Treatment Quarterly*, 13(4), 83-96.
- Bywaters, P., Brady, G., Bunting, L., Daniel, B., Featherstone, B., Jones, C., Morris, K., Scourfield, J., Sparks, T., & Webb, C. (2018). Inequalities in English child protection practice under austerity: A universal challenge? *Child & Family Social Work*, 23(1), 53-61.
- Bywaters, P., Brady, G., Sparks, T., Bos, E., Bunting, L., Daniel, B., Featherstone, B.,



- Morris, K., & Scourfield, J. (2015). Exploring inequities in child welfare and child protection services: Explaining the 'inverse intervention law'. *Children and Youth Services Review*, *57*, 98-105.
- Bywaters, P., Bunting, L., Davidson, G., Hanratty, J., Mason, W., McCartan, C., & Steils, N. (2016). The relationship between poverty, child abuse and neglect: An evidence review. York: Joseph Rowntree Foundation.
- Campbell, N. (2002). Using women: Gender, drug policy, and social justice. Routledge.
- Campbell, N., & Ettorre, E. (2011). Gendering addiction: The politics of drug treatment in a neurochemical world. Springer.
- Campbell, R. (2014). Not getting away with it: Linking sex work and hate crime in Merseyside. In *Responding to Hate Crime* (pp. 55-70). Policy Press.
- Campbell, R., & O'Neill, M. (2013). *Sex work now*. Routledge.
- Campbell, R. (2016) Not Getting Away With It: addressing violence against sex workers as hate crime in Merseyside. Doctoral thesis, Durham University.
- Campbell, R., & Sanders, T. (2021). Sex work and hate crime: Innovating policy, practice and theory. Springer.
- Campbell, R., & Storr, M. (2001). Challenging the kerb crawler rehabilitation programme. *Feminist Review*, *67*(1), 94-108.
- Campbell, R., Adams, A. E., Wasco, S. M., Ahrens, C. E., & Sefl, T. (2010). "What has it been like for you to talk with me today?": The impact of participating in interview research on rape survivors. *Violence Against Women*, *16*(1), 60-83.
- Cancian, M., Yang, M., & Slack, K. S. (2013). The effect of additional child support income on the risk of child maltreatment. *Social Service Review*, *87*(3), 417-437.
- Carlen, P., & Worrall, A. (2013). *Analysing women's imprisonment*. Willan.

Carline, A., & Scoular, J. (2015). Saving fallen women now? critical perspectives on engagement and support orders and their policy of forced welfarism. *Social Policy and Society*, 14(1), 103-112.

Carline, A., & Scoular, J. (2017). 'Almost abolitionism: The peculiarities of prostitution policy in England and Wales.' In *Feminism, prostitution and the state* (pp. 103-120). Routledge.

Casady, A., Diener, M., Isabella, R., & Wright, C. (2001). Attachment security among families in poverty: Maternal, child, and contextual characteristics.

Casey, C. (2022, January 10). Without somewhere safe to go women leaving prison 'do not stand a chance'. Inside Housing <https://www.insidehousing.co.uk/insight/insight/without-somewhere-safe-to-gowomen-leaving-prison-do--not-stand-a-chance-73453>.

Cerny, P. G. (2008). Embedding neoliberalism: The evolution of a hegemonic paradigm. *The Journal of International Trade and Diplomacy*, 2(1), 1-46.

Chandler, M. J., & Lalonde, C. (1998). Cultural continuity as a hedge against suicide in Canada's first nations. *Transcultural Psychiatry*, 35(2), 191-219.

Chandler, M. J., Lalonde, C. E., Sokol, B. W., Hallett, D., & Marcia, J. E. (2003). Personal persistence, identity development, and suicide: A study of native and non-native north American adolescents. *Monographs of the Society for Research in Child Development*, i- 138.

Charman, S. (2019). Making sense of policing identities: The 'deserving' and the 'underserving': policing accounts of victimisation. *Policing and Society*.

Chase, E., & Statham, J. (2005). Commercial and sexual exploitation of children and young people in the UK—A review. *Child Abuse Review: Journal of the British Association for the Study and Prevention of Child Abuse and Neglect*, 14(1), 4-25.

Chase, E., & Walker, R. (2013). The co-construction of shame in the context of poverty: Beyond a threat to the social bond. *Sociology*, 47(4), 739-754.

- Christie, B. (2020). *Summit on drug deaths ends with no agreement*. British Medical Journal Publishing Group.
- Christie, B. (2021). Scotland intends to set up safe spaces for drug users in defiance of UK government. British Medical Journal Publishing Group.
- Christopher, H., & Hood, C. (2006). Gaming in target world: The targets approach to managing British public services. *Public Administration Review*, 66(4), 515-521.
- Chunn, D. E., & Gavigan, S. A. (2004). Welfare law, welfare fraud, and the moral regulation of the 'never deserving' poor. *Social & Legal Studies*, 13(2), 219-243.
- Church, S., Henderson, M., Barnard, M., & Hart, G. (2001). Violence by clients towards female prostitutes in different work settings: Questionnaire survey. *BMJ*, 322(7285), 524-525.
- Cook, K. (2011). Rape investigation and prosecution: Stuck in the mud? *Journal of Sexual Aggression*, 17(3), 250-262.
- Ciccone, D. S., Elliott, D. K., Chandler, H. K., Nayak, S., & Raphael, K. G. (2005). Sexual and physical abuse in women with fibromyalgia syndrome: A test of the trauma hypothesis. *The Clinical Journal of Pain*, 21(5), 378-386.
- Clapton, G., Cree, V., & Smith, M. (2013). Moral panics, claims-making and child protection in the UK. *British Journal of Social Work*, 43(4), 803-812.
- Clark, H. W. (2001). Residential substance abuse treatment for pregnant and postpartum women and their children: Treatment and policy implications. *Child Welfare*, 179-198.
- Clark, M. (2011). Conceptualising addiction: How useful is the construct. *International Journal of Humanities and Social Science*, 1(13), 55-64.
- Clarke, B., & Chadwick, K. (2017). From 'troubled' women to failing institutions: The necessary narrative shift for the decarceration of women post-Corston. In *Women's imprisonment and the case for abolition* (pp. 51-70). Routledge.
- Clark, J., & McGoey, L. (2016). The black box warning on philanthrocapitalism. *The Lancet*, 388(10059), 2457-2459.

- Clist, P. (2019). Payment by results in international development: Evidence from the first decade. *Development Policy Review*, 37(6), 719-734.
- Cloitre, M., Stolbach, B. C., Herman, J. L., Kolk, B. v. d., Pynoos, R., Wang, J., & Petkova, E. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, 22(5), 399-408.
- Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance use & Misuse*, 43(12-13), 1971-1986.
- Coade, S., & de Wolf, S. (2008). *Yarning up on trauma*. Richmond, Berry Street.
- Cohen, L. R., & Hien, D. A. (2006). Treatment outcomes for women with substance abuse and PTSD who have experienced complex trauma. *Psychiatric Services*, 57(1), 100-106.
- Colten, M. E. (1979). A descriptive and comparative analysis of self-perceptions and attitudes of heroin-addicted women. *Addicted Women: Family Dynamics, Self-Perceptions, and Support Systems*, 7-36.
- Colten, M. E., & Marsh, J. C. (1984). A sex-roles perspective on drug and alcohol use by women. In *Sex roles and psychopathology* (pp. 219-248). Springer, Boston, MA.
- Corrigan, F. M., Fisher, J. J., & Nutt, D. J. (2011). Autonomic dysregulation and the window of tolerance model of the effects of complex emotional trauma. *Journal of Psychopharmacology*, 25(1), 17-25.
- Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, 59(7), 614.
- Coulton, C. J., Crampton, D. S., Irwin, M., Spilsbury, J. C., & Korbin, J. E. (2007). How neighbourhoods influence child maltreatment: A review of the literature and alternative pathways. *Child Abuse & Neglect*, 31(11-12), 1117-1142.

Courtin, E., Allchin, E., Ding, A. J., & Layte, R. (2019). The role of socioeconomic interventions in reducing exposure to adverse childhood experiences: A systematic review. *Current Epidemiology Reports*, 6(4), 423-441.

Courtwright, D. T. (2010). The NIDA brain disease paradigm: History, resistance, and spinoffs. *BioSocieties*, 5(1), 137-147.

Covington, J. (1985). Gender differences in criminality among heroin users. *Journal of Research in Crime and Delinquency*, 22(4), 329-353.

Covington, S. (1997). Women, addiction, and sexuality. *Gender Issues in Addiction: Men and Women in Treatment*, 71-95.

Covington, S. (2002). Helping women recover: Creating gender-responsive treatment. *The Handbook of Addiction Treatment for Women: Theory and Practice*, 52- 72.

Covington, S. S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs*, 40, 377-385.

Covington, S. S., & Kohen, J. (1984). Women, alcohol, and sexuality. *Advances in Alcohol & Substance Abuse*, 4(1), 41-56.

Covington, S. S., Burke, C., Keaton, S., & Norcott, C. (2008). Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment. *Journal of Psychoactive Drugs*, 40, 387-398.

Cowden, S. and Singh, G. (2007), The 'user': friend, foe or fetish? A critical exploration of user involvement in health and social care. *Critical Social Policy*, 27, 1: 5-21  
Coyle, A. (2005). *Understanding prisons*. McGraw-Hill Education (UK).

Crawford, A. (2010). If 'the body keeps the score': Mapping the dissociated body in trauma narrative, intervention, and theory. *University of Toronto Quarterly*, 79(2), 702- 719.

- Cree, V. E., Clapton, G., & Smith, M. (2016). Standing up to complexity: Researching moral panics in social work. *European Journal of Social Work*, 19(3-4), 354-367.
- Cromby, J., & Harper, D.J. (2009). Paranoia: A social account. *Theory & Psychology*, 19(3), 335-361.
- Crossley, S. (2016). 'Realising the (troubled) family','crafting the neoliberal state'. *Families, Relationships and Societies*, 5(2), 263-279.
- Cunradi, C. B., Caetano, R., Clark, C., & Schafer, J. (2000). Neighborhood poverty as a predictor of intimate partner violence among White, Black, and Hispanic couples in the United States: A multilevel analysis. *Annals of epidemiology*, 10(5), 297-308.
- Curran, V., & Golombok, S. (1985). *Bottling it up*. Faber & Faber.
- Cusick, L. (2006). Widening the harm reduction agenda: From drug use to sex work. *International Journal of Drug Policy*, 17(1), 3-11.
- Cusick, L., & Berney, L. (2005). Prioritizing punitive responses over public health: Commentary on the home office consultation document paying the price. *Critical Social Policy*, 25(4), 596-606.
- Cusick, L., & Hickman, M. (2005). 'Trapping' in drug use and sex work careers. *Drugs: Education, Prevention and Policy*, 12(5), 369-379.
- Cusick, L., Martin, A., & May, T. (2003). *Vulnerability and involvement in drug use and sex work* (Vol. 207). London: Home Office.
- Cusick, L., Brooks-Gordon, B., Campbell, R., & Edgar, F. (2011). 'Exiting' drug use and sex work: Career paths, interventions and government strategy targets. *Drugs: Education, Prevention and Policy*, 18(2), 145-156.
- D'Hombres, B., Schnepf, S., Barjaková, M., & Mendonça, F. T. (2018). Loneliness—an unequally shared burden in Europe. *Science for Policy Briefs: European Union*, 3-4.
- Dabrowski, V. (2018). The Role of the State in Shaping Young Women's Experiences of *Austerity* (Doctoral dissertation, Goldsmiths, University of London).

- Dass-Brailsford, P., & Myrick, A. C. (2010). Psychological trauma and substance abuse: The need for an integrated approach. *Trauma, Violence, & Abuse, 11*(4), 202-213.
- Davidson, J.O.C., 1996. Prostitution and the contours of control. In *Sexual Cultures* (pp. 180-198). Palgrave Macmillan, London.
- Davies, J. (2018). Addiction is not a brain disease. *Addiction Research & Theory, 26*(1), 1- 2.
- Davies, L., & Krane, J. (2006). Collaborate with caution: Protecting children, helping mothers. *Critical Social Policy, 26*(2), 412-425.
- Davies, R. (2011). Modernising commissioning: Increasing the role of charities, social enterprises, mutuals and cooperatives in public service delivery.
- Dawson, A., Jackson, D., & Cleary, M. (2013). Mothering on the margins: Homeless women with an SUD and complex mental health co-morbidities. *Issues in Mental Health Nursing, 34*(4), 288-293.
- Day, M. (2018). On trauma and safety: Toward trauma-informed research methods. In *Making future matters*. Computers and Composition Digital Press.
- de Olarte, E. G., & Llosa, P. G. (1999). Does poverty cause domestic violence? Some answers from Lima. PUCP. CISEPA.
- Deacon, A. and Patrick, R. (2011), A new welfare settlement? The coalition government and welfare to work. In H. Bochel (ed.), *The Conservative Party and Social Policy*. Bristol: Policy Press.
- DeCou, C. R., Mahoney, C. T., Kaplan, S. P., & Lynch, S. M. (2019). Coping self-efficacy and trauma-related shame mediate the association between negative social reactions to sexual assault and PTSD symptoms. *Psychological Trauma: Theory, Research, Practice, and Policy, 11*(1), 51.

- Decriminalization, W. E. (1973). Prostitution: A non-victim crime? *Issues in Criminology*, 8(2), 137-162.
- Deering, K. N., Amin, A., Shoveller, J., Nesbitt, A., Garcia-Moreno, C., Duff, P., Argento, E., & Shannon, K. (2014). A systematic review of the correlates of violence against sex workers. *American Journal of Public Health*, 104(5), e42-e54.
- Denscombe, M. (2010). *The Good Research Guide for Small Scale Research Projects* (4th ed.). Buckingham: Open University Press.
- Depner, R. (2017). In search of wholeness: An exploration of social connection as a mediating factor in addiction (Doctoral dissertation, City University of Seattle).
- DFE and Hawkins. (2018). Working together to safeguard children. UK Government.
- Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2007). Doing sensitive research: What challenges do qualitative researchers face? *Qualitative Research*, 7(3), 327-353.
- DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. *Motivational Interviewing: Preparing People for Change*, 2, 201-216.
- Diener, M. L., Nievar, M. A., & Wright, C. (2003). Attachment security among mothers and their young children living in poverty: Associations with maternal, child, and contextual characteristics. *Merrill-Palmer Quarterly (1982-)*, 154-182.
- Dobash, R. E., & Dobash, R. (1979). *Violence against wives: A case against the patriarchy*. Free Press New York.
- Dowden, C., & Andrews, D. A. (1999). What works for female offenders: A meta-analytic review. *Crime & Delinquency*, 45(4), 438-452.
- Duane, A. M., Stokes, K. L., DeAngelis, C. L., & Bocknek, E. L. (2020). Collective trauma



and community support: Lessons from Detroit. *Psychological Trauma: Theory, Research, Practice, and Policy*, 12(5), 452.

Duff, P., Deering, K., Gibson, K., Tyndall, M., & Shannon, K. (2011). Homelessness among a cohort of women in street-based sex work: The need for safer environment interventions. *BMC Public Health*, 11(1), 1-7.

Duff, P., Shoveller, J., Chettiar, J., Feng, C., Nicoletti, R., & Shannon, K. (2015). Sex work and motherhood: Social and structural barriers to health and social services for pregnant and parenting street and off-street sex workers. *Health Care for Women International*, 36(9), 1039-1055.

Duke, K. (2013). From crime to recovery: The reframing of British drugs policy? *Journal of Drug Issues*, 43(1), 39-55.

Duke, K., Herring, R., Thickett, A., & Thom, B. (2013). Substitution treatment in the era of "recovery": An analysis of stakeholder roles and policy windows in Britain. *Substance use & Misuse*, 48(11), 966-976.

Dunn, A. (2010). Welfare conditionality, inequality and unemployed people with alternative values. *Social Policy and Society*, 9(4), 461-473.

Durbin, S., Page, M., & Walby, S. (2017). Gender equality and 'austerity': Vulnerabilities, resistance and change. *Gender, Work & Organization*, 24(1), 1-6.

Dwyer, P., Scullion, L., Jones, K., McNeill, J., & Stewart, A. B. (2020). Work, welfare, and wellbeing: The impacts of welfare conditionality on people with mental health impairments in the UK. *Social Policy & Administration*, 54(2), 311-326.

Earle, J. (2018). Why Focus on Reducing Women's Imprisonment? In *Women and the Criminal Justice System* (pp. 187-219). Palgrave Macmillan, Cham.

Edmiston, D. (2017). Welfare, austerity and social citizenship in the UK. *Social Policy and Society*, 16(2), 261-270.

- Edwards, F. (2016). Saving children, controlling families: Punishment, redistribution, and child protection. *American Sociological Review*, *81*(3), 575-595.
- Eggertson L. Stigma a major barrier to treatment for pregnant women with addictions. *CMAJ*. 2013 Dec 10;185(18):1562. doi: 10.1503/cmaj.109-4653. Epub 2013 Nov 11. PMID: 24218532; PMCID: PMC3855110.
- Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology*, *33*(4), 461-477.
- Ellis, A. (2019). A de-civilizing reversal or system normal? Rising lethal violence in post-recession austerity United Kingdom. *The British Journal of Criminology*, *59*(4), 862-878.
- Ellison, L., & Munro, V. E. (2017). Taking trauma seriously: Critical reflections on the criminal justice process. *The International Journal of Evidence & Proof*, *21*(3), 183-208.
- Ellison, G., Ni Dhonaill, C. & Early, E. (2019). A review of the criminalisation of the payment for sexual services in Northern Ireland. *ERin, A Review of the Criminalisation of the Payment for Sexual Services in Northern Ireland (September 19, 2019)*.
- Emsley, E., Smith, J., Martin, D., & Lewis, N. V. (2022). Trauma-informed care in UK: Where are we? A qualitative study of health policies and professional perspectives.
- English Collective of Prostitutes. (2003). Anti-trafficking legislation: Protection or deportation? *Feminist Review*, *73*(1), 135-139.
- Erickson, P. G., Butters, J., McGillicuddy, P., & Hallgren, A. (2000). Crack and prostitution: Gender, myths, and experiences. *Journal of Drug Issues*, *30*(4), 767-788.
- Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. Princeton University Press.

Etherington, K. (2007). Trauma, drug misuse and transforming identities: A life story approach. Jessica Kingsley Publishers.

Ettore, E., Mullins, C., Sommers, I., Baskin, D., Katsulis, Y., Blankenship, K., Saum, C., Gray, A., Kelley, M., & Malloch, M. (2008). *Neither villain nor victim: Empowerment and agency among women substance abusers*. Rutgers University Press. Ettore, E. (1994). What can she depend on? Substance use and women's health. *Women and health: Feminist perspectives*, 85-101.

Ettore, E. (2004). Revisioning women and drug use: Gender sensitivity, embodiment and reducing harm. *International Journal of Drug Policy*, 15(5-6), 327-335.

Ettore, E. (2007). Embodiment, Emotions and Female Drug Use. In *Revisioning Women and Drug Use* (pp. 124-140). Palgrave Macmillan, London.

Ettore, E. (2008). Seeing women, power, and drugs through the lens of *embodiment*. *Neither villain nor victim* (pp. 33-48). Rutgers University Press. Ettore, E. (2016). *Revisioning women and drug use*. Springer.

European Committee of Social Rights. (2009). *European committee of social rights: General Introduction* para 15 (2009).

Fahmy, E., Williamson, E., & Pantazis, C. (2016). *Evidence and policy review: Domestic violence and poverty*. Joseph Rowntree Foundation. Retrieved from [https://research-information.bristol.ac.uk/files/80376377/JRF\\_DV\\_POVERTY\\_REPORT\\_FINAL\\_COPY\\_.pdf](https://research-information.bristol.ac.uk/files/80376377/JRF_DV_POVERTY_REPORT_FINAL_COPY_.pdf).

Falkin, G. P., & Strauss, S. M. (2003). Social supporters and drug use enablers: A dilemma for women in recovery. *Addictive Behaviors*, 28(1), 141-155.

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology*, 45(3), 305-325.

Farrall, S. (2002). 'Desistance, change and probation supervision'. In *Rethinking What Works with Offenders* (pp. 173-192). Routledge.

Featherstone, B., & Gupta, A. (2018). *Protecting children: A social model*. Policy Press.

Featherstone, B., & Peckover, S. (2007). Letting them get away with it: Fathers, domestic violence, and child welfare. *Critical Social Policy*, 27(2), 181-202.

Featherstone, B., Morris, K., & White, S. (2014). Re-imagining child protection: Towards humane social work with families. Policy Press.

Feis-Bryce, A. (2017). Policing sex work in Britain: A patchwork approach. Policing the sex industry (pp. 19-37). Routledge.

Fenton, J., & Kelly, T. B. (2017). 'Risk is king and needs to take a backseat!' Can social workers' experiences of moral injury strengthen practice? *Journal of Social Work Practice*, 31(4), 461-475.

Ferguson, A., Philipson, I., Diamond, I., Quimby, L., Vance, C. S., & Snitow, A. B. (1984). The feminist sexuality debates. *Signs*, 10(1), 106-135.

Ferguson, T. J., & Crowley, S. L. (1997). Gender differences in the organization of guilt and shame. *Sex Roles*, 37(1), 19-44.

Fine, M., & Weis, L. (2000). Disappearing acts: The state and violence against women in the twentieth century. *Signs: Journal of Women in Culture and Society*, 25(4), 1139-1146.

Finlay-Jones, R., & Brown, G. W. (1981). Types of stressful life event and the onset of anxiety and depressive disorders. *Psychological Medicine*, 11(4), 803-815.

Firmin, C., Warrington, C., & Pearce, J. (2016). Sexual exploitation and its impact on developing sexualities and sexual relationships: The need for contextual social work interventions. *The British Journal of Social Work*, bcw134.

Fisher, G. (2014). *The complexity of severe and multiple disadvantage*. London: Synthesis and Lankelly Chase.

Fitzpatrick, S., & Jones, A. (2005). Pursuing social justice or social cohesion? Coercion in street homelessness policies in England. *Journal of Social Policy*, 34(3), 389-406.

Fitzpatrick, S., Bramley, G., & Johnsen, S. (2013). Pathways into multiple exclusion homelessness in seven UK cities. *Urban Studies*, *50*(1), 148-168.

Flanagan O. (2013) The shame of addiction. *Front Psychiatry*. *8*; 4:120.

Fleetwood, J., & Haas, N. U. (2011). Gendering the agenda: Women drug mules in resolution 52/1 of the commission of narcotic drugs at the United Nations. *Drugs and Alcohol Today*.

Fletcher, D. R. (2011). Welfare reform, jobcentre plus and the street-level bureaucracy:

Towards inconsistent and discriminatory welfare for severely disadvantaged groups? *Social Policy and Society*, *10*(4), 445-458.

Fletcher, D. R. (2013). The governance of social marginality in the UK: Towards the centaur state? *British Journal of Community Justice*, *11*(1). 19-34.

Fletcher, D. R. (2015). Workfare—a blast from the past? contemporary work conditionality for the unemployed in historical perspective. *Social Policy and Society*, *14*(3), 329-339.

Fletcher, D. R., & Flint, J. (2018). Welfare conditionality and social marginality: The folly of the tutelary state? *Critical Social Policy*, *38*(4), 771-791.

Fletcher, D. R., Flint, J., Batty, E., & McNeill, J. (2016). Gamers or victims of the system? welfare reform, cynical manipulation and vulnerability. *Journal of Poverty and Social Justice*, *24*(2), 171-185.

Foddy, B., & Savulescu, J. (2006). Addiction and autonomy: Can addicted people consent to the prescription of their drug of addiction? *Bioethics*, *20*(1), 1-15.

Foddy, B., & Savulescu, J. (2010). A liberal account of addiction. *Philosophy, Psychiatry, & Psychology: PPP*, *17*(1), 1-22.

Fomiatti, R. (2020). 'It's good being part of the community and doing the right

thing':(Re) problematising 'community' in new recovery-oriented policy and consumer accounts. *International Journal of Drug Policy*, 80, 102450.

Fomiatti, R. D. (2017). Hope, choice and the improvable self: A critical analysis of 'new recovery' in Australia. (Doctoral dissertation, Curtin University).

Fomiatti, R., Moore, D., & Fraser, S. (2019). The improvable self: Enacting model citizenship and sociality in research on 'new recovery'. *Addiction Research & Theory*, 27(6), 527-538.

Fomiatti, R., Moore, D., Fraser, S., & Farrugia, A. (2021). Holding 'new recovery' together: Organising relations and forms of coordination in professional sociomaterial practices of addiction recovery. *International Journal of Drug Policy*, 97, 103357.

Fonagy, P., FBA, F., Allison, F. E., & Campbell, C. (2019). *Mentalizing*,

resilience. Handbook of Mentalizing in Mental Health Practice. American Psychiatric Publishing.

Fong, K. (2019). Concealment and constraint: Child protective services fears and poor mothers' institutional engagement. *Social Forces*, 97(4), 1785-1810.

Fontes, L. A. (2004). Ethics in violence against women research: The sensitive, the dangerous, and the overlooked. *Ethics & Behavior*, 14(2), 141-174.

Foucault, M. (2009). Alternatives to the prison: Dissemination or decline of social control? *Theory, Culture & Society*, 26(6), 12-24.

Fox, S. (2020). [...] you feel there's nowhere left to go: the barriers to support among women who experience substance use and domestic abuse in the UK. *Advances in Dual Diagnosis*, 13(2), 57-71.

Fox, C., & Albertson, K. (2011). Payment by results and social impact bonds in the criminal justice sector: New challenges for the concept of evidence-based policy? *Criminology & Criminal Justice*, 11(5), 395-413.

Frank, D. (2018). "I was not sick, and I didn't need to recover": Methadone maintenance treatment (MMT) as a refuge from criminalization. *Substance use & Misuse*, 53(2), 311- 322.

Frank, L. E., & Nagel, S. K. (2017). Addiction and moralization: The role of the underlying model of addiction. *Neuroethics*, 10(1), 129-139.

Fraser, S., & Valentine, K. (2008). Substance and substitution: Methadone subjects in liberal societies. Springer.

Frišaufová, M. (2012). The female drug user as a 'victim' or 'villain' and the implications for social work. *Social Work & Society*, 10(1).

Froggett, L. (2002). Love, Hate and Welfare: Psychosocial Approaches to Policy and *Practice*. Bristol: Policy Press.

Fujiwara, T. and Kawachi, I., 2008. A prospective study of individual-level social capital and major depression in the United States. *Journal of Epidemiology & Community Health*, 62(7), pp.627-633.

Fullilove, M. T., Fullilove, R. E., Smith, M., Winkler, K., Michael, C., Panzer, P. G., & Wallace, R. (1993). Violence, trauma, and post-traumatic stress disorder among women drug users. *Journal of Traumatic Stress*, 6(4), 533-543.

Fullilove, M. T., Lown, E. A., & Fullilove, R. E. (1992). *Crack 'hos and skeezers: Traumatic* experiences of women crack users.

Furniss, H. S. (1912). Syndicalism and Labour. Notes upon some Aspects of Social and Industrial Questions of the Day.

Gage, S. H., & Sumnall, H. R. (2019). Rat Park: How a rat paradise changed the narrative of addiction. *Addiction*, 114(5), 917-922.

Gainford, A. (2017). Mad, Bad or Sad? The Historical Persecution of Women and the Birth of Female Criminality. *The Historical Persecution of Women and the Birth of Female Criminality (December 9, 2017)*.

- Galtung, J. (1969). Violence, peace, and peace research. *Journal of Peace Research*, 6(3), 167-191.
- Garland, D. (2015). On the concept of 'social rights'. *Social & Legal Studies*, 24(4), 622-628.
- Gatz, M., Russell, L. A., Grady, J., Kram-Fernandez, D., Clark, C., & Marshall, B. (2005). Women's recollections of victimization, psychological problems, and substance use. *Journal of Community Psychology*, 33(4), 479-493.
- Gerassi, L. (2015). A heated debate: Theoretical perspectives of sexual exploitation and sex work. *Journal of Sociology and Social Welfare*, 42(4), 79.
- Gilchrist, G., Gruer, L., & Atkinson, J. (2005). Comparison of drug use and psychiatric morbidity between prostitute and non-prostitute female drug users in Glasgow, Scotland. *Addictive behaviors*, 30(5), 1019-1023.
- Gilchrist, G., Taylor, A., Goldberg, D., Mackie, C., Denovan, A., & Green, S. T. (2001). Behavioural and lifestyle study of women using a drop-in centre for female street sex workers in Glasgow, Scotland: A 10 year comparative study. *Addiction Research & Theory*, 9(1), 43-58.
- Gilroy, H., Nava, A., Maddoux, J., McFarlane, J., Symes, L., Koci, A., & Fredland, N. (2015a). Poverty, partner abuse, and women's mental health: New knowledge for better practice. *Journal of Social Service Research*, 41(2), 145-157.
- Gilroy, H., Symes, L., & McFarlane, J. (2015b). Economic solvency in the context of violence against women: A concept analysis. *Health & Social Care in the Community*, 23(2), 97-106.
- Ginn, J. (2013). Austerity and inequality. exploring the impact of cuts in the UK by gender and age. *Research on Ageing and Social Policy*, 1(1), 28-53.



- Giordano, P. C., Cernkovich, S. A., & Rudolph, J. L. (2002). Gender, crime, and desistance: Toward a theory of cognitive transformation. *American Journal of Sociology*, *107*(4), 990-1064.
- Giugliano, R. J. (2004). The systemic neglect of New York's young adults with mental illness. *Psychiatric Services*, *55*(4), 451-453.
- Glueck, S., & Glueck, E. T. (1974). *Of delinquency and crime: A panorama of years of search and research*. CC Thomas Springfield, IL.
- Goetz, T. G., Becker, J. B., & Mazure, C. M. (2021). Women, opioid use and addiction. *The FASEB Journal*, *35*(2), e21303.
- Goffman, E. (2009). *Stigma: Notes on the management of spoiled identity*. Simon and Schuster.
- Goldhill, R. (2009). The Corston report: Reading between the lines. *The Prison Service Journal*, *184*, 13-19.
- Goode, E. (2019). *Deviant behavior*. Routledge.
- Goodman, A. (1990). Addiction: Definition and implications. *British Journal of Addiction*, *85*(11), 1403–1408.
- Gore, T., Bimpson, E., Dobson, J., & Parkes, S. (2021) *Local government responses to the COVID-19 pandemic in the UK: A thematic Review*. Sheffield Hallam University. Available from: <https://doi.org/10.7190/cresr.2021.6172521344>
- Gosline, A. (2007). Bored? *Scientific American Mind*, *18*(6), 20-27.
- Gosling, H. (2018). A critical insight into practitioners' lived experience of payment by results in the alcohol and drug treatment sector. *Critical Social Policy*, *38*(2), 244-261.
- Gossop, M., Powis, B., Griffiths, P., & Strang, J. (1995). Female prostitutes in south London: use of heroin, cocaine and alcohol, and their relationship to health risk behaviours. *AIDS care*, *7*(3), 253-260.

- Gottfried, H. (1998). Beyond patriarchy? theorising gender and class. *Sociology*, *32*(3), 451-468.
- Graham, H., & McNeill, F. (2017). Desistance: envisioning futures. In *Alternative criminologies* (pp. 433-451). Routledge.
- Granfield, R., & Cloud, W. (2001). Social context and “natural recovery”: The role of social capital in the resolution of drug-associated problems. *Substance use & Misuse*, *36*(11), 1543-1570.
- Green, C. A. (2006). Gender and use of substance abuse treatment services. *Alcohol Research & Health*, *29*(1), 55.
- Greenberg, N., Megnin-Viggars, O., & Leach, J. (2019). Occupational health professionals and 2018 NICE post-traumatic stress disorder guidelines. *Occupational Medicine (Oxford)*, *69*(6), 397-399. Available from: <https://doi.org/10.1093/occmed/kqz058>
- Greenfield, S. F., Back, S. E., Lawson, K., & Brady, K. T. (2010). Substance abuse in women. *Psychiatric Clinics*, *33*(2), 339-355.
- Greenfield, S. F., Brooks, A. J., Gordon, S. M., Green, C. A., Kropp, F., McHugh, R. K., Lincoln, M., Hien, D., & Miele, G. M. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and Alcohol Dependence*, *86*(1), 1-21.
- Greer, A., Bungay, V., Pauly, B., & Buxton, J. (2020). ‘Peer’ work as precarious: a qualitative study of work conditions and experiences of people who use drugs engaged in harm reduction work. *International Journal of Drug Policy*, *85*, 102922.
- Greer, I. (2016). Welfare reform, precarity and the re-commodification of labour. *Work, employment and society*, *30*(1), 162-173.
- Greer Murphy, A. (2017). Austerity in the United Kingdom: The intersections of spatial and gendered inequalities. *Area*, *49*(1), 122-124.

Grella, C. E. (2008). From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment. *Journal of Psychoactive Drugs*, 40(sup5), 327-343.

Griffiths, T., & Patterson, T. (2014). Work capability assessment concerns. *Journal of Poverty and Social Justice*, 22(1), 59-70.

Grosenick, J. K., & Hatmaker, C. M. (2000). Perceptions of staff attributes in substance abuse treatment. *Journal of Substance Abuse Treatment*, 19(3), 273-284.

Grover, C. (2017). Ending reassessment for employment and support allowance for some disabled people in the UK. *Disability & Society*, 32(8), 1269-1274.

Gulland, J. (2019). Only Those Unconscious or Asleep: Definitions of Incapacity for Work. In *Gender, Work and Social Control* (pp. 33-52). Palgrave Macmillan, London.

Gupta, A. (2017). Poverty and child neglect—the elephant in the room? *Families, Relationships and Societies*, 6(1), 21-36.

Gurd, A., & O'Brien, E. (2013). Californian 'John schools' and the social construction of prostitution. *Sexuality Research and Social Policy*, 10(2), 149-158.

Hall, W., & Carter, A. (2013). Anticipating possible policy uses of addiction neuroscience research. *Drugs: Education, Prevention and Policy*, 20(3), 249-257.

Hall, W., Carter, A., & Barnett, A. (2017). Disease or developmental disorder: Competing perspectives on the neuroscience of addiction. *Neuroethics*, 10(1), 103-110.

Hall, W., Carter, A., & Forlini, C. (2015). The brain disease model of addiction: Is it supported by the evidence, and has it delivered on its promises? *The Lancet Psychiatry*, 2(1), 105-110.

Hannah-Moffat, K. (2007). Gendering dynamic risk: Assessing and managing the maternal identities of women prisoners. *Gendered risks* (pp. 237-256). Routledge-Cavendish.

- Harcourt, C., Egger, S., & Donovan, B. (2005). *Sex work and the law. Sexual Health*, 2(3), 121-128.
- Hardy, K. & Caradonna, L. (1/7/2021). *Scrapping Britain's First Red Light District Will Be a Disaster For Sex Workers*. Novara Media. Available from: <https://novaramedia.com/2021/07/01/scrapping-britains-first-red-light-district-will-be-a-disaster-for-sex-workers/>
- Harris, M. E., & Fallot, R. D. (2001). *Using trauma theory to design service systems*. Jossey-Bass/Wiley.
- Harris, M., & Fallot, R. D. (2001b). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, 2001(89), 3-22.
- Harris, N. (2010). Conditional rights, benefit reform, and drug users: Reducing dependency? *Journal of Law and Society*, 37(2), 233-263.
- Hart, C. (2010). Austerity hysteria. *Mental Health Practice*, 14(2), 8-9.
- Hasenfeld, Y., & Garrow, E. E. (2012). Non-profit human-service organizations, social rights, and advocacy in a neoliberal welfare state. *Social Service Review*, 86(2), 295-322.
- Haslam, N., & Loughnan, S. (2014). Dehumanization and inhumanization. *Annual Review of Psychology*, 65, 399-423.
- Hastings, A., Bailey, N., Besemer, K., Bramley, G., Gannon, M., & Watkins, D. (2013). *Coping with the cuts?: Local government and poorer communities*. Joseph Rowntree Foundation York.
- Haynes, E., Crouch, E., Probst, J., Radcliff, E., Bennett, K., & Glover, S. (2020). Exploring the association between a parent's exposure to adverse childhood experiences (ACEs) and outcomes of depression and anxiety among their children. *Children and Youth Services Review*, 113, 105013.

- Heather, N. (2005). Motivational interviewing: Is it all our clients need?. *Addiction Research & Theory*, 13(1), 1-18.
- Heather, N. (2017). Q: Is addiction a brain disease or a moral failing? A: Neither. *Neuroethics*, 10(1), 115-124.
- Henden, E., Melberg, H., & Røgeberg, O. (2013). Addiction: Choice or compulsion? *Frontiers in Psychiatry*, 4, 77.
- Henriksson, C. M., Liedberg, G. M., & Gerdle, B. (2005). Women with fibromyalgia: Work and rehabilitation. *Disability and Rehabilitation*, 27(12), 685-694.
- Hester, M., & Westmarland, N. (2004). *Tackling street prostitution: Towards a holistic approach*. Home Office Research, Development and Statistics Directorate.
- Hien, D., Cohen, L., & Campbell, A. (2005). Is traumatic stress a vulnerability factor for women with substance use disorders? *Clinical Psychology Review*, 25(6), 813-823.
- HM Government. (2010). Drug Strategy 2010: Reducing Demand, Restricting Supply, Building Recovery. London: Home Office.
- HM Government. (2017). *Drug Strategy 2017*. London: Home Office.
- HM Government. (2021). *Drug Strategy 2021: From Harm to Hope*. London: Home Office.
- HM Government. (1998). *Human Rights Act*. London: Home Office.
- Hodkinson, S., & Robbins, G. (2013). The return of class war conservatism? Housing under the UK Coalition Government. *Critical Social Policy*, 33(1), 57-77.
- Hohl, K., & Stanko, E. A. (2015). Complaints of rape and the criminal justice system: Fresh evidence on the attrition problem in England and Wales. *European journal of criminology*, 12(3), 324-341.
- Holly, J. (2017). Mapping the Maze: Services for women experiencing multiple disadvantage in England and Wales. *London: Agenda & AVA*.

- Holmwood, J. (2000). Three pillars of welfare state theory: TH Marshall, Karl Polanyi and Alva Myrdal in defence of the national welfare state. *European Journal of Social Theory*, 3(1), 23-50.
- Horn, D. (2015). The criminal body: Lombroso and the anatomy of deviance. Routledge.
- Horton, E. G., Diaz, N., Peluso, P. R., Mullaney, D., Weiner, M., & McIlveen, J. W. (2009). Relationships between trauma, posttraumatic stress disorder symptoms, dissociative symptoms, and lifetime heroin use among individuals who abuse substances in residential treatment. *Journal of Addictions & Offender Counselling*, 29(2), 81-95.
- Howatt, W. A. (2003). Choice theory: A core addiction recovery tool. *International Journal of Reality Therapy*, 22(2).
- Hubbard, P. (1998). Community action and the displacement of street prostitution: Evidence from British cities. *Geoforum*, 29(3), 269-286.
- Hubbard, P., & Sanders, T. (2003). Making space for sex work: Female Street prostitution and the production of urban space. *International Journal of Urban and Regional Research*, 27(1), 75-89.
- Hubbard, P., & Scoular, J. (2009). Making the vulnerable more vulnerable? The contradictions of street prostitution policy.
- Hughes, D. M. (2005). The demand for victims of sex trafficking. Women's Studies Program, University of Rhode Island, 26.
- Humphreys, C., & Absler, D. (2011). History repeating: Child protection responses to domestic violence. *Child & Family Social Work*, 16(4), 464-473.
- Hunt, N., & Stevens, A. (2004). Whose harm? harm reduction and the shift to coercion in UK drug policy. *Social Policy and Society*, 3(4), 333-342.

- Hyman, S. E. (2007). The neurobiology of addiction: Implications for voluntary control of behavior. *The American Journal of Bioethics*, 7(1), 8-11.
- Iacobucci, G. (2019). Drug deaths: Scottish minister vows to tackle “public health emergency”. *British Medical Journal Publishing Group*.
- Ishkanian, A. (2014). Neoliberalism and violence: The big society and the changing politics of domestic violence in England. *Critical Social Policy*, 34(3), 333-353.
- Jacobs, B. A., & Miller, J. (1998). Crack dealing, gender, and arrest avoidance. *Social Problems*, 45(4), 550-569.
- Jakupcak, M. (2003). Masculine gender role stress and men’s fear of emotions as predictors of self-reported aggression and violence. *Violence and Victims*, 18(5), 533-541.
- Jeal, N., Macleod, J., Salisbury, C., & Turner, K. (2017). Identifying possible reasons why female street sex workers have poor drug treatment outcomes: A qualitative study. *BMJ Open*, 7(3), e013018.
- Jeal, N., Macleod, J., Turner, K., & Salisbury, C. (2015). Systematic review of interventions to reduce illicit drug use in female drug-dependent street sex workers. *BMJ Open*, 5(11), e009238.
- Jeal, N., Patel, R., Redmond, N. M., Kesten, J. M., Ramsden, S., Macleod, J., Coast, J., Telfer, M., Wilcox, D., & Nowland, G. (2018). Drug use in street sex workers (DUSK) study protocol: A feasibility and acceptability study of a complex intervention to reduce illicit drug use in drug-dependent female street sex workers. *BMJ Open*, 8(11), e022728.
- Jean, R. (2015). Prostitution and the Concept of Agency. In *Women and Violence* (pp. 52-67). Palgrave Macmillan, London.
- Jeffreys, S. (2008). *The idea of prostitution*. Spinifex Press.

- Jessop, B. (2015). Margaret Thatcher and Thatcherism: Dead but not buried. *British Politics*, 10(1), 16-30.
- Jewkes, R. (2002). Intimate partner violence: Causes and prevention. *The Lancet*, 359(9315), 1423-1429.
- Jiwani, Y., & Young, M. L. (2006). Missing and murdered women: Reproducing marginality in news discourse. *Canadian Journal of Communication*, 31(4).
- Jones, A. (2019). Help seeking in the perinatal period: A review of barriers and facilitators. *Social Work in Public Health*, 34(7), 596-605.
- Jones, A., Pierce, M., Sutton, M., Mason, T., & Millar, T. (2018). Does paying service providers by results improve recovery outcomes for drug misusers in treatment in England? *Addiction*, 113(2), 279-286.
- Joseph Rowntree Foundation, Goulden, C., & D'Arcy, C. (2014). *A definition of poverty*. York: Joseph Rowntree Foundation.
- Kantola, J., & Squires, J. (2004). Discourses surrounding prostitution policies in the UK. *European Journal of Women's Studies*, 11(1), 77-101.
- Karasaki, M., Fraser, S., Moore, D., & Dietze, P. (2013). The place of volition in addiction: Differing approaches and their implications for policy and service provision. *Drug and Alcohol Review*, 32(2), 195-204.
- Kaschak, E. (1992). *Engendered lives*. New York: Basic Books.
- Kemshall, H. (2002). Effective practice in probation: An example of 'advanced liberal' responsabilisation? *The Howard Journal of Criminal Justice*, 41(1), 41-58.
- Kendler, K. S., Hettema, J. M., Butera, F., Gardner, C. O., & Prescott, C. A. (2003). Life event dimensions of loss, humiliation, entrapment, and danger in the prediction of onsets of major depression and generalized anxiety. *Archives of general psychiatry*, 60(8), 789-796.



Kennedy, G. E. (1978). Women Redeemed: Dickens's Fallen Women. *Dickensian*, 74(384), 42.

Kenny, K. S., Barrington, C., & Green, S. L. (2015). "I felt for a long time like everything beautiful in me had been taken out": Women's suffering, remembering, and survival following the loss of child custody. *International Journal of Drug Policy*, 26(11), 1158-1166.

Kesler, K. (2002). Is a feminist stance in support of prostitution possible? An exploration of current trends. *Sexualities*, 5(2), 219-235.

Khalifeh, H., Hargreaves, J., Howard, L. M., & Birdthistle, I. (2013). Intimate partner violence and socioeconomic deprivation in England: Findings from a national cross-sectional survey. *American Journal of Public Health*, 103(3), 462-472.

Kielty, S. (2008). Working hard to resist a 'bad mother' label: Narratives of non-resident motherhood. *Qualitative Social Work*, 7(3), 363-379.

Kiker, B. F. (1966). The historical roots of the concept of human capital. *Journal of Political Economy*, 74(5), 481-499.

Kiser, L. J., & Black, M. M. (2005). Family processes in the midst of urban poverty: What does the trauma literature tell us? *Aggression and Violent Behavior*, 10(6), 715-750.

Kissil, K., & Davey, M. (2010). The prostitution debate in feminism: Current trends, policy and clinical issues facing an invisible population. *Journal of Feminist Family Therapy*, 22(1), 1-21.

Klambauer, E. (2018). Policing roulette: Sex workers' perception of encounters with police officers in the indoor and outdoor sector in England. *Criminology & Criminal Justice*, 18(3), 255-272.

Klee, H., Jackson, M., & Lewis, S. (2002). *Drug misuse and motherhood*. Routledge London.

- Klest, B. (2012). Childhood trauma, poverty, and adult victimization. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(3), 245.
- Kretzmann, J. P., McKnight, J., & Puntenney, D. (2005). *Discovering community power: A guide to mobilizing local assets and your organization's capacity*. Evanston, IL: Asset- Based Community Development Institute, School of Education and Social Policy, North- western University.
- Krusi, A., Pacey, K., Bird, L., Taylor, C., Chettiar, J., Allan, S., Bennett, D., Montaner, J., Kerr, T., & Shannon, K. (2014). Criminalisation of clients: Reproducing vulnerabilities for violence and poor health among street-based sex workers in Canada—A qualitative study. *BMJ Open*, 4, e005191. Available from: <https://doi.org/10.1136/bmjopen-2014005191>
- Kulesza, M., Matsuda, M., Ramirez, J. J., Werntz, A. J., Teachman, B. A., & Lindgren, K. P. (2016). Towards greater understanding of addiction stigma: Intersectionality with race/ethnicity and gender. *Drug and Alcohol Dependence*, 169, 85-91.
- Kurtz, S. P., Surratt, H. L., Kiley, M. C., & Inciardi, J. A. (2005). Barriers to health and social services for street-based sex workers. *Journal of Health Care for the Poor and Underserved*, 16(2), 345-361.
- Kvale, S. (1996). Interview Views: An Introduction to Qualitative Research Interviewing. Thousand Oaks, CA: Sage Publications.
- Laird, J. J., Klettke, B., Hall, K., Clancy, E., & Hallford, D. (2020). Demographic and psychosocial factors associated with child sexual exploitation: A systematic review and meta-analysis. *JAMA Network Open*, 3(9), e2017682.
- Lancaster K. Performing the Evidence-Based Drug Policy Paradigm. *Contemporary Drug Problems*. 2016;43(2):142-153.

Lancaster, K., Duke, K., & Ritter, A. (2015). Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports. *International Journal of Drug Policy*, 26(7), 617-625.

Lancaster, K., Ritter, A., & Diprose, R. (2018). Recasting participation in drug policy. *Contemporary Drug Problems*, 45(4), 351-365.

Laudet, A. (2013). " Life in recovery": Report on survey findings. *Faces & Voices of Recovery*.

Law, J. (2013). Collateral realities. The politics of knowledge (pp. 156-178). Routledge.

Lazarus, L., Deering, K. N., Nabess, R., Gibson, K., Tyndall, M. W., & Shannon, K. (2012). Occupational stigma as a primary barrier to health care for street-based sex workers in Canada. *Culture, Health & Sexuality*, 14(2), 139-150.

Lee, C. (2015). Policing prostitution, 1856–1886: Deviance, surveillance and morality. Routledge.

Leshner, A. I. (1996). Understanding drug addiction: Implications for treatment. *Hospital Practice*, 31(10), 47-59.

Leshner, A. I. (2001). Addiction is a brain disease. *Issues in Science and Technology*, 17(3), 75-80.

Levine, H. G. (2009). Review of "the globalisation of addiction: A study in poverty of the spirit" by Bruce K. Alexander. *Harm Reduction Journal*, 6, 12. Available from: <https://doi.org/10.1186/1477-7517-6-12>

Levy, N. (2006). Autonomy and addiction. *Canadian Journal of Philosophy*, 36(3), 427-447.

Lewis, M. (2017). Addiction and the brain: Development, not disease. *Neuroethics*, 10(1), 7-18.

Liazos, A. (1972). The poverty of the sociology of deviance: Nuts, sluts, and Perverts. *Social Problems*, 20(1), 103-120.

Lindsay, C., & Houston, D. (2013). Disability benefits, welfare reform and employment policy. Springer.

Lipsky, M. (2010). Street-level bureaucracy: Dilemmas of the individual in public service. Russell Sage Foundation.

Logan, C. (23/06/2019). *Warning over Pause project that only supports women using contraception.* The National Scotland. Available from: <https://www.thenational.scot/news/17724137.warning-pause-project-supports-women-using-contraception/>

London, M. (2005). History of addiction: A UK perspective. *American Journal on Addictions*, 14(2), 97-105.

Loopstra, R., Reeves, A., Taylor-Robinson, D., Barr, B., McKee, M., & Stuckler, D. (2015). Austerity, sanctions, and the rise of food banks in the UK. *Bmj*, 2015 Apr 8;350:h1775.

Lopez-Martinez, A. E., Serrano-Ibanez, E. R., Ruiz-Párraga, G. T., Gomez-Perez, L., Ramirez-Maestre, C., & Esteve, R. (2018). Physical health consequences of interpersonal trauma: A systematic review of the role of psychological variables. *Trauma, Violence, & Abuse*, 19(3), 305-322.

Love, R. (2015). Street level prostitution: A systematic literature review. *Issues in Mental Health Nursing*, 36(8), 568-577.

Lucas, A. M. (2005). The work of sex work: Elite prostitutes' vocational orientations and experiences. *Deviant Behavior*, 26(6), 513-546.

Luoma, J. B., Twohig, M. P., Waltz, T., Hayes, S. C., Roget, N., Padilla, M., & Fisher, G. (2007). An investigation of stigma in individuals receiving treatment for substance abuse. *Addictive Behaviors*, 32(7), 1331-1346.

Luty, J. (2003). What works in drug addiction? *Advances in Psychiatric Treatment*, 9(4), 280-287.

Lynch, T. (2015). Regulating street sex workers: A reflection on the use and reform of anti-social behaviour measures. *The management of change in criminal justice* (pp. 186- 205). Palgrave Macmillan, London.

Lyon, E. (2000). Welfare, poverty, and abused women: new research and its *implications*. National Resource Center on Domestic Violence Harrisburg, PA.

Macedo, T., Wilhelm, L., Gonçalves, R., Coutinho, E. S. F., Vilete, L., Figueira, I., & Ventura, P. (2014). Building resilience for future adversity: A systematic review of interventions in non-clinical samples of adults. *BMC Psychiatry*, *14*(1), 1-8.

MacGregor, S. (1999). Welfare, neo-liberalism and new paternalism: Three ways for social policy in late capitalist societies. *Capital & Class*, *23*(1), 91-118.

Macgregor, S. (2017). Drug policy in the United Kingdom. In *European Drug Policies* (pp. 217-237). Routledge.

MacKinnon, C. A. (1982). Feminism, Marxism, method, and the state: An agenda for theory. *Signs: Journal of Women in Culture and Society*, *7*(3), 515-544.

MacKinnon, C. A. (1989). Sexuality, pornography, and method:" Pleasure under patriarchy. *Ethics*, *99*(2), 314-346.

MacLeavy, J. (2011). A 'new politics of austerity, workfare and gender? the UK coalition government's welfare reform proposals. *Cambridge Journal of Regions, Economy and Society*, *4*(3), 355-367.

MacInnes, T., Bushe, S., Tinson, A., Born, T. B., & Aldridge, H. (2014). *Monitoring poverty and social exclusion 2014*. York: Joseph Rowntree Foundation.

Mahase, E. (2019). Drug policy: MPs call for radical change to stem rising death rate. *BMJ: British Medical Journal (Online)*, *367*.

Maher, L., & Daly, K. (1996). Women in the street-level drug economy: Continuity or change? *Criminology*, *34*(4), 465-492.

- Main, M., Hesse, E., & Hesse, S. (2011). Attachment theory and research: Overview with suggested applications to child custody. *Family Court Review*, 49(3), 426-463.
- Malloch, M. (2004a). Missing out: Gender, drugs and justice. *Probation Journal*, 51(4), 295-308.
- Malloch, M. (2016). Justice for women: A penal utopia? *Justice, Power and Resistance*, 151-169.
- Malloch, M. S. (2004). Not 'fragrant' at all: Criminal justice responses to 'risky' women. *Critical Social Policy*, 24(3), 385-405.
- Malloch, M., & McIvor, G. (2010). Women, drugs and community interventions. Working with women offenders in the community (pp. 216-241). Willan.
- Malloch, M., & McIvor, G. (2011). Women and community sentences. *Criminology & Criminal Justice*, 11(4), 325-344.
- Mandel, D. (2010). Child welfare and domestic violence: Tackling the themes and thorny questions that stand in the way of collaboration and improvement of child welfare practice. *Violence Against Women*, 16(5), 530-536.
- Månsson, S., & Hedin, U. (1999). Breaking the Matthews effect—on women leaving prostitution. *International Journal of Social Welfare*, 8(1), 67-77.
- Marcovitz, E. (2018). *Dignity matters* (pp. 61-72). Routledge.
- Marinetto, M. (2011). A Lipskian analysis of child protection failures from Victoria Climbié to 'baby p': A street-level re-evaluation of joined-up governance 1. *Public Administration*, 89(3), 1164-1181.
- Marr, B. (2008). Making the invisible visible. *Journal of Accountancy*, 206(3), 64.
- Marryat, L., & Frank, J. (2019). Factors associated with adverse childhood experiences in Scottish children: A prospective cohort study. *BMJ Paediatrics Open*, 3(1)

Martin, D., & Wilcox, P. (2012). Women, welfare and the carceral state. In *Criminalisation and Advanced Marginality* (pp. 151-170). Policy Press.

Martin, F. S., & Aston, S. (2014). A “special population” with “unique treatment needs”:

Dominant representations of “women's substance abuse” and their effects. *Contemporary Drug Problems*, 41(3), 335-360.

Maruna, S. (2001). *Making good*. Washington, DC: American Psychological Association. Maruna, S. (2010). Mixed method research in criminology: Why not go both ways?

In *Handbook of quantitative criminology* (pp. 123-140). Springer, New York, NY.

Maruna, S. (2012). Elements of successful desistance signalling. *Criminology & Pub.Pol'Y*, 11, 73.

Masarik, A. S., & Conger, R. D. (2017). Stress and child development: A review of the family stress model. *Current Opinion in Psychology*, 13, 85-90.

Mason, J. (2017). Qualitative researching. Sage.

Mastrocola, E. L., Taylor, A. K., & Chew-Graham, C. (2015). Access to healthcare for long-term conditions in women involved in street-based prostitution: A qualitative study. *BMC Family Practice*, 16(1), 1-7.

Maté, G. (2008). In the realm of hungry ghosts: Close encounters with addiction.

Random House Digital, Inc.

Maté, G. (2012). Addiction: Childhood trauma, stress and the biology of addiction. *Journal of Restorative Medicine*, 1(1), 56-63.

Matheson, C., & Weightman, E. (2021). Research and recovery: Can patient participation in research promote recovery for people with complex post-traumatic stress disorder, CPTSD? *Health Expectations*, 24, 62-69.

- Mathieson, A., Branam, E., & Noble, A. (2015). Prostitution policy: Legalization, decriminalization and the Nordic model. *Seattle J. Soc.just.*, *14*, 367.
- Matthews, R., Easton, H., Young, L., & Bindel, J. (2014). *Exiting, policy and practice. Exiting prostitution* (pp. 122-149). Springer.
- Matto, H. C., & Cleaveland, C. L. (2016). A social-spatial lens to examine poverty, violence, and addiction. *Journal of Social Work Practice in the Addictions*, *16*(1-2), 7-23.
- May, T., & Hunter, G. (2013). Sex work and problem drug use in the UK: the links, problems and possible solutions. In *Sex work now* (pp. 190-210). Willan.
- Maynard, A., Street, A., & Hunter, R. (2011). Using 'payment by results' to fund the treatment of dependent drug users—proceed with care! *Addiction*, *106*(10), 1725-1729.
- McBride, B., Shannon, K., Murphy, A., Wu, S., Erickson, M., Goldenberg, S. M., & Krüsi, A. (2021). Harms of third-party criminalisation under end-demand legislation: Undermining sex workers' safety and rights. *Culture, Health & Sexuality*, *23*(9), 1165-1181.
- McCarthy, L., Batty, E., Beatty, C., Casey, R., Foden, M., & Reeve, K. (2015). Homeless people's experiences of welfare conditionality and benefit sanctions.
- McCarthy, L., Parr, S., Green, S., & Reeve, K. (2020). Understanding models of support for people facing multiple disadvantage: A Literature Review.
- McCluskey, M. T. (2003). Efficiency and social citizenship: Challenging the neoliberal attack on the welfare state. *Ind.LJ*, *78*, 783.
- McCray, K., Wesely, J. K., & Rasche, C. E. (2011). Rehab retrospect: Former prostitutes and the (re) construction of deviance. *Deviant Behavior*, *32*(8), 743-768.
- McCulloch, T. (2005). Probation, social context and desistance: Retracing the relationship. *Probation Journal*, *52*(1), 8-22.



McDonald, R., Cheraghi-Sohi, S., Tickle, M., Roland, M., Doran, T., Campbell, S., ... & Milsom, K. (2010). The impact of incentives on the behaviour and performance of primary care professionals. *Queen's Printer and Controller of HMSO*.

McDowell, L. (2005). Love, money, and gender divisions of labour: Some critical reflections on welfare-to-work policies in the UK. *Journal of Economic Geography*, 5(3), 365-379.

McDonough, P. (2000). Job insecurity and health. *International journal of health services*, 30(3), 453-476.

McGarvey, D. (2019). *Poverty safari*. Rizzoli.

McGrath, L., Griffin, V., & Mundy, E. (2015). The psychological impact of austerity: A briefing paper.

McKay, A., Campbell, J., Thomson, E., & Ross, S. (2013). Economic recession and recovery in the UK: What's gender got to do with it? *Feminist Economics*, 19(3), 108-123.

McKeganey, N. (2006a). The lure and the loss of harm reduction in UK drug policy and practice. *Addiction Research & Theory*, 14(6), 557-588.

McKeganey, N. (2006b). Street prostitution in Scotland: The views of working women. *Drugs: Education, Prevention and Policy*, 13(2), 151-166.

McKeganey, N. (2012). Harm reduction at the crossroads and the rediscovery of drug user abstinence. *Drugs: Education, Prevention and Policy*, 19(4), 276-283.

McKeganey, N. (2014). Clear rhetoric and blurred reality: The development of a recovery focus in UK drug treatment policy and practice. *International Journal of Drug Policy*, 25(5), 957-963.

McKeganey, N. P., & Barnard, M. (1996). *Sex work on the streets: Prostitutes and their clients*. Open University Press Buckingham.

- McKenzie, L. (2015). *Getting by: Estates, class and culture in austerity Britain*. Policy Press.
- McLean, K. (2016). "There's nothing here": Deindustrialization as risk environment for overdose. *International Journal of Drug Policy*, 29, 19-26.
- McLellan, A. T., Hagan, T. A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction*, 93(10), 1489–1499
- McLeod, S. (2007). Maslow's hierarchy of needs. *Simply Psychology*, 1(1-18)
- McNaughton, C. C., & Sanders, T. (2007). Housing and transitional phases out of 'disordered' lives: The case of leaving homelessness and street sex work. *Housing Studies*, 22(6), 885-900.
- McPhee, I., Brown, A., & Martin, C. (2013). Stigma and perceptions of recovery in Scotland: a qualitative study of injecting drug users attending methadone treatment. *Drugs and alcohol today*.
- McWade, B. (2016). Recovery-as-policy as a form of neoliberal state making. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity, and Practice*, 5(3), 62–81.
- Mellor, R., & Lovell, A. (2012). The lived experience of UK street-based sex workers and the health consequences: An exploratory study. *Health Promotion International*, 27(3), 311-322.
- Melrose, M. (2009) 'Out on the streets and out of control? Drug-using sex workers and the prostitution strategy' in Phoenix, J. (ed) 'Regulating Sex for Sale: Prostitution, Policy Reform and the UK'. Policy Press.
- Mendoza, K. (2014). *Austerity: The demolition of the welfare state and the rise of the zombie economy*. New Internationalist.

- Messina, N., Calhoun, S., & Braithwaite, J. (2014). Trauma-informed treatment decreases posttraumatic stress disorder among women offenders. *Journal of Trauma & Dissociation*, *15*(1), 6-23.
- Miller, C. L., Fielden, S. J., Tyndall, M. W., Zhang, R., Gibson, K., & Shannon, K. (2011). Individual and structural vulnerability among female youth who exchange sex for survival. *Journal of Adolescent Health*, *49*(1), 36-41.
- Miller, D. (2012). Distributing responsibilities. Global responsibilities (pp. 117-138). Routledge.
- Miller, K. M., Cahn, K., Anderson-Nathe, B., Cause, A. G., & Bender, R. (2013). Individual and systemic/structural bias in child welfare decision making: Implications for children and families of color. *Children and Youth Services Review*, *35*(9), 1634-1642.
- Miller, M., & Neaigus, A. (2002). An economy of risk: Resource acquisition strategies of inner-city women who use drugs. *International Journal of Drug Policy*, *13*(5), 409-418.
- Millman, R. B., Khuri, E. T., & Nyswander, M. E. (1972). *A model for the study and treatment of heroin addiction in an urban adolescent population*. Paper presented at the Proceedings of the Fourth National Conference on Methadone Treatment. NAPAN, 47-49.
- Miralles, M., Stierand, M. B., Lee, B., & Dörfler, V. (2020). *Methodological and emotional challenges of studying traumatic experiences*. Paper presented at the BAM 2020: 34th Annual Conference of the British Academy of Management,
- Mitra, S., Lee, W., Hayashi, K., Boyd, J., Milloy, M. J., Dong, H., Wood, E., & Kerr, T. (2021). A gender comparative analysis of post-traumatic stress disorder among a community-based cohort of people who use drugs in Vancouver, Canada. *Addictive Behaviors*, *115*, 106793.

- Monaghan, M. (2011). Evidence versus politics: Exploiting research in UK drug policy making? Policy Press.
- Monroe, J. (2005). Women in street prostitution: The result of poverty and the brunt of inequity. *Journal of Poverty*, 9(3), 69-88.
- Moore, K., & Measham, F. (2013). Exploring emerging perspectives on gender and drug use. *Emerging Perspectives on Substance Misuse*, 80-97.
- Moran, R., & Farley, M. (2019). Consent, coercion, and culpability: Is prostitution stigmatized work or an exploitive and violent practice rooted in sex, race, and class inequality? *Archives of Sexual Behavior*, 48(7), 1947-1953.
- Morgan, N. (2014). The heroin epidemic of the 1980 s and 1990 s and its effect on crime trends.
- Morris, K., Mason, W., Bywaters, P., Featherstone, B., Daniel, B., Brady, G., Bunting, L., Hooper, J., Mirza, N., & Scourfield, J. (2018). Social work, poverty, and child welfare interventions. *Child & Family Social Work*, 23(3), 364-372.
- Morrow, M., Hankivsky, O., & Varcoe, C. (2004). Women and violence: The effects of dismantling the welfare state. *Critical Social Policy*, 24(3), 358-384.
- Mortimer, S., Fileborn, B., & Henry, N. (2021). Beyond Formal Ethics Reviews: Reframing the Potential Harms of Sexual Violence Research. *Australian Feminist Studies*, 36(108), 142-155.
- Mulia, N. (2000). Questioning sex: Drug-using women and heterosexual relations. *Journal of Drug Issues*, 30(4), 741-765.
- Mulia, N. (2002). Ironies in the pursuit of well-being: The perspectives of low-income, substance-using women on service institutions. *Contemporary Drug Problems*, 29(4), 711-748.
- Mulia, N., Schmidt, L., Bond, J., Jacobs, L., & Korcha, R. (2008). Stress, social support and problem drinking among women in poverty. *Addiction*, 103(8), 1283-1293.

Munro, V. E., & Scoular, J. (2012). Abusing vulnerability? contemporary law and policy responses to sex work in the UK. *Feminist Legal Studies*, 20(3), 189-206.

Murphy, L. S. (2010). Understanding the social and economic contexts surrounding women engaged in street-level prostitution. *Issues in Mental Health Nursing*, 31(12), 775-784.

Nader, M. A., Czoty, P. W., Gould, R. W., & Riddick, N. V. (2008). Positron emission tomography imaging studies of dopamine receptors in primate models of addiction. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 363(1507), 3223-3232.

Najavits, L. M. (2015). Trauma and substance abuse: A clinician's guide to treatment. In

U. Schnyder & M. Cloitre (Eds.), *Evidence based treatments for trauma-related psychological disorders: A practical guide for clinicians* (pp. 317–330). Springer International Publishing AG. Available from: <https://doi.org/10.1007/978-3-319-07109-07109-1>

[1 16](#)

Najavits, L. M., Sonn, J., Walsh, M., & Weiss, R. D. (2004). Domestic violence in women with PTSD and substance abuse. *Addictive Behaviors*, 29(4), 707-715.

Najavits, L. M., Weiss, R. D., & Shaw, S. R. (1997). The link between substance abuse and posttraumatic stress disorder in women: A research review. *American Journal on Addictions*, 6(4), 273-283.

Neale, J. (1998). Drug users' views of drug service providers. *Health & Social Care in the Community*, 6(5), 308-317.

Neale, J., Nettleton, S., & Pickering, L. (2013). Does recovery-oriented treatment prompt heroin users prematurely into detoxification and abstinence programmes? Qualitative study. *Drug and Alcohol Dependence*, 127(1-3), 163-169.

Neale, J., Nettleton, S., & Pickering, L. (2014). Gender sameness and difference in recovery from heroin dependence: A qualitative exploration. *International Journal of Drug Policy*, 25(1), 3-12.

Neale, J., Tompkins, C. N., Marshall, A. D., Treloar, C., & Strang, J. (2018). Do women with complex alcohol and other drug use histories want women-only residential treatment? *Addiction*, 113(6), 989-997.

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D.,

Wykes, T., & Strang, J. (2015). "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. *Drugs: Education, Prevention and Policy*, 22(1), 26-34.

Nelson-Zlupko, L., Dore, M. M., Kauffman, E., & Kaltenbach, K. (1996). Women in recovery: Their perceptions of treatment effectiveness. *Journal of Substance Abuse Treatment*, 13(1), 51-59.

Nettleton, S. (2020). *The sociology of health and illness*. John Wiley & Sons.

Newcomer, K.E., Hatry, H. P., & Wholey, J.S. (2015). Conducting semi-structured interviews. In: *K. E. Newcomer, H. P. Hatry, & J. S. Wholey, J.*

S. (Eds.). *Handbook of Practical Program Evaluation*, 492 -505.

Nutt, D. (2010). Science and non-science in UK drug policy. *Addiction (Abingdon, England)*, 105(7), 1154.

Nutt, D. J., King, L. A., & Phillips, L. D. (2010). Drug harms in the UK: A multicriteria decision analysis. *The Lancet*, 376(9752), 1558-1565.

Nyashanu, M., Pfende, F., & Ekpenyong, M. (2020). Exploring the challenges faced by frontline workers in health and social care amid the COVID-19 pandemic: Experiences of

frontline workers in the English Midlands region, UK. *Journal of Interprofessional Care*, 34(5), 655-661.

- O'Hara, M. (2015). *Austerity bites: A journey to the sharp end of cuts in the UK*. Policy Press.
- Ogden, P. (2009). Modulation, mindfulness, and movement in the treatment of trauma- related depression. *Pat*.
- Olf, M., Langeland, W., Draijer, N., & Gersons, B. P. R. (2007). Gender differences in posttraumatic stress disorder. *Psychological Bulletin*, 133(2), 183–204. Available from: <https://doi.org/10.1037/0033-2909.133.2.183>
- Olsen, A., Banwell, C., & Madden, A. (2014). Contraception, punishment and women who use drugs. *BMC Women's Health*, 14, 5. <https://doi.org/10.1186/1472-6874-14-5>
- O'Neill, M. (2003). Prostitute women now. In *Rethinking prostitution* (pp. 21-46). Routledge.
- O'Neill, M. (2013). *Prostitution and feminism: Towards a politics of feeling*. John Wiley & Sons.
- O'Neill, M. (2017). Sex work, censure and transgression. In *Social Censure and Critical Criminology* (pp. 191-215). Palgrave Macmillan, London.
- O'Neill, M., & Seal, L. (2012). *Transgressive imaginations: Crime, deviance and culture*.
- O'Neill, M., Campbell, R., Hubbard, P., Pitcher, J., & Scoular, J. (2008). Living with the other: Street sex work, contingent communities and degrees of tolerance. *Crime, Media, Culture*, 4(1), 73-93.
- Orford, J. (2001). Addiction as excessive appetite. *Addiction*, 96(1), 15-31.
- Quimette, P. C., Kimerling, R., Shaw, J., & Moos, R. H. (2000). Physical and sexual abuse among women and men with substance use disorders. *Alcoholism Treatment Quarterly*, 18(3), 7-17.

Owca, J. (2020). The Association between a Psychotherapist's Theoretical Orientation and Perception of Complex Trauma and Repressed Anger in the Fawn Response (Doctoral dissertation, The Chicago School of Professional Psychology).

Park, J. N., Decker, M. R., Bass, J. K., Galai, N., Tomko, C., Jain, K. M., Footer, K. H. A., & Sherman, S. G. (2021). Cumulative violence and PTSD symptom severity among urban street-based female sex workers. *Journal of Interpersonal Violence*, *36*(21-22), 10383- 10404.

Parker, Howard, Keith Bakx, and Russell Newcombe. *Living with heroin*. Milton Keynes: Open University Press, 1988.

Parker, H. (2004). Heroin epidemics and social exclusion in the UK, 1980–2000. *Heroin Addiction and The British System: Volume I Origins and Evolution*, 171.

Parsons, G. (2019). Drug-related deaths: practical responses to a growing problem. *Prescriber*, *30*(12), 19-23.

Patel, R., Redmond, N. M., Kesten, J. M., Linton, M., Horwood, J., Wilcox, D., Munafo, J., Coast, J., Macleod, J., & Jeal, N. (2020). Drug use in street sex workers (DUSSK) study: Results of a mixed methods feasibility study of a complex intervention to reduce illicit drug use in drug dependent female sex workers. *BMJ Open*, *10*(12), e036491.

Paternoster, R., & Bushway, S. (2009). Desistance and the "feared self": Toward an identity theory of criminal desistance. *The Journal of Criminal Law and Criminology*, 1103-1156.

Patrick, R. (2017). For whose benefit? The everyday realities of welfare reform. Policy Press.

Pearson, R. (2019). A feminist analysis of neoliberalism and austerity policies in the UK. *Soundings*, *71*(71), 28-39.

Peck, J. (2010). Constructions of neoliberal reason. OUP Oxford.



Peck, J., & Tickell, A. (2007). Conceptualizing neoliberalism, thinking Thatcherism.

Contesting Neoliberalism: Urban Frontiers, 26, 50.

Peckover, S. (2014). Domestic abuse, safeguarding children and public health: Towards an analysis of discursive forms and surveillant techniques in contemporary UK policy and practice. *British Journal of Social Work, 44*(7), 1770-1787.

Pelton, L. H. (2015). The continuing role of material factors in child maltreatment and placement. *Child Abuse & Neglect, 41*, 30-39.

Penfold, C., Hunter, G., Campbell, R., & Barham, L. (2004). Tackling client violence in female street prostitution: Inter-agency working between outreach agencies and the police. *Policing & Society, 14*(4), 365-379.

Phoenix, J. (2008). Be helped or else! Economic exploitation, male violence and prostitution policy in the UK. *Demanding sex: Critical reflections on the regulation of prostitution*, 35-50.

Pickard, H. (2017). Responsibility without blame for addiction. *Neuroethics, 10*(1), 169-180.

Pickard, H., Ahmed, S. H., & Foddy, B. (2015). Alternative models of addiction. *Frontiers in Psychiatry, 6*, 20.

Pickett, K. E., & Pearl, M. (2001). Multilevel analyses of neighbourhood socioeconomic context and health outcomes: A critical review. *Journal of Epidemiology & Community Health, 55*(2), 111-122.

Plummer, K. (2001). Documents of life 2: An invitation to a critical humanism. Sage.

Polanyi, K. (1944). The great transformation. Beacon Press, Boston.

Potterat, J. J., Rothenberg, R. B., Muth, S. Q., Darro, W. W., & Phillips-Plummer, L.

(1998). Pathways to prostitution: The chronology of sexual and drug abuse milestones. *Journal of Sex Research, 35*(4), 333-340.

Povey, L. (2017). Where welfare and criminal justice meet: Applying Wacquant to the experiences of marginalised women in austerity Britain. *Social Policy and Society*, 16(2), 271-281.

Powis, Michael Gossop, Catherine Bury, Katherine Payne, Paul Griffiths, Beverly. (2000). Drug-using mothers: Social, psychological and substance use problems of women opiate users with children. *Drug and Alcohol Review*, 19(2), 171-180.

Purtle, J. (2020). Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings. *Trauma, Violence, & Abuse*, 21(4), 725-740.

Pyett, P., & Warr, D. (1999). Women at risk in sex work: Strategies for survival. *Journal of Sociology*, 35(2), 183-197.

Radcliffe, P. (2011a). Motherhood, pregnancy, and the negotiation of identity: The moral career of drug treatment. *Social Science & Medicine*, 72(6), 984-991.

Radcliffe, P. (2011b). Substance-misusing women: Stigma in the maternity setting.

*British Journal of Midwifery*, 19(8), 497-506.

Rafter, N. H. (1990). The social construction of crime and crime control. *Journal of Research in Crime and Delinquency*, 27(4), 376-389.

Redman, J. (2020). *From welfare to warfare: class struggle on the margins* (Doctoral dissertation, Sheffield Hallam University).

Reed, B. G. (1985). Drug misuse and dependency in women: The meaning and implications of being considered a special population or minority group. *International Journal of the Addictions*, 20(1), 13-62.

Reed, B. G. (1987). Developing women-sensitive drug dependence treatment services: Why so difficult? *Journal of Psychoactive Drugs*, 19(2), 151-164.

Reeve, K. (2013). The morality of the "immoral": The case of homeless, drug-using street prostitutes. *Deviant Behavior*, 34(10), 824-840.

Reeve, K. (2017). Welfare conditionality, benefit sanctions and homelessness in the UK:

Ending the 'something for nothing culture' or punishing the poor? *Journal of Poverty and Social Justice*, 25(1), 65-78.

Reeve, K. (2018). Women and homelessness: Putting gender back on the agenda. *People, Place and Policy Online*, 11(3), 165-174.

Reeve, K., & Batty, E. (2011). The hidden truth about homelessness: Experiences of single homelessness in England.

Reeves, D. (2019). Dignity and austerity. *Number 314–February 2019*, 314, 45.

Reeves, E. (2015). A synthesis of the literature on trauma-informed care. *Issues in Mental Health Nursing*, 36(9), 698-709.

Reeves, J. L., & Campbell, R. (1994). *Cracked coverage*. Duke University Press.

Reinarman, C., & Levine, H. G. (2004). Crack in the rear-view mirror: Deconstructing drug war mythology. *Social Justice*, 31(1/2 (95-96), 182-199.

Reis, S. (2019). DWP data reveals: Women and children continue to be worst affected by poverty. UK Women's Budget Group, London.

Rekart, M. L. (2005). Sex-work harm reduction. *The Lancet*, 366(9503), 2123-2134.

Renedo, A., & Jovchelovitch, S. (2007). Expert knowledge, cognitive polyphasia and health: A study on social representations of homelessness among professionals working in the voluntary sector in London. *Journal of Health Psychology*, 12(5), 779-790.

Rex, S. (1999). Desistance from offending: Experiences of probation. *The Howard Journal of Criminal Justice*, 38(4), 366-383.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage.

Roach, J., Wood, K., Percy-Smith, B., Cartwright, A., Rogerson, M., & Armitage, R. (2020).

*An Independent Review of the Managed Approach to onstreet sex working in Leeds 2014-2020.* University of Huddersfield. Available from: [https://stlukesholbeck.org.uk/wpcontent/uploads/sites/5/2020/07/IR\\_Report\\_June\\_20\\_v2.pdf](https://stlukesholbeck.org.uk/wpcontent/uploads/sites/5/2020/07/IR_Report_June_20_v2.pdf)

Rodermond, E., Kruttschnitt, C., Slotboom, A., & Bijleveld, Catrien C. J. H. (2016). Female desistance: A review of the literature. *European Journal of Criminology*, 13(1), 3-28.

Rogers, A., & Pilgrim, D. (2002). *Mental health and inequality*. Macmillan International Higher Education.

Rogowski, S. (2015). From child welfare to child protection/safeguarding: A critical practitioner's view of changing conceptions, policies and practice. *Practice*, 27(2), 97-112.

Room, R. (2005). Stigma, social inequality and alcohol and drug use. *Drug and Alcohol Review*, 24(2), 143-155.

Rose, E. (2015). A feminist reconceptualisation of intimate partner violence against women: A crime against humanity and a state crime. Paper presented at the Women's Studies International Forum, 53 31-42.

Ross, C. E., Mirowsky, J., & Pribesh, S. (2001). Powerlessness and the amplification of threat: Neighborhood disadvantage, disorder, and mistrust. *American Sociological Review*, 568-591.

Roxburgh, A., Degenhardt, L., & Copeland, J. (2006). Posttraumatic stress disorder among female street-based sex workers in the greater Sydney area, Australia. *BMC Psychiatry*, 6(1), 1-12.

Roy, A., & Buchanan, J. (2016). The paradoxes of recovery policy: Exploring the impact of austerity and responsabilisation for the citizenship claims of people with drug problems. *Social Policy & Administration*, 50(3), 398-413.

Rubery, J. (2015). Austerity, the public sector and the threat to gender equality-geary lecture 2014. *The Economic and Social Review*, 46(1), 1-27.

Saar-Heiman, Y., & Gupta, A. (2020). The poverty-aware paradigm for child protection: A critical framework for policy and practice. *The British Journal of Social Work*, 50(4), 1167-1184.

Sagar, T. (2007). Tackling on-street sex work: Anti-social behaviour orders, sex workers and inclusive inter-agency initiatives. *Criminology & Criminal Justice*, 7(2), 153-168.

Sagar, T. (2010). Anti-social powers and the regulation of street sex work. *Social Policy and Society*, 9(1), 101-109.

Sallmann, J. (2010). Living with stigma: Women's experiences of prostitution and substance use. *Affilia*, 25(2), 146-159.

Sampson, R. J., & Laub, J. H. (1992). Crime and deviance in the life course. *Annual Review of Sociology*, 18(1), 63-84.

Sanders, T. (2004). The risks of street prostitution: Punters, police and protesters. *Urban Studies*, 41(9), 1703-1717.

Sanders, T. (2005a). 'It's Just Acting': Sex Workers' Strategies for Capitalizing on Sexuality. *Gender, Work and Organization*, 12, 319-342.

Sanders, T. (2005b). Blinded by morality? prostitution policy in the UK. *Capital & Class*, 29(2), 9-15.

Sanders, T. (2006). Sexing up the subject: Methodological nuances in researching the female sex industry. *Sexualities*, 9(4), 449-468.

- Sanders, T. (2007). Becoming an ex-sex worker: Making transitions out of a deviant career. *Feminist Criminology*, 2(1), 74-95.
- Sanders, T. (2009a). Controlling the 'anti sexual' city: Sexual citizenship and the disciplining of female street sex workers. *Criminology & Criminal Justice*, 9(4), 507-525.
- Sanders, T. (2009b). UK sex work policy: Eyes wide shut to voluntary and indoor sex. *Regulating Sex for Sale: Prostitution Policy Reform in the UK*, 67.
- Sanders, T., & Campbell, R. (2007). Designing out vulnerability, building in respect: Violence, safety and sex work policy. *The British Journal of Sociology*, 58(1), 1-19.
- Sanders-McDonagh, E., & Neville, L. (2017). Too little, too late: Domestic violence policy in the age of austerity. Discovery Society.
- Sanders-McDonagh, E., Neville, L., & Nolas, S. (2016). From pillar to post: Understanding the victimisation of women and children who experience domestic violence in an age of austerity. *Feminist Review*, 112(1), 60-76.
- Saunders, J. B. (2017). Substance use and addictive disorders in DSM-5 and ICD 10 and the draft ICD 11. *Current Opinion in Psychiatry*, 30(4), 227-237.
- Savic, M., & Fomiatti, R. (2016). Producing "progress" through the implementation of outcome monitoring in alcohol and other drug treatment. *Contemporary Drug Problems*, 43(2), 169-187.
- Saxena, P., Messina, N. P., & Grella, C. E. (2014). Who benefits from gender-responsive treatment? accounting for abuse history on longitudinal outcomes for women in prison. *Criminal Justice and Behavior*, 41(4), 417-432.
- Schur, E. M. (1984). Labeling women deviant: Gender, stigma, and social control. Random House New York.

Schweiger, V., Del Balzo, G., Raniero, D., De Leo, D., Martini, A., Sarzi-Puttini, P., & Polati, E. (2017). Current trends in disability claims due to fibromyalgia syndrome. *Clin Exp Rheumatol*, 35(Suppl 105), 119.

Scoular, J. (2004). The 'subject' of prostitution: Interpreting the discursive, symbolic and material position of sex/work in feminist theory. *Feminist Theory*, 5(3), 343-355.

Scoular, J. (2010). What's law got to do with it? How and why law matters in the regulation of sex work. *Journal of Law and Society*, 37(1), 12-39.

Scoular, J. (2015). The subject of prostitution: Sex work, law and social theory.

Scoular, J., & Carline, A. (2014). A critical account of a 'creeping neo-abolitionism': Regulating prostitution in England and Wales. *Criminology & Criminal Justice*, 14(5), 608-626.

Scoular, J., & O'Neill, M. (2007). Regulating prostitution: Social inclusion, responsabilization and the politics of prostitution reform. *The British Journal of Criminology*, 47(5), 764-778.

Scourfield, J., & Welsh, I. (2003). Risk, reflexivity and social control in child protection: new times or same old story? *Critical Social Policy*, 23(3), 398-420.

Seddon, T. Drugs, Crime and Social Exclusion: *Social Context and Social Theory in British*

*Drugs–Crime Research*, *The British Journal of Criminology*, Volume 46, Issue 4, July 2006, Pages 680–703, <https://doi.org/10.1093/bjc/azi079>

Seddon, T. (2011). Court-ordered treatment, neoliberalism and homo economicus. *The Drug Effect: Health, Crime and Society*, 155-170.

Sexton, S. (2003). A stitch in time: A short study into the needs of women working in the sex industry in Edinburgh. Edinburgh: SCOTPEP.

- Sexton, S. (2009). Over the parapet: A short study into the needs and aspirations of sex workers in Edinburgh. Edinburgh: SCOTPEP.
- Shah, S. P. (2004). Prostitution, sex work and violence: Discursive and political contexts for five texts on paid sex, 1987–2001. *Gender & History*, 16(3), 794-812.
- Shand, F. L., Degenhardt, L., Slade, T., & Nelson, E. C. (2011). Sex differences amongst dependent heroin users: Histories, clinical characteristics and predictors of other substance dependence. *Addictive Behaviors*, 36(1-2), 27-36.
- Shapiro, H. (2012) '*Walk the line.*' Druglink, (July/August) p. 67.
- Sharpen, J. (2018). Jumping through hoops: How are coordinated responses to multiple disadvantage meeting the needs of women? London: AVA, MEAM, Agenda.
- Sharpley, J. M. (2014). *Thinking outside the brain: Testing predictors of drug addiction anticipated by dislocation theory*. Simon Fraser University (Doctoral Thesis). Available from: [https://www.academia.edu/38521030/Dislocation\\_Theory\\_of\\_Addiction\\_pdf](https://www.academia.edu/38521030/Dislocation_Theory_of_Addiction_pdf)
- Shaver, F. M. (2005). Sex work research: Methodological and ethical challenges. *Journal of Interpersonal Violence*, 20(3), 296-319.
- Shdaimah, C. S., & Wiechelt, S. A. (2013). Crime and compassion: Women in prostitution at the intersection of criminality and victimization. *International Review of*
- Victimology*, 19(1), 23-35.
- Shdaimah, C., & Leon, C. S. (2016). Relationships among stigmatized women engaged in street-level prostitution: Coping with stigma and stigma management. *Special issue: Problematizing prostitution: Critical research and scholarship*. Emerald Group Publishing Limited.
- Shinn, M., & Weitzman, B. (1996). Homeless families are different. In *Homelessness in America: A reference book*. National Coalition for the Homeless and Oryx Press.



- Shetty, P. (2011). Nora Volkow—challenging the myths about drug addiction. *The Lancet*, 378(9790), 477.
- Showden, C. R. (2016). Feminist sex wars. The Wiley Blackwell encyclopaedia of gender and sexuality studies, 1-3.
- Shultziner, D., & Rabinovici, I. (2012). Human dignity, self-worth, and humiliation: A comparative legal–psychological approach. *Psychology, Public Policy, and Law*, 18(1), 105.
- Siegler, M., & Osmond, H. (1968). Models of drug addiction. *International Journal of the Addictions*, 3(1), 3-24.
- Simmonds, L. (2016). The potential impact of local commissioning on victim services in England and Wales. *International Review of Victimology*, 22(3), 223-237.
- Simmonds, L. (2019). The impact of local commissioning on victim services in England and Wales: An empirical study. *International Review of Victimology*, 25(2), 181-199.
- Simpson, M., & McNulty, J. (2008). Different needs: Women's drug use and treatment in the UK. *International Journal of Drug Policy*, 19(2), 169-175.
- Simpson, R., Slutskaya, N., Lewis, P., & Höpfl, H. (2012). *Dirty work: Concepts and identities*. Palgrave Macmillan.
- Siporin, S. (2010). Addicts to artists: The 'good enough mother' in the substance abuse clinic. *Psychodynamic Practice*, 16(3), 323-329.
- Slee, J. (2012). Addressing systemic neglect of young indigenous children's rights to attend school in the northern territory, Australia. *Child Abuse Review*, 21(2), 99-113.
- Smart, C. (1984). Social policy and drug addiction: A critical study of policy development. *British Journal of Addiction*, 79(1), 31-39.
- Smith, C., & Riach, K. (2016). Drug taking and employment: Exploring the employable citizen in UK policy. *Sociology*, 50(1), 24-42.

Smith, F. M., & Marshall, L. A. (2007). Barriers to effective drug addiction treatment for women involved in street-level prostitution: A qualitative investigation. *Criminal Behaviour and Mental Health*, 17(3), 163-170.

Smith, M., & Mac, J. (2018). Revolting prostitutes: The fight for sex workers' rights. Verso Books.

Smith, T. L., Zufferey, C., Bilic, S., & Loeser, C. (2022). Questioning policy representations

of women's alcohol consumption: Implications for social work. *Qualitative Social Work*, 21(4), 731–747. Available from: <https://doi.org/10.1177/14733250211025086>

Sokoloff, N. J., & Dupont, I. (2005). Domestic Violence at the Intersections of Race, Class, and Gender: Challenges and Contributions to Understanding Violence Against Marginalized Women in Diverse Communities. *Violence Against Women*, 11(1), 38–64. <https://doi.org/10.1177/1077801204271476>

Solinas, M., Chauvet, C., Thiriet, N., El Rawas, R., & Jaber, M. (2008). Reversal of cocaine addiction by environmental enrichment. *Proceedings of the National Academy of Sciences*, 105(44), 17145-17150.

Solinas, M., Thiriet, N., Chauvet, C., & Jaber, M. (2010). Prevention and treatment of drug addiction by environmental enrichment. *Progress in Neurobiology*, 92(4), 572-592.

Sparasci, O., Bhui, K., Biswas, A., Chamberlain, S., Dubicka, B., Dudas, R., Farooq, S., Ford, T., Husain, N., & Jones, I. (2022). Impact of COVID-19 on mental health research: Is this the breaking point? *The British Journal of Psychiatry*, 220(5), 254-256.

Speake, A. E. C. (2020). “Like having a perpetrator on your back”: Violence in the Welfare System. Sheffield Hallam University (United Kingdom).

Spice, W. (2007). Management of sex workers and other high-risk groups. *Occupational Medicine*, 57(5), 322-328.

Sprankle, E., Bloomquist, K., Butcher, C., Gleason, N., & Schaefer, Z. (2018). The role of sex work stigma in victim blaming and empathy of sexual assault survivors. *Sexuality Research and Social Policy*, 15(3), 242-248.

Springer, S., Birch, K., & MacLeavy, J. (2016). *Handbook of neoliberalism*. Routledge

Stallybrass, P., & White, A. (1986). Reading the body and the Jacobean theatre of consumption. *The Politics and Poetics of Transgression*, 210-20.

Steele, H., Bate, J., Steele, M., Dube, S. R., Danskin, K., Knafo, H., Nikitiades, A., Bonuck, K., Meissner, P., & Murphy, A. (2016a). Adverse childhood experiences, poverty, and parenting stress. *Canadian Journal of Behavioural Science/Revue Canadienne Des Sciences Du Comportement*, 48(1), 32.

Stengel, C. (2014). The risk of being 'too honest': Drug use, stigma and pregnancy. *Health, Risk & Society*, 16(1), 36-50.

Stephenson, M. (2012). Unravelling equality: The combined impact of spending cuts on women. *Local Economy*, 27(8), 859-863.

Stevens, A. (2019). 'Being human' and the 'moral sidestep' in drug policy: Explaining government inaction on opioid-related deaths in the UK. *Addictive Behaviors*, 90, 444-450.

Stewart, H. and Topham, G. (May 22<sup>nd</sup>, 2002). *Boris Johnson to stress work as the fix for cost-of-living crisis*. The Guardian. Available from:

<https://www.theguardian.com/business/2022/may/22/boris-johnson-to-stress-work-as-the-fix-for-cost-of-living-crisis>

Stewart, M. (2016). *Cash do not care*. New Generation Publishing.

Stone, R. (2015). Pregnant women and substance use: Fear, stigma, and barriers to care. *Health & Justice*, 3(1), 1-15.

Stone, R. (2016). Desistance and identity repair: Redemption narratives as resistance to stigma. *British Journal of Criminology*, 56(5), 956-975.

Storbjörk, J., & Stenius, K. (2019). Why research should pay attention to effects of marketization of addiction treatment systems. *Journal of Studies on Alcohol and Drugs, Supplement*, (s18), 31-39.

Strang, J., Ruben, S., Farrell, M., Witton, J., Keaney, F., & Gossop, M. (2004). The history of prescribing heroin and other injectable drugs as addiction treatment in the UK. In *Heroin addiction and the British system* (pp. 15-30). Routledge.

Straussner, S. L. A., & Brown, S. (2001). *The handbook of addiction treatment for women: Theory and practice*. John Wiley & Sons.

Street, A. E., & Dardis, C. M. (2018). Using a social construction of gender lens to understand gender differences in posttraumatic stress disorder. *Clinical Psychology Review*, 66, 97-105.

Strega, S., Casey, L., & Rutman, D. (2009). Sex workers addressing treatment. *Women's Health and Urban Life*. 8: 42-53.

Stuart, R. and Grenfell, P. (2022) Left out in the cold: The extreme unmet health and service needs of street sex workers in East London before and during the COVID-19 pandemic. London: London School of Hygiene and Tropical Medicine (LSHTM), pp. 1 - 33

(33). Available from: <https://www.doctorsoftheworld.org.uk/wp-content/uploads/2021/05/Left-out-in-the-cold-full-report.pdf>.

Sutherland, C. A., Sullivan, C. M., & Bybee, D. I. (2001). Effects of intimate partner violence versus poverty on women's health. *Violence against women*, 7(10), 1122-1143.

Sverke, M., Hellgren, J., & Näswall, K. (2002). No security: a meta-analysis and review of job insecurity and its consequences. *Journal of occupational health psychology*, 7(3), 242.

Sweeney, L., Sixsmith, J., & Molcho, M. (2019). Giving voice to women in the sex industry: A voice-centred relational model based qualitative study. *Journal of Social Care, 2*(1), 4.

Sztompka, P. (1999). *Trust: A sociological theory*. Cambridge university press.

Taplin, S., & Mattick, R. P. (2015). The nature and extent of child protection involvement among heroin-using mothers in treatment: High rates of reports, removals at birth and children in care. *Drug and Alcohol Review, 34*(1), 31-37.

Taylor, J. (2010, April 10). *Charity that sterilises addicts comes to the UK*. The Independent. Available from: <https://www.independent.co.uk/life-style/health-and-families/health-news/charity-that-sterilises-addicts-to-come-to-uk-1940722.html>

Taylor, M. C. (2005). Interviewing. *Qualitative research in health care, 39*-55.

Taylor, S. (2008). Outside the outsiders: Media representations of drug use. *Probation Journal, 55*(4), 369-387.

Thanki, D. & Vicente, J. (2013). EMCDDA PDU (problem drug use) revision summary.

Available

from:[http://www.emcdda.europa.eu/attachements.cfm/att\\_218205\\_EN\\_PDU%20revision.pdf](http://www.emcdda.europa.eu/attachements.cfm/att_218205_EN_PDU%20revision.pdf).

The Blindboy Podcast. *A Mental Health Plan for 2022*. 05/01/22. Spotify.

The Financial Times Editorial Board. (2022, May 27th). *A striking U-turn to alleviate the UK cost of living crisis*. The Financial Times. Available from: <https://www.ft.com/content/05e49e39-a569-4346-88b9-4543ec9efbe1>

Thomas, N., & Bull, M. (2018). Representations of women and drug use in policy: A critical policy analysis. *International Journal of Drug Policy, 56*, 30-39.

Thomas, N., Bull, M., Dioso-Villa, R., & Smith, K. (2019). The movement and translation of drug policy ideas: The case of 'new recovery'. *International Journal of Drug Policy, 73*, 72-80.

- Thompson, R. A. (2008). Early attachment and later development: Familiar questions, new answers.
- Thorsen, D. E., & Lie, A. (2006). What is neoliberalism. Oslo, University of Oslo, Department of Political Science, Manuscript, 1-21.
- Tinson, A., Ayrton, C., Barker, K., Born, T. B., Aldridge, H., & Kenway, P. (2016). Monitoring poverty and social exclusion 2016. *Children*, 3, 3-7.
- Tomura, M. (2009). A prostitute's lived experiences of stigma. *Journal of Phenomenological Psychology*, 40(1), 51-84.
- Trebilcock, J., & Dockley, A. (2015). 'A very high price to pay?': Transforming rehabilitation and short prison sentences for women. *Women and Criminal Justice: From the Corston Report to Transforming Rehabilitation*, 213.
- Tschoeke, S., Borbe, R., Steinert, T., & Bichescu-Burian, D. (2019). A systematic review of dissociation in female sex workers. *Journal of Trauma & Dissociation*, 20(2), 242-257.
- Tsui, T. (2016). *Understanding Resilience: Uncovering The Common Themes* (Doctoral dissertation, City University of Seattle).
- Tuchman, E. (2010). Women and addiction: The importance of gender issues in substance abuse research. *Journal of Addictive Diseases*, 29(2), 127-138.
- Türkoğlu, B. (2013). Violence as a way of reconstructing manhood : the role of threatened manhood and masculine ideology on violence against women [M.S. - Master of Science]. Middle East Technical University.
- Tweed, E. J., Miller, R. G., Schofield, J., Barnsdale, L., & Matheson, C. (2022). Why are drug-related deaths among women increasing in Scotland? A mixed-methods analysis of possible explanations. *Drugs: Education, Prevention and Policy*, 29(1), 62-75.

Tyler, M. (2021). All roads lead to abolition? Debates about prostitution and sex work through the lens of unacceptable work. *Labour & Industry: a journal of the social and economic relations of work*, 31(1), 66-86.

Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors*, 38(6), 2219-2223.

Urada, L. A., & Simmons, J. (2014). Social and structural constraints on disclosure and informed consent for HIV survey research involving female sex workers and their bar managers in the Philippines. *Journal of Empirical Research on Human Research Ethics*, 9(1), 29-40.

Vacchelli, E., Kathrecha, P., & Gyte, N. (2015a). Is it really just the cuts? neo-liberal tales from the women's voluntary and community sector in London. *Feminist Review*, 109(1), 180-189.

Valera, R. J., Sawyer, R. G., & Schiraldi, G. R. (2001). Perceived health needs of inner-city street prostitutes: A preliminary study. *American Journal of Health Behavior*, 25(1), 50- 59.

Van der Kolk, Bessel A. (2015). The body keeps the score: Brain, mind, and body in the healing of trauma. Penguin Books.

Van Draanen, J., Tsang, C., Mitra, S., Karamouzian, M., & Richardson, L. (2020). Socioeconomic marginalization and opioid-related overdose: A systematic review. *Drug and Alcohol Dependence*, 214, 108127.

Van Olphen, J., Eliason, M. J., Freudenberg, N., & Barnes, M. (2009). Nowhere to go: How stigma limits the options of female drug users after release from jail. *Substance Abuse Treatment, Prevention, and Policy*, 4(1), 1-10.

Vanwesenbeeck, I. (2001). Another decade of social scientific work on sex work: A review of research 1990–2000. *Annual Review of Sex Research*, 12(1), 242-289.

- Vest, J. R., Catlin, T. K., Chen, J. J., & Brownson, R. C. (2002). Multistate analysis of factors associated with intimate partner violence. *American journal of preventive medicine*, 22(3), 156-164.
- Vickers, E. L. (2019). Unexpected trauma in oral interviewing. *The Oral History Review*, 46 (1). ISSN 1533-8592
- Vilenica, A., McElroy, E., Ferreri, M., Fernández Arrigoitia, M., García-Lamarca, M., & Lancione, M. (2020). Covid-19 and housing struggles: The (re) makings of austerity, disaster capitalism, and the no return to normal. *Radical Housing Journal*, 2(1), 9-28.
- Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, 374(4), 363-371.
- Volkow, N., & Li, T. (2005). The neuroscience of addiction. *Nature Neuroscience*, 8(11), 1429-1430.
- Vranceanu, A., Hobfoll, S. E., & Johnson, R. J. (2007). Child multi-type maltreatment and associated depression and PTSD symptoms: The role of social support and stress. *Child Abuse & Neglect*, 31(1), 71-84.
- Wacquant, L. (2009). In Steinmetz, G. (ed.), *Punishing the poor: The Neoliberal government of social insecurity*. Duke University Press.
- Wahab, S., & Sloan, L. (2004). Ethical dilemmas in sex work research. *Research for Sex Work*, 7(1), 3-5.
- Wakeman, S. (2014). *Rethinking Heroin: Use, Addiction and Policy in 'Austerity Britain'*. The University of Manchester (United Kingdom).
- Wall-Wieler, E., Roos, L. L., Bolton, J., Brownell, M., Nickel, N., & Chateau, D. (2018). Maternal mental health after custody loss and death of a child: A retrospective cohort study using linkable administrative data. *The Canadian Journal of Psychiatry*, 63(5), 322- 328.



- Walsh, G. M. (2020). The arrival of the ACEs movement in Scotland: Policy entrepreneurship and critical activist responses. *Scottish Affairs*, 29(4), 456-474.
- Walton, M. T., & Hall, M. T. (2016). The effects of employment interventions on addiction treatment outcomes: A review of the literature. *Journal of Social Work Practice in the Addictions*, 16(4), 358-384.
- Wardle, I. (2009). Recovery and the UK drug treatment system: Key dimensions of change. Lifeline Project Limited, Manchester, 350
- Wardle, I. (2012). Five years of recovery: December 2005 to December 2010—From challenge to orthodoxy. *Drugs: Education, Prevention and Policy*, 19(4), 294-298.
- Warner, J. (2013). Social work, class politics and risk in the moral panic over baby P. *Health, Risk & Society*, 15(3), 217-233.
- Wasco, S. M. (2003). Conceptualizing the harm done by rape: Applications of trauma theory to experiences of sexual assault. *Trauma, Violence, & Abuse*, 4(4), 309-322.
- Watson, J. (2011). Understanding survival sex: Young women, homelessness and intimate relationships. *Journal of Youth Studies*, 14(6), 639-655.
- Watson, J. (2013). The good, the bad and the vague: Assessing emerging Conservative drug policy. *Critical Social Policy*, 33(2), 285-304.
- Wechsberg, W. M., Luseno, W., & Ellerson, R. M. (2008). Reaching women substance abusers in diverse settings: Stigma and access to treatment 30 years later. *Substance use & Misuse*, 43(8-9), 1277-1279.
- Weitzer, R. (2000). Deficiencies in the sociology of sex work. *Sociology of Crime, Law, and Deviance*, 2, 259-279.
- Weitzer, R. (2005). New directions in research on prostitution. *Crime, Law and Social Change*, 43(4), 211-235.
- Weitzer, R. (2009). Sociology of sex work. *Annual Review of Sociology*, 35, 213-234.

Weitzer, R. (2010). The mythology of prostitution: Advocacy research and public policy. *Sexuality Research and Social Policy*, 7(1), 15-29.

Weitzer, R. (2012). Legalizing prostitution: From illicit vice to lawful business. NYU Press.

West, R. (2001). Theories of addiction. *Addiction*, 96(1), 3- 13.  
<https://doi.org/10.1046/j.1360-0443.2001.96131.x>

West, R., & Brown, J. (2013). Theory of addiction.

Westwood, A., Sensier, M., & Pike, N. (2021). Levelling Up, Local Growth and Productivity in England.

White, K. P., Carette, S., Harth, M., & Teasell, R. W. (2000, February). Trauma and fibromyalgia: is there an association and what does it mean?. In *Seminars in arthritis and rheumatism* (Vol. 29, No. 4, pp. 200-216). WB Saunders.

White, W. L. (1998). *Slaying the dragon: The history of addiction treatment and recovery in America*. Chestnut Health Systems/Lighthouse Institute Bloomington, IL.

White, W. L., & Kelly, J. F. (2010). Recovery management: What if we really believed that addiction was a chronic disorder?. In *Addiction recovery management* (pp. 67-84). Humana Press, Totowa, NJ.

Whitehead, P. (2015). Payment by results: the materialist reconstruction of criminal justice. *International journal of sociology and social policy*.

Whitfield, D. (2012). The payment-by-results road to marketization. Critical Reflections:

Social and Criminal Justice in the First Year of Coalition Government, 22.

Whittle, H. J., Palar, K., Ranadive, N. A., Turan, J. M., Kushel, M., & Weiser, S. D. (2017). "The land of the sick and the land of the healthy": disability, bureaucracy, and stigma

among people living with poverty and chronic illness in the United States. *Social Science & Medicine*, 190, 181-189.

Wilbanks, W. (1989). The danger in viewing addicts as victims: A critique of the disease model of addiction. *Criminal Justice Policy Review*, 3(4), 407-422.

Wilkinson, I. G. (2016). Why some children come to school with “baggage”: The effects of trauma due to poverty, attachment disruption and disconnection on social skills and relationships. *Canadian Journal of Family and Youth/Le Journal Canadien De Famille Et De La Jeunesse*, 8(1), 173-203.

Wilkinson, R. G., & Pickett, K. E. (2009). Income inequality and social dysfunction. *Annual Review of Sociology*, 35, 493-511.

Wilkinson, R., & Pickett, K. (2010). *The spirit level. Why Equality is Better for Everyone*. London: Penguin.

Williams, K. S., & Earle, J. (2022). Successful Resettlement or Setting Women Up to Fail?

Policy and Practice for Women Released from Prison in England and Wales. The Wiley Handbook on What Works with Girls and Women in Conflict with the Law: A Critical Review of Theory, Practice, and Policy, 396-408.

Williamson, C. (2000). Entrance, maintenance, and exit: The socio-economic influences and cumulative burdens of female street prostitution. Indiana University.  
Williamson, C., & Folaron, G. (2003). Understanding the experiences of street level prostitutes. *Qualitative Social Work*, 2(3), 271-287.

Wilson, B., & Butler, L. D. (2014). Running a gauntlet: A review of victimization and violence in the pre-entry, post-entry, and peri-/post-exit periods of commercial sexual exploitation. *Psychological Trauma: Theory, Research, Practice, and Policy*, 6(5), 494.

Wincup, E. (2016). Gender, recovery and contemporary UK drug policy. *Drugs and Alcohol Today*.

Wincup, E. (1999). Researching women awaiting trial: Dilemmas of feminist ethnography. *Qualitative research in criminology*, 112-129.

Wise, R. A., & Koob, G. F. (2014). The development and maintenance of drug addiction. *Neuropsychopharmacology*, 39(2), 254-262.

Witte, H. D. (1999). Job insecurity and psychological well-being: Review of the literature

and exploration of some unresolved issues. *European Journal of work and Organizational psychology*, 8(2), 155-177.

Women's Budget Group. (2012). *The Impact on Women of the Budget*. UK Women's Budget Group, London.

World Health Organization. (2002). *Gender and mental health*. WHO: Geneva. World Health Organisation Constitution. (1946). *World Health Organisation*.

WHO: Geneva.

Worrall, A., & Gelsthorpe, L. (2009). 'What works' with women offenders: The past 30 years. *Probation Journal*, 56(4), 329-345.

Zavaleta, D. (2015). Shame, humiliation and social isolation: Missing dimensions of poverty and suffering analysis. In *World suffering and quality of life* (pp. 251-266).

Springer, Dordrecht.

# Appendices

## Interview Questions (Original version)

This is just a rough guide to the interview topics- I will not be following a structured Q&A but am keen that the interviews are flexible, discursive and responsive so while the questions below cover the general theme of respondent's lives leading up to their involvement with your service and the formal and informal help and support they have and have not received, I will ask other questions responsively as they arise.

Intro- I'm interested in the impact of poverty and inequality on women and how different approaches to that can affect the experiences of women. Some policies and services seem to treat problems like trauma, deprivation and addiction as matters of individual responsibility and expect people to change in particular ways, without any changes made by the government to address the bigger factors.

1,) Can you tell me a little bit about your life leading up to your involvement with this project/ your recovery?

What did you need from life at the time and much were you able to access what you needed? E.g. a stable job, safe housing, good relationships

Prompts e.g.-was there anything else going on in your life during that time that is memorable to you now?

-How did you feel things were going?

Who were you living with at that time?

How were your relationships going?

What were your priorities at that time?

I will also be sure to emphasise choice and freedom, e.g. 'would you like to give more detail or rather not'

Regular prompt- were you receiving any support with that and if so, what? And how was that?

-Did you feel support sources were working towards the same goals as you and able to help you meet those?

What did you feel were the expectations of services (e.g. probation, benefits, social services)/ friends/family?

2.) Could you tell me about a time where a service or services were unhelpful to you?

I'd like to hear about what you felt you needed and wanted from life and from them at the time.

Did you feel their expectations matched with what you wanted and needed? How do you think they set goals or targets for you?

Did you feel that they understood the difficulties you were facing and how that might have made doing what they wanted hard?

How did they respond if you couldn't or didn't do what they wanted or if you disagreed with them?

Other Qs and prompts – was it to do with how they made you feel ? what they could or couldn't provide you with support for? What do you think could've been done differently so your experience was positive?

3.) Could you tell me about a time where a service or services really helped you?

-I'd like to hear about what you felt you needed and wanted from life and from them at the time.

Other possible Qs and prompts here are:- could you pinpoint what it was that worked so well for you/why it helped?

How do you think they set goals or a care plan for you?

-Was there a particular worker that you got on with?

-Was there anything that went well for you then, no matter how small?

-What was different about this service compared to others that you had not found helpful?

## Information Sheet

PhD Research: The needs and autonomy of women with histories of street sex working and/or problem drug use

### Participant Information Sheet

Invitation and Purpose. I am inviting you to take part in research into the needs and experiences of women with histories of street sex work and/ problem drug use. I'd like to hear a bit about your life history leading up to your recovery and about the support you wanted and received (or didn't receive) throughout this. I would like to understand the bigger picture behind street sex working and/or problem drug use as policy often puts a lot of responsibility on the individual for change, without acknowledging the impact of issues such as poverty, inequality and trauma. The research is for my (Rebecca Hamer)

PhD conducted through The Centre for Regional Economic and Social Research at Sheffield Hallam University. Please read the following information carefully so you can decide whether or not to take part.

Legal Basis for Research Studies This research has received full ethical approval from the University and is considered to contribute to understandings of the needs and experiences of women with specific life histories of inequality and adversity. Data protection allows me to use personal data (the information you provide during an interview) for research with appropriate safeguards in place under the legal basis of public tasks that

are in the public interest. A full statement of your rights can be found at: <https://www.shu.ac.uk/about-this-website/privacy-policy/privacy->

All University research is reviewed to ensure that participants are treated appropriately, and their rights respected. This study has been approved by the University Research

Ethics Committee (UREC). Further information can be found at:

<https://www.shu.ac.uk/research/ethics-integrity-and-practice>

You have been approached about this study because you have experienced problem drug use and/or street sex work.

Do I have to take part? Taking part in this research is voluntary. If you would prefer not to take part, you do not have to give any reason, and it will not affect the support you receive

through any services. If you change your mind you should contact me (rh7188@exchange.shu.ac.uk) up to 14 days after the interview date. If you withdraw after this point your data may be retained as part of the study.

What will taking part involve? The interview will be with me (Rebecca Hamer) and because of health and safety concerns over COVID-19 will be conducted either over the phone or virtually, such as by Skype or Zoom, depending on your preference. If you wish to have a support worker with you, that is absolutely welcome. The interview will be an informal conversation and should last about 30-45 minutes. In the interview you will be asked some questions about your life up until your involvement with the service; how you

came to be involved with the service, the important moments in your life leading up to it, what your wants and needs were and are and how much you have been able to get support with what you need.

What are the possible disadvantages and risks of taking part? I do not anticipate there will be any risks involved. I would like to emphasise that you are free to talk about



what you feel is important and what you are comfortable with- this is about your experiences and opinions. You will not be under any pressure to answer questions or talk about topics that you prefer not to discuss, and you can choose to halt or withdraw from the interview at any point.

What are the possible benefits of taking part? The findings of the research will be fed back (after being anonymised) to policy makers and shared with the aim of raising understanding about the self-expressed needs and experiences of women with histories of street sex work and/or problem drug use. You will be compensated for your time with a £20 Love to Shop voucher.

How will my confidentiality be protected? I will record the interview, with your consent. This allows me to accurately reflect what is said. The recording will be transcribed (written out), with any names or identifying information removed. Any quotes that we use will be anonymised (using pseudonyms). Confidentiality will only be broken in circumstances where myself or your support worker (if present) is concerned that there is a risk of harm to you or someone else. In this instance I must report this information to the relevant

agency that can provide assistance.

What will happen to my data during the study and once the study is over?

Sheffield Hallam University will be responsible for all of the data during the study and when it is over. No one outside of the research team will have access to this data, which will be held securely on Sheffield Hallam University servers. CRESR data management protocols are consistent with government GSAD and NHS Data Security and Protection Toolkit requirements, as well as GDPR legislation.

Data from this study may be retained by Sheffield Hallam University for up to 10 years after the study has finished and may be available to the public but only if it can be sufficiently anonymised to protect your identity. The only personal data we keep will be your signed consent form. We have to keep this for 10 years from the end of the project so we will keep it separately in a secure file for this length of time.

How will the data be used? We will use data from your interview to inform my PhD thesis, and it may also be used in other research/academic publications or presentations. If you are interested, copies of the finished thesis will be available on request

Who can I contact if I have any questions or concerns about the study?

Rebecca Hamer: rh7188@exchange.shu.ac.uk

Kesia Reeve: k.reeve@shu.ac.uk

Del Fletcher: seddrf@exchange.shu.ac.uk

You should contact the Data You should contact the Head of

Protection Officer if: Research Ethics (Professor Ann

Macaskill) if:

- you have a query about how your data is used by the University • you have concerns with how
- you would like to report a data the research was undertaken or security breach (e.g., if you think how you were treated your personal data has been lost or [a.macaskill@shu.ac.uk](mailto:a.macaskill@shu.ac.uk)

disclosed inappropriately)

- you would like to complain about how the University has used your personal data

DPO@shu.ac.uk

Postal address: Sheffield Hallam University, Howard Street, Sheffield S1 1WBT.

Telephone: 0114 225 5555

## Invitation Leaflet

Would you like to take part in a research study about women with experience of addiction and/or street sex working and their needs?

Why is the study being done?

A lot of theory and policy on

street sex work and addiction focuses on individual factors like behavioural or medical issues but does not fully consider the importance of the influence of poverty, trauma and need. It is understood that women experience multiple

disadvantages at once and a lot of these are caused by and made more difficult by a

How do I take part?

I would like to interview you about your life experiences up 'til now; what you feel has helped you and would have helped, and what you

feel hasn't helped. I am

particularly interested in your experiences in services, like drug treatment, probation, healthcare etc. I am also interested in your experience of informal support, such as if your family and friends were in a position to be able to support you.

lack of resources and support. However, policy and practice still often expect women to be able to change in specific ways without providing the right resources and support for them to be able to do so if they wish. This research would like to understand your experiences, what you need and the support that you have found helpful and unhelpful, to understand the bigger picture behind street sex work and/or addiction.

Who can participate?

You can take part if you are a woman who has experience of problem drug use and/or

The interview would be conducted informally, like a conversation.

To say thank you for taking part, you'll receive a £20 gift voucher.

The discussion would take place

somewhere where you feel

comfortable of your choice and be by telephone or web chat.

You don't have to talk about anything you don't want to discuss, and you can stop the interview at any time, and you will

still receive your voucher. Everything you say will be

confidential - your name won't be used, and we won't pass your details to anyone else.

Need more information or want to know more?

Contact Rebecca Hamer at

street sex work.

Please note you don't have to have been involved in both. If you have experience of addiction alone or just street sex working, then I'd like to hear from you too.

rh7188@shu.ac.uk

or

my

supervisor

Kesia

Reeve

K.Reeve@shu.ac.uk

Who is doing this research?

The research is being conducted by PhD student

Rebecca Hamer at the

Centre for Social Regional and Economic Research

(CRESR) at Sheffield Hallam

University.

## Consent Form

PhD Research: The Needs and Experiences of Women with Histories of Street Sex Working and/or Problem Drug Use

Please answer the following questions by ticking the response that applies

Yes

☐

1. I have read the Information Sheet for this study and / or had details of the research explained to me and understand that I may ask further questions at any point.

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2. I understand that I am free to withdraw from the study without giving a reason. If I change my mind, I should contact Rebecca Hamer ([rh7188@exchange.shu.ac.uk](mailto:rh7188@exchange.shu.ac.uk)) or ask my support worker to do so, up to 14 days after the interview date. If I withdraw after this point, then I understand that my data may be retained as part of the study.

☐



3. I understand that I can stop the interview at any point or choose

not to answer any particular questions and this will not have any impact on me or the support I am receiving.

4. I understand that the information collected will remain confidential, unless I say anything that makes the researcher concerned that there is a risk of harm to me or someone else. In these circumstances I understand that the researcher must report this information to the relevant agency that can provide assistance.

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5. I understand that my personal details such as my name will not be shared.

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6. I agree that the data in anonymised form can be used for other research purposes (e.g., writing articles in journals).

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7. I understand that the data from this study may be retained by Sheffield Hallam University for up to 10 years after the study has finished and may be available to the public (but only if it can be sufficiently anonymised to protect your identity).

8. I agree to take part in the interview for the above study.

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9. I agree for the interview to be recorded and to quotes being used. I understand my name won't be used.

Name of participant      Signature

Date

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