

# Women and girls facing severe and multiple disadvantage

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An interim report

Lankelly Chase

## Acknowledgements

We are grateful to the many groups and individuals who have contributed to this report. Members of our reference group were:

Sally McManus, NatCen  
Sophie Laws, Barnardo's  
Rachel Coffey, Barnardo's  
Carol McNaughton Nichols, Truth  
Alison Park, Institute of Education  
Sophie Khadr, University College London  
Shannon Harvey, Shelter  
Alison Dickens, DMSS Associate  
Emma Gardiner, Praxis  
Sharon Hooniman, Women's Health and Family Service, Tower Hamlets  
Katharine Sacks-Jones, AGENDA  
Liz Hogarth, AGENDA  
Clare Jones, Women's Centre  
Debbie Pippard, BarrowCadbury  
Georgina Naylor, Pilgrim Trust  
Bobby Duffy, Ipsos Mori (LC Trustee)  
Marion Janner, Trustee, LankellyChase  
Sufina Ahmed, BIG Lottery  
George Hosking, Wave Trust  
Janet Veitch, EVAW  
Paula Harriott, User Voice  
Ceri Goddard, Young Foundation  
Liz Kelly, Child and Women Abuse Studies Unit, London Metropolitan University  
Kate Smith, University of Huddersfield  
Jennie Williams, Inequality Agenda  
Vicki Heylar-Cardwell, Revolving Doors

We would particularly like to thank the women who participated in the consultations for this report and the organisations who helped us by hosting and supporting consultation events. A special thanks to:

Clare Jones and colleagues at Women's Centre, Kirklees and Calderdale  
Emma Gardiner and colleagues at Praxis, East London  
Sharon Hooniman and colleagues at Women's Health and Family Services, Tower Hamlets  
The Scottish Consortium for Learning Disabilities  
One Voice 4 Travellers

## Contents

Acknowledgements.....	2
Acronyms used in chapter 2.....	5
Introduction .....	6
Purpose of report.....	6
Background .....	6
Structure of this report .....	6
Chapter 1: Towards a conceptual framework for understanding severe and multiple disadvantage for women and girls.....	7
1.1.Defining severe and multiple disadvantage.....	7
1.2.Five conceptual approaches.....	8
1.3.The defined categories approach.....	10
1.4.The risk factors approach.....	16
1.5.A social inequalities approach.....	24
1.6.A rights based approach.....	27
1.7.A capabilities approach .....	30
1.8. Implications of these approaches .....	34
Chapter 2: Feasibility study on developing a profile of women and girls facing SMD .....	37
2.1. Introduction .....	37
2.1.1. Aims of the feasibility study .....	37
2.1.2. Methodology.....	39
2.1.3. Considerations regarding data sources.....	39
2.2. Women Experiencing SMD – the ‘defined categories’ approach.....	41
2.2.1. How many women in the UK are experiencing SMD?.....	41
2.2.2. How many women live with partners affected by SMD?.....	47
2.2.3. What are the overlaps between SMD domains in the case of women? .....	48
2.3. What are the risk factors associated with SMD among women? .....	50
2.4. What is the quality of life of women affected by SMD?.....	51
2.5. Women experiencing SMD – the rights and capabilities approaches .....	51
2.6. Girls Experiencing SMD .....	53
2.6.1. How many girls in the UK are experiencing SMD? .....	54
2.6.2. How many girls live with parents/carers affected by SMD? How many girls have parents/carers affected by SMD? .....	60

2.6.3. What are the overlaps between SMD domains in the case of girls?.....	61
2.6.4. What are the risk factors associated with SMD among girls? .....	66
2.7. Implications and recommendations .....	67
Appendix 1: Additional gender analysis of Heriot-Watt SMD profile data.....	69
Appendix 2. Long list of data sources investigated in some detail.....	70
Appendix 3. Short list of data sources investigated in full detail. ....	72
Appendix 4: Report on Consultations .....	73

## Acronyms used in chapter 2

ADLS – Administrative Data Liaison Service  
ALSPAC – Avon Longitudinal Study of Parents & Children  
APMS - Adult Psychiatric Morbidity Survey  
B&B – Bed & Breakfast  
CHAIN – Combined Homelessness and Information Network  
CHR - Centre for Housing Research (University of St Andrews)  
CIN – Children in Need  
CR – Client Records (Supporting People)  
CSEW – Crime Survey of England and Wales  
DCLG - Department of Communities and Local Government  
DfE – Department for Education  
EUL – End User Licence  
FSM – Free School Meals  
HE/FE – Higher Education / Further Education  
LA – Local Authority  
LAC – Looked After Children  
MCS – Millennium Cohort Study  
MEH – Multiple Exclusion Homelessness  
MHCYP – Mental Health of Children and Young People  
NDTMS – National Drug Treatment Monitoring System  
NOMS - National Offender Management Service  
NPD – National Pupil Database  
OASys – Offender Assessment System  
PMR – Pupil matching Reference  
PSE – Poverty and Social Exclusion  
SL – Special Licence  
SMD – Severe and Multiple Disadvantage  
SP – Supporting People  
SWF – Scottish Welfare Fund  
TFP – Troubled Families Programme (2012-15)  
USS – Understanding Society Survey

# Introduction

## Purpose of report

This paper was commissioned by LankellyChase in order to conceptualise what severe and multiple disadvantage (SMD) looks like for women and girls in the UK and to assess the feasibility of developing a statistical profile. It is intended to contribute to a better understanding of SMD for women and girls and to inform the work of AGENDA, a new cross-sector Alliance to reframe debate on gender and disadvantage and to reshape systems and services for women and girls at risk. Increasing our understanding of how many women and girls are facing SMD, who is most likely to face SMD and whether and how prevalence of SMD changes over time, are all critical to developing effective policy and practice responses.

## Background

A recent analysis by Heriot-Watt University of available data on homelessness, substance misuse and the criminal justice system (commissioned by LankellyChase) provides a picture of those living on the 'extreme margins' as predominantly male (Bramley, Fitzpatrick et al., 2015). At the same time, a review commissioned by the Alliance from DMSS Research highlighted the importance of understanding women's experience of SMD differently to that of men (McNeish and Scott, 2014). In particular, DMSS emphasised three interacting factors pertinent to women across the life-course: social inequalities, gender expectations and experience of abuse and violence.

LankellyChase therefore commissioned DMSS Research and Heriot-Watt University to do two things: first to develop a conceptualisation of what SMD looks like for women; and second, to explore what data sources might be available to develop a statistical profile of women and girls with experience of SMD.

## Structure of this report

The report is presented in two chapters. In chapter one, we explore five potential frameworks for conceptualising SMD and their implications for an understanding of SMD for women and girls. In developing this conceptualisation of SMD for women and girls, we have consulted with a range of experts, including academics, service providers and women and girls with expertise from lived experience. We carried out a desk based analysis of existing definitions of SMD for women and girls in order to produce a discussion paper to act as a focus for consultation. In May/June 2015 we held consultation workshops with five groups of women with a range of lived experience of disadvantage (Appendix 4 includes a summary of these), as well as a seminar for researchers and professionals working in relevant fields.

In chapter two, we assess whether it would be feasible to build up a statistical profile of women and girls experiencing severe and multiple disadvantage using existing datasets and consider the practicalities involved in doing so.

# Chapter 1: Towards a conceptual framework for understanding severe and multiple disadvantage for women and girls.

## 1.1. Defining severe and multiple disadvantage

There is no single agreed definition of the concept of SMD. A review of key texts on the issue carried out for LankellyChase (Duncan and Corner, 2012)<sup>1</sup> pointed out that the existing literature uses a range of terminology, sometimes interchangeably, in dealing with the same issues, including ‘complex needs’, ‘multiple needs’ and ‘deep, chronic or extreme social exclusion’. They argue that the choice of SMD as the preferred terminology is, to some extent, a political one, in that:

*‘It recognises the social nature of **disadvantage** by emphasising its relativity: as the experience of disadvantages that most others don’t experience. This avoids the individualising effect of talking about ‘needs’, which appear to originate from the peculiarities of the person rather than inhering in social relations and requiring social and political solutions’. (2012:3)*

They conclude that the texts summarised in their review point towards a definition of severe and multiple disadvantage as:

*‘The coalescence within a population of serious social problems that often act in a mutually reinforcing manner leading to their further entrenchment.... While **severe** indicates the extreme nature of some of the social harms, **multiple** points to an added dimension of difficulty – that their very co-occurrence is a stand-alone factor which makes experience of, and solutions for, SMD different from the component disadvantages experienced individually.’ (2012:18)*

It follows that in developing profiles of populations facing SMD, we are looking for those who are experiencing *multiple* disadvantages to a *severe* degree. But in so doing there are a number of key questions:

- What are the ‘serious social problems’ that should be included in a definition of SMD?
- At what point does disadvantage become severe?
- Which clusters of disadvantages are relevant in defining who is multiply disadvantaged? Which patterns of coalescence result in SMD?
- Are the definitions and patterns different for different populations e.g. for women and men, younger and older people?

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<sup>1</sup> Mark Duncan with Julian Corner (2012) Severe and Multiple Disadvantage: A review of key texts, LankellyChase [http://www.lankellychase.org.uk/assets/0000/1402/CHF\\_Lit\\_Review.pdf](http://www.lankellychase.org.uk/assets/0000/1402/CHF_Lit_Review.pdf)

- How can disadvantage be measured, and crucially for a profile of SMD, are there data which enable us to identify populations experiencing clusters of severe disadvantage?

## **1.2. Five conceptual approaches**

Our formulation of these five conceptual approaches derive both from a desk based review of how disadvantage gets defined and discussed in the policy and research literature and from our consultation with a range of experts (see above). We discuss each in turn but there are considerable overlaps between them. The core focus, advantages and disadvantages of each are summarised in Table 1 overleaf.

**Table 1: Five conceptual approaches**

Defined categories	Risk factors	Rights based	Social Inequalities	Capabilities
Start with measurable categories of extreme disadvantage and profile from them.	Start with known risk factors and assess likely profiles and prevalence	Start with rights and assess the circumstances which undermine and threaten them	Identify those groups who experience the worst consequences of inequality	Identify the core capabilities for a flourishing life and identify those groups with the fewest capabilities
<b>Advantages</b> Provides a clear definition of the categories which can be consulted on and challenged	<b>Advantages</b> Avoids narrow categorisations and enables a wider range of factors to be considered	<b>Advantages</b> A more inclusive approach which incorporates structural inequalities	<b>Advantages</b> Sensitive to changes in social hierarchies;	<b>Advantages</b> Focuses on valuable <b>ends</b> , rather than instrumental <b>means</b>
Good for profiling if data is available & provides prevalence of SMD at any one time	Enables an assessment of risk at different stages of the life-course	A profile would include hidden groups which do not presently feature in most analyses	Pays attention to the advantaged as well as the disadvantaged	Focuses on what people value & what it is actually <i>feasible</i> for a person to do and be
	Draws on data from representative population samples.	It can be applied at different stages of the life-course.		Recognises the importance of <i>constraints</i> for the analysis of individual freedom.
<b>Disadvantages</b> Profiles dependent on the categories included in definition.	<b>Disadvantages</b> Population surveys exclude some very disadvantaged groups	<b>Disadvantages</b> Defining what constitutes serious threats to rights would be a challenge	<b>Disadvantages</b> Can lead to quite narrow measures of inequality e.g. income	<b>Disadvantages</b> Concepts open to misinterpretation – not easy to communicate
Risks being data driven	Identifies those <i>at risk of</i> not necessarily those who <i>are</i> SMD;	It is difficult to measure the presence and absence of rights in a way that is quantifiable.	A focus on broader inequalities is not a good fit with datasets	Finding data sources which measure capabilities is a challenge
Profiles are fixed at a particular point in time - not able to take account of disadvantage across the life-course.	Less focused on those at the extreme margins.			

### 1.3. The defined categories approach

Applying this approach to developing a profile of SMD would involve agreeing the categories of disadvantage to be included and using available data to analyse the number and characteristics of those who appear in these categories, particularly those who feature in clusters of categories. The two main challenges of using this approach are determining which categories and clusters to include, and which data sources to use to measure them.

**Advantages** of conceptualising SMD in this way are:

- It provides a clear and explicit definition of the categories of disadvantage included in the analysis.
- Provided the data sources are available, categorising people in this way enables them to be counted and profiled thereby enabling estimates to be made of the prevalence of people experiencing SMD at any one time.

**Disadvantages** of conceptualising SMD in this way are:

- The profiles produced are entirely dependent on the categories included in the definition and the data sources used.
- The approach runs the risk of being data driven – some categories have data more readily available than others with the result that the profile can end up counting what can be counted rather than what might count (at least to some groups).
- The profiles generated are fixed at a particular point in time, i.e. it measures who was in the defined categories when the data were collected.

The recent mapping of SMD by researchers at Heriot-Watt (Bramley, Fitzpatrick et al, 2015)<sup>2</sup> in the 'Hard Edges' report can be seen as an example of this approach and illustrates both the advantages and disadvantages, particularly with regard to a profile of women and girls.

The Heriot-Watt profile of SMD is based on a deliberately tight definition. By focusing on a limited number of key domains of disadvantage, it aims to identify those at the extreme margins. They started with a proposed focus on people who had experienced some combination of **homelessness, substance misuse, mental health problems, and offending behaviours**, arguing that this particular set of experiences is strongly resonant with what is often termed 'multiple needs', 'complex needs' or 'chronic exclusion', and that there is evidence that this combination of issues comprises a set of mutually reinforcing inter-relationships that serve to push people to the edge of mainstream society. In the scoping

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<sup>2</sup> Bramley G and Fitzpatrick S with Edwards, J, Ford D, Johnsen S, Sosenko F and Watkins D (2015) Hard Edges: Mapping Severe and Multiple Disadvantage  
[http://www.lankellychase.org.uk/assets/0000/2858/Hard\\_Edges\\_Mapping\\_SMD\\_FINAL\\_VERSION\\_Web.pdf](http://www.lankellychase.org.uk/assets/0000/2858/Hard_Edges_Mapping_SMD_FINAL_VERSION_Web.pdf)

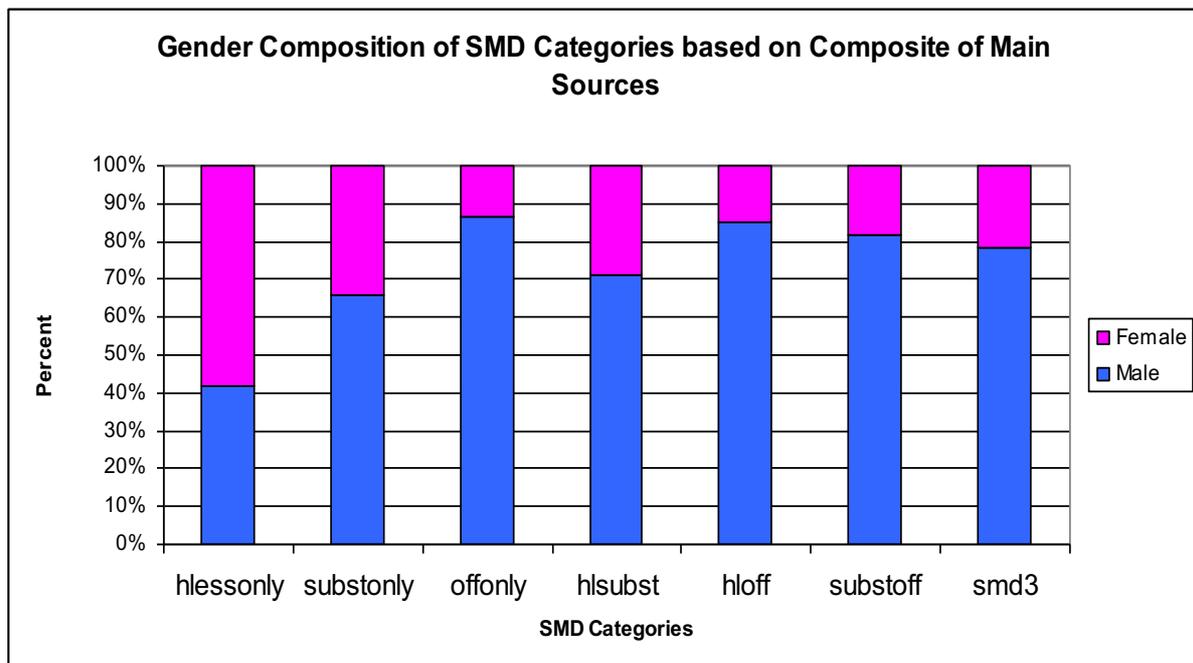
phase of their study Heriot-Watt found that their concept of SMD encompassing these four interlocking 'disadvantage domains' commanded broad consensus amongst stakeholders.

Heriot-Watt's SMD profile of those with experience of these domains is based on data relating to people in receipt of services. The rationale for this was that service use data provides a focus on those demonstrating disadvantage, rather than on data from representative population samples such as household surveys (which obviously include only a small percentage of people who experience disadvantage). There is an embedded assumption that service use is a reasonable indicator of severity of experience (and given the thresholds for particular services, these can be viewed as a fair assumption). However, as the authors acknowledge, there are two key drawbacks of service data. First, they only include those who are able/willing to access services (thus excluding some 'hidden' groups who do not take up services or who are not reached by them). Second, some services collect data that are more useable for profiling purposes than others.

The Heriot-Watt study illustrates some of the difficulties of generating profiles using service use data, in particular, the absence of a unified national dataset of mental health service use which also included data on the other domains of interest. Hence, in the final analysis mental ill-health was not treated as a fourth domain of SMD but as a major aspect of the 'quality of life' profiling of people experiencing the remaining three SMD domains. The authors noted that the formulation of SMD employed in the study was distinct from other forms of disadvantage because of the degree of dislocation from societal norms that these intersecting experiences represent. Notably, there is high degree of stigma associated with homelessness, criminal behaviour and substance misuse deriving, in part, from perceptions regarding the degree of social harm associated with each activity and the extent to which it is perceived to be in the locus of a person's control (Bramley, Fitzpatrick et al., 2015).

Heriot-Watt's final profile of SMD, therefore, is composed of adults in contact with the homelessness, substance misuse and criminal justice systems. They found substantial overlap between the three: two-thirds of single homeless people and offenders are also found in one of the other systems; one third of homeless people show up in all three (see Figure 1).

**Figure 1: Gender Composition of SMD categories**



(Source: Bramley, Fitzpatrick et al, 2015)

The study is an important one in that it is the first major attempt to profile the population of those facing SMD. Notably, the population profile generated from this analysis is predominantly male. While women represent a small majority of those who experience homelessness only, males predominate in the substance misuse and, especially, offending domains. 78% of those with experience of all three disadvantage domains are male. This begs the question: why might this be the case?

The profile generated is inevitably a consequence of the domains selected. Some types of disadvantage are highly gendered. For example, men substantially outnumber women in the criminal justice system. Some forms of disadvantage are more significant for people at different life stages. Different clusters of disadvantage are likely to be relevant for different populations, including for men and women, but also for younger and older people. Similarly, the definition of severity may need to vary according to the nature of the disadvantage and the population group e.g. the thresholds which define 'severe' may need to be different for men and women in particular domains. If other domains such as mental ill-health and experience of violence and abuse were included, it is likely that the gender profile produced would be different. However, including other domains has implications for data sources. For example, the absence of a unified national dataset on mental health service use which include data on other domains of interest means that other data sources would have to be used such as the Adult Psychiatric Morbidity Survey (APMS). As the Heriot-Watt team acknowledge, the profile generated via their analysis should be viewed as a profile, rather than the profile of SMD.

Even so, the profile does provide some valuable data on women with experience of SMD. The Heriot-Watt analysis found that 22% of those in the group experiencing all three SMD categories (SMD3) were female and there are larger percentages in the SMD2 and SMD1 groups. Women were found to be in the majority in one of the SMD1 groups (homeless only). It would therefore be of value to explore what the relevant datasets can tell us about the women that appear in each of these groupings.

A preliminary analysis provided by Heriot-Watt using the same datasets employed in the original study, highlights differences in the backgrounds and characteristics of men and women with experience of SMD (see Appendix 1). This indicates that compared to men, women (across all SMD categories) are:

MORE likely to:

- be receiving medication for mental health problems
- be dually diagnosed
- have no qualifications
- report significant financial problems
- report significant family relationship problems
- report some or significant partner relationship problems
- have had significant adverse experiences in childhood
- have been a victim of domestic violence

LESS likely to:

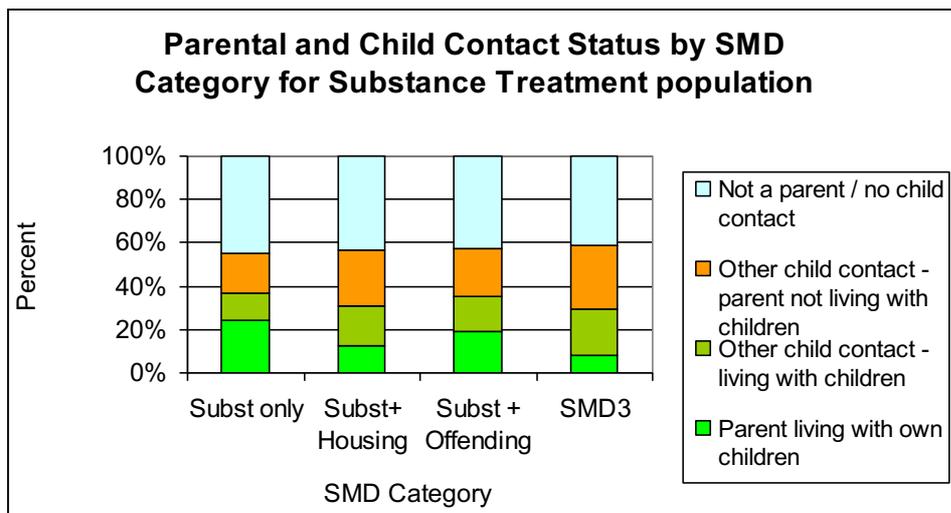
- have been a perpetrator of domestic violence
- have had psychiatric problems during childhood

According to this analysis, women were also more likely to be a parent living with their own child, or children, across all SMD groups and, notably, for those experiencing all three disadvantage domains (SMD3s):

- 12% of women live with their own child(ren) *cf.* 6% of men
- 34% of women are not a parent or have no child contact *cf.* 44% of men
- The differences are minimal for other categories ('other child contact – living with children' and 'other child contact – parent not living with children')

The Heriot-Watt analysis also offers some insight into the lives of women 'hidden behind' men experiencing SMD. For example, whilst 85-90% of SMD cases in the Supporting People database are 'single homeless', the National Drug Treatment Management dataset shows that *a majority* of people with experience of SMD have links with children either as a parent, living with their own children, as parent, not living with own children but in contact with them or having other child contact, i.e. living with a partner's children (see Figure 2 below)

**Figure 2: Parental and child contact status by SMD category**



(Source: Bramley, Fitzpatrick et al, 2015)

This suggests that a sizeable proportion of men experiencing SMD are living with or having regular contact with women as well as children. It is not unreasonable to assume that a large percentage of these ‘hidden’ women are themselves experiencing SMD but for one reason or another do not appear in this particular set of service use data.

### 1.3.1. Could a defined categories approach be used to generate a profile of women facing SMD?

We sought to assess the feasibility of defining a set of categories which would resonate for women by exploring the approach in the consultation workshops. Our theory was that if we could generate an agreed set of disadvantage categories that were pertinent to the lives of women, it may then be possible to identify relevant data sources.

Appendix 4 provides more detail about our approach to the consultations, but in brief, we asked groups to define those women they thought experienced SMD by asking them to tell us who were the women in their communities that had the most difficult lives. There was a fair degree of consensus across the groups with a number of recurring themes. Each of the consultations came up with groups of women they thought were particularly disadvantaged including:

- Women with mental health problems
- Lone mothers
- Migrant women
- Women who speak little English
- Traveller women
- Those who are isolated

- Women with disabilities/learning disabilities
- Women who are homeless or in poor quality or insecure housing
- Women dependent on drugs and/or alcohol
- Women who are sexually exploited/involved in prostitution
- Women subjected to domestic violence and abuse
- Women who have lost their children to the care system
- Women involved with the criminal justice system

In every group discussion the point was made that the most severely disadvantaged women were those who had a multiplicity of issues in their lives: that is, those who had an accumulation of bad experiences. These were women who had experienced abusive and neglected childhoods, then abusive relationships as adults, culminating in poor mental health, low self-esteem, usually combined with poverty and often accompanied by substance misuse and other disadvantages such as homelessness or insecure accommodation.

When we asked women what life was like for those facing SMD, responses did not tend to focus on the practical, physical hardships of life -it was as though these were taken for granted. There was much more emphasis given to the emotional impacts: recurring words and phrases were low self-esteem, lack of confidence, depression, anxiety, fear, exhaustion, no motivation, loss of pride and dignity. The responses of other people were also recurring themes: being judged, feeling blamed, getting labelled and being let down, loss of trust. The most dominant discourse across all the groups was women and girls' experiences in relationships with others, particularly their experiences of abuse and violence as children and as adults.

The implications of these discussions are that an approach to generating an SMD profile for women would need to access data sources on all the categories of women above and identify those who appeared in one or more. The range of configurations would be quite extensive e.g. women with learning disabilities who are sexually exploited and isolated; migrant women with mental health problems living with domestic violence. These configurations may well lead to

'Single mums raising children without support from family or from services ... there can be post-natal depression, everything is new and you don't know what to do, language barriers mean you are isolated and cannot ask for help...'

'Young women with learning disabilities get less information about what to expect from and how to manage relationships. ..In our rural area young women with learning disabilities are regularly asked to perform sexual favours in exchange for a lift – and the young women don't have the knowledge and confidence to refuse.'

'Traveller women on the road - they don't know where they will be the next day - could have to move on at any time because people won't let you stay. They have no access to medical help if they need it – you can take a sick child to the doctors in one place then be 40 miles away the next day. And your only community is your family – you are with them 24/7'

'Women who have lots of things going on – poverty and when you've had bad childhood there's a domino effect – it's a vicious cycle.'

different groups of women, all of whom could be reasonably judged to have experience of SMD, but would be found in different places – and in different datasets (if data were available at all).

#### 1.4. The risk factors approach

'Risk factors' are most generally understood to refer to aspects of people's lives which precede SMD and which are considered to be indicators of the possibility of later SMD. For example, living in severe material deprivation, having a family member in prison or being excluded from school in childhood are seen as risk factors for poor outcomes in adulthood.

A risk factors approach to developing a profile of SMD would identify the most relevant indicators of risk, and clusters of risks (those factors which evidence has shown to be the most reliable predictors of SMD) and using data from population samples to estimate likely prevalence.

**Advantages** of conceptualising SMD in this way are:

- It avoids very narrow categorisations and enables a wider range of risk factors to be taken into account for different populations;
- It enables an assessment of risk at different stages of the life-course;
- It might draw on data from representative population samples thus avoiding the bias inherent in service use data.

**Disadvantages** of conceptualising SMD in this way are:

- It hinges on the currently available evidence on risk factors and therefore excludes potentially relevant factors about which less is known;
- Estimates of prevalence are based on what information is collected via population surveys which has a critical bias in that it excludes some very disadvantaged groups e.g. those in prison or street homeless;
- The profiles generated tend to be broader, i.e. less focused on those at the extreme margins;
- And most critically, the profiles produced are of those most *at risk of* SMD – not necessarily those who *are experiencing* SMD.

An example of using a risk factors approach to estimate the prevalence of disadvantage is a 2010 report from the Coalition Government<sup>3</sup> which considered the six domains of education, health, employment, income, social support and housing. They defined those who are experiencing 'multiple disadvantage' as adults who are disadvantaged at any one time in three of these six areas using the following indicators:

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<sup>3</sup> HM Government (2010) State of the Nation Report: Poverty, Worklessness and Welfare Dependency in the UK. London: Cabinet Office.

<http://www.bristol.ac.uk/poverty/downloads/keyofficialdocuments/CONDEM%20-poverty-report.pdf>

- living in a workless household
- in income poverty and experiencing material disadvantage
- lacking social support
- are disabled
- living in poor housing and a poor living environment
- having no qualification.

Using household survey data they estimated that 1.2 million people (2.5% of all adults) are multiply disadvantaged.

Applying this definition, women appear to be at greater risk of multiple disadvantage than men at key stages of the life-course. The report notes that those most at risk of multiple disadvantage are (our italics):

- Families with children with some or all of the following characteristics: *lone parents*, those living in social housing or rented accommodation, those living in large families (i.e. those with three or more children), those who have a *young mother*, those who have a *black mother*, and those who live in urban and the most deprived areas. Families with these characteristics, as well as those in which one or both partners has a physical disability, limiting illness or mental health problem, are also most at risk of persistent multiple disadvantage.<sup>4</sup>
- Young people aged 16–24 with some or all of the following characteristics: *females*, those living independently with their own children, those living with a lone parent, social and private renters, and those living in more deprived areas.<sup>5</sup>
- Working-age people without dependent children with some or all of the following characteristics: *women*, older working-age people, those from manual occupational groups, *home-makers*, early retirees, sick and disabled people, those who never married, and those living in single-person households.<sup>6</sup>
- Older people aged 60 and over with some or all of the following characteristics: *those aged 80 years and over*, those who live alone and those who have poor access to services.

Given that risk factors for multiple disadvantage are similar, if not greater, for women and girls, one might reasonably expect women to feature in SMD groupings at least to the same degree as men. If women do not appear in these groupings to the same extent, then this begs the question why might that be the case?

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<sup>4</sup> Oroyemi, Damioli, Barnes & Crosier (2009). Understanding the risks of social exclusion across the life course: Families with Children. Social Exclusion Task Force, Cabinet Office. Analysis by Strategy Unit and Social Exclusion Task Force

<sup>5</sup> Cusworth, Bradshaw, Coles, Keung & Chzhen (2009). Understanding the risks of social exclusion across the life course: Youth and young adulthood. University of York

<sup>6</sup> Fahmy, Levitas, Gordon & Patsios (2009). Understanding the risks of social exclusion across the life course: Working age adults without dependent children. University of Bristol.

We suggest that there is good evidence that that there are gendered pathways to SMD and that men and women who have similar risk factors in their lives frequently have different life trajectories so are found in different places.

In our 2014 report on women and girls at risk<sup>7</sup> we suggested a model for understanding the relationship between risk factors and the pathways leading to extensive disadvantage frequently taken by women and girls. This model highlights the significance of three interrelated sets of factors: social inequalities, experience of abuse and violence, and gender expectations:

**Figure 3:**



Whilst social inequalities and experience of abuse and violence underlie the risk factors at different stages of the life-course, gender expectations shape responses to them. So boys and girls who, on the face of it, experience very similar sets of risk factors are likely to respond to them in different ways and be responded to differently by others. For example:

- Girls are less likely than boys to act out distress and exhibit conduct disorder.
- Girls generally have less freedom of movement and are less likely to get involved in the anti-social behaviour that is often linked to male bonding in adolescence.
- Violent and criminal behaviour is strongly linked to masculinity and it does not generally confer peer status on girls as it does on boys.
- Girls are less likely to be excluded from school and 'locked up' young.
- Girls are less likely to become estranged from family and friendship networks.

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<sup>7</sup> Di McNeish and Sara Scott (2014) Women and Girls at Risk: Evidence Across the Lifecourse [http://www.lankellychase.org.uk/assets/0000/2675/Women\\_Girls\\_at\\_Risk\\_-\\_Evidence\\_Review\\_040814.pdf](http://www.lankellychase.org.uk/assets/0000/2675/Women_Girls_at_Risk_-_Evidence_Review_040814.pdf)

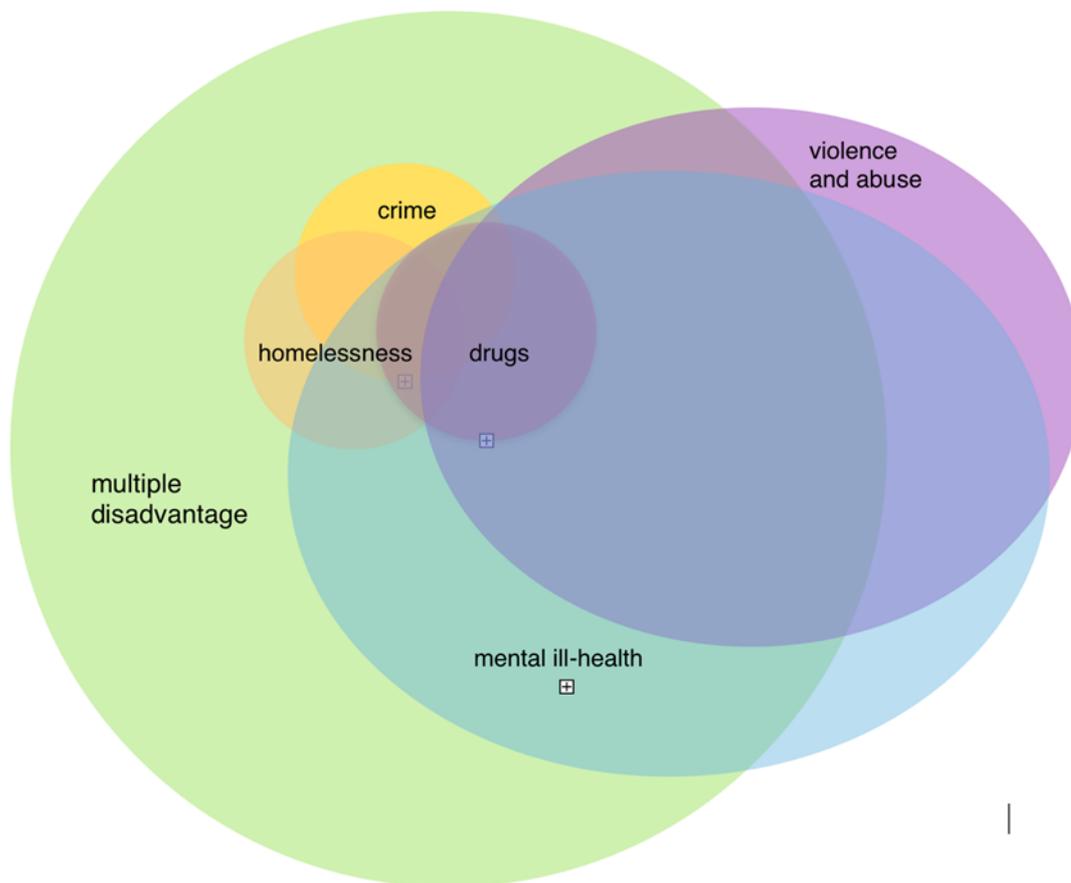
So whilst boys and young men frequently respond to childhood disadvantage and trauma by behaving in ways that get them excluded from school, involved in criminality and place them at risk of serious exclusion such as street homelessness, the more likely trajectories for girls and young women who start with similar early life experiences include:

- The internalisation of distress and development of early mental health difficulties.
- Entry into early sexual relationships often characterised by further violence and abuse, including sexual exploitation.
- Early parenthood and ongoing responsibility for children.

One way of looking at it is that, in relation to some SMD definitions, maleness (and particularly masculinity) is a major risk factor, whilst femaleness (or some aspects of femininity) can be seen as a protective factor. But it also suggests that key features of SMD for women are missing from current analyses.

The figure below illustrates the relationship between multiple disadvantage, the three SMD domains as defined in the Heriot-Watt analysis and two other domains of mental ill-health and experience of violence and abuse. It shows that all (or at least the vast majority) of those in the SMD groupings sit within a wider population of people who are multiply disadvantaged. This wider population, as we have noted, is likely to be composed of a slightly higher proportion of women than men.

Figure 4



Mental ill-health is a key feature of those in the three core SMD groupings. However, there are large numbers of people with mental ill-health who do not enter a SMD category (and some sit completely outside the wider multiply disadvantaged population too). The prevalence of serious mental illness is similar for men and women, but there are gender differences in the type of disorder diagnosed. For example, women are more likely to suffer anxiety and depression and men are more likely to be diagnosed with an anti-social personality disorder and alcohol dependency (APMS 2007)<sup>8</sup> These differences may in part explain why mental illness in men is a contributory factor for their entry into one of the SMD groupings, whereas for women it may be less so.

Experience of violence and abuse is strongly associated with mental ill-health and extensive violence and abuse is strongly associated with multiple disadvantage. Recent analysis of the Adult Psychiatric Morbidity Survey<sup>9</sup> (identified a number of discrete groups of people with

<sup>8</sup> Adult psychiatric morbidity in England, 2007 Results of a household survey. Edited by Sally McManus, Howard Meltzer, Traolach Brugha, Paul Bebbington, Rachel Jenkins, Health and Social Care Information Centre, 2011 <http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morb-res-hou-sur-eng-2007-rep.pdf>

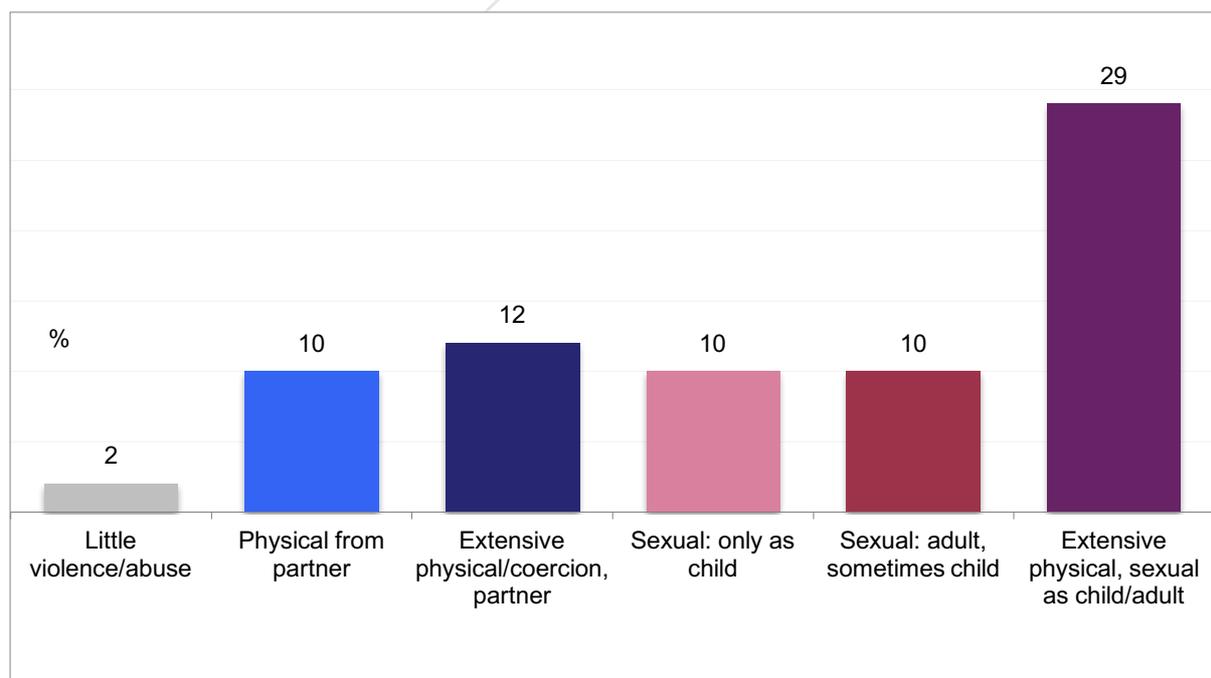
<sup>9</sup> Scott S, Williams J, Kelly L, McNaughton Nicholls C, Lovett J and McManus S (2013) *Violence, abuse and mental health in England*, London, UK: NatCen, <http://www.natcen.ac.uk/media/205520/rev-a-strand-1-13th-may-briefing-report-2-.pdf>

distinct patterns of abuse experience and mental health outcomes. One group, representing 1 in 25 of the population, had experienced extensive physical and sexual violence, with an abuse history extending back to childhood. Nearly all members of this group had been assaulted by a partner. Half had been threatened with death. Most had been sexually abused as children and some severely beaten by a parent. Many had also been raped as an adult. 80% of this group were women and over half had a common mental disorder (CMD) such as clinical depression or anxiety - making them five times more likely than those with little experience of abuse to have a CMD. There was also a strong link with experiencing more than one disorder. People in the 'extensive physical and sexual abuse' group were about 15 times more likely than those with little experience of violence and abuse to have three or more mental disorders.

People in all the groups characterised by experiences of violence and abuse were at least five times more likely than those with little experience to have attempted to take their own life (see chart below). However those in the 'extensive physical and sexual group' were 15 times more likely to have done so. Over half (56%) of people in this group had self-harmed at some time – compared to 10% of those with little experience of violence and abuse.

In a further group, characterised by extensive physical violence and coercive control in an adult relationship – and representing 1 in 50 of the population – 37% had a CMD. The mental health implications of domestic violence are clearly considerable, but have received very little attention until now.

**Figure 5: Proportion of each violence and abuse group who have attempted suicide, APMS Analysis, 2013**



A risk factors approach to conceptualising SMD for women and girls emphasises that, as a result of gendered pathways and gender expectations, women and girls are more likely to become visible as clients of mental health, violence and abuse and children's services. Amongst those women who do fall into the drugs/crime/ homelessness categories, experiences of interpersonal violence/abuse and mental health issues are likely to be of particular significance and particular gendered experiences (e.g. having been sexually exploited and having children taken into care) are likely to feature in their life histories.

We tested this out with groups of women in our consultation sessions by asking, what are the biggest risks for women: that is, what experiences or life events meant women were more likely to face SMD. Again, women did not tend to dwell so much on the practical challenges that face women at risk of SMD. Lack of money, loss of benefits, eviction – these were all mentioned, but much more prominent in the discussions were things that happen to women in relationship to others.

Poor family relationships and trauma from abuse in childhood were viewed as setting girls on the path to later disadvantage. And as adult women, it was their continued experiences in abusive relationships with men which was the most dominant discourse across all the groups. Many women were explicit about what they saw as a clear thread linking what happened to them as children (in abusive relationships within their families) to what happened to them as adults (in abusive relationships with partners) and how these experiences were connected to the circumstances they were in (e.g. their experiences of mental health problems, substance misuse and/or involvement with the criminal justice system).

'What happens in childhood – I lost my child because of my childhood.'

'Sometimes the only way for young women to secure their safety is to sever ties with family because they are not believed re abuse. Sometimes ties have to be severed from an entire community. The prospect of 'rocking a community' and being excluded is a heavy burden to bear.... Sometimes women see securing new relationships as the only way to safety'.

One woman talked of being trafficked to this country and spending 7 years in one place as a captive, not knowing where she was or even what country she was in. She could speak no English. She eventually escaped and ran to a church where people helped her. She said you could not see because she was clothed but her body bore the scars of what had happened to her.

'I asked one woman about her black eye and she told me she'd got a Crown Derby plate for that. Every time her husband hit her he tried to make up by giving her Crown Derby. She told me she's got the whole tea set'.

'Women don't go to services cos they're frightened of losing their kids – or can't go because of the kids'.

'Women are still there because of their children...In theory, you could leave and go to a safe house with your children – but you would have to cut all communication with your family and leave the community entirely because otherwise your whereabouts would get round by word of mouth and your husband would find you.'

Individual women's experiences differed but the themes they highlighted were similar. We heard examples from young women, older women, learning disabled women, ethnic minority women, migrant women and traveller women which all had abuse, violence and coercion at their heart, and, fundamentally, a lack of control over their own lives.

When we asked groups of women what was different about their experiences to those of men who are also disadvantaged, recurring responses highlighted the greater freedom experienced by men. Women also discussed differences in the amount of power and control enjoyed by men and women – for example, they pointed out that even within very disadvantaged families, men often have greater financial control over the available resources. And, however disadvantaged men themselves are, they are often able to exert power over the women in their lives.

A further theme was the different expectations placed on men and women. One of the greatest expectations on women is that they will 'keep going' in order to look after others, particularly children. This was not necessarily seen as a bad thing – for example, women talked about the need to look after their children as the main thing that kept them 'strong'. However, the imperative to care for children comes with risks. They may tolerate violent relationships or avoid services which might help them, for example.

Given the expectations on women of caring for their children, the cost of 'failure' can be very high. Some women who had lost children to the care system were distressed and angry that the men they saw as contributing to their loss could get involved with another partner and have more children, while they felt labelled for life as 'bad mothers.'

Women also highlighted widely held gendered expectations about the behaviour and demeanour of women. They described the pressure on women to have particular kinds of passive, non-assertive

'Men (especially young men) get status by acting out – their image is important and they're more likely to be involved with gangs etc. Women gain status through relationships. Women are also more likely to internalise issues and are at greater risk of self-medicating and/or self-harming.... Men tend to take it out on others; women take it out on themselves'

'Young women often self-harm by cutting themselves in visible places e.g. arms (and this is often perceived as 'attention-seeking' by professionals). Young men often self-harm by seeking out fights they know they cannot win.'

'Young women tend to be more disaffected from family therefore have weaker (or no) support networks to return to when coming out of prison, for example. Many young women end up in homeless hostels when young men would return to family. Severed family ties makes young women 'doubly disadvantaged'

'Men also have hard lives but women's lives can be much harder if not supported by their husbands. Men work hard but can go out to meet friends. Women work even harder – often have two jobs.'

personality traits, to have particular kinds of body shapes and to be sexual in particular ways. They talked about the sexualisation of women starting at a very early age and about the ways in which these expectations shaped the way women and men respond differently to adversity.

### 1.5. A social inequalities approach

This approach starts from the assumption that SMD needs to be understood in the context of a dynamic system of social inequality. All societies have group-based hierarchies which result in the dominance of some groups and the oppression of others. These hierarchies are a commonplace and striking feature of social life. They are dynamic systems that are continually re-organising themselves and may be sustained or challenged, enhanced or undermined at a variety of levels. Humans can construct group distinctions on the basis of anything that seems meaningful at the time. It is when social categories (such as, race, caste, ethnicity, nationality, social class, religion) are linked with power that they manifest as social hierarchies.

The nature of these hierarchies may change over time and vary between societies, but there are some stratification systems which are very pervasive, including gender (where men have disproportionate political and social power) and age (where adults and middle-age people have disproportionate social power over children and younger adults).

Subordinate groups are likely to encounter various forms of oppression from being subject to the processes and institutions which reinforce inequality and uphold the power of more dominant groups and from having a lesser share of material resources.

Developing a profile of SMD using this conceptual framework would involve identifying those groups who

‘The husband goes out gambling and drinking then comes home demanding sex and beating the woman if she does not comply or threatening to tell other people if she won’t give it to him. So the woman just lets him do what he wants – but she is very depressed and has to take anti-depressants and go out to work to earn money for the family. She wants to commit suicide – but the need to care for her children stops her’.

‘I’ve had four bad relationships, all involving domestic violence and drugs. But it’s women who pay the consequences for bad decisions – men can just walk off. When women have kids taken off them, men can walk away and have as many as he wants. Women are watched like a hawk. Sometimes I wish I wasn’t a woman’.

‘If women try to take control they’re seen as wrong and it can lead to domestic violence’.

‘Women will put up with domestic violence because of the kids. In the end I only left cos I knew otherwise I’d be coming out in a straitjacket or a body bag.’

experience the most toxic consequences of inequality and oppression – those with the most unequal access to power and resources and who are most oppressed by dominant ideologies and institutions.

**Advantages** of conceptualising SMD in this way are:

- It is sensitive to the rapidly shifting social hierarchies of the 21<sup>st</sup> century e.g. those associated with migration and global economics
- It directs attention to the advantaged as well as the disadvantaged

**Disadvantages** of conceptualising SMD in this way are:

- This approach is not a good fit with existing databases in that few are likely to include potentially relevant indicators.

Our consultation events provided some very powerful illustrations of the impact of gender and other inequalities on disadvantaged women's lives. As we have already highlighted, women were clear in articulating their gendered experiences of oppression in their relationships with their partners, families and communities. Most vulnerable are those who experienced abuses of power as children, especially when perpetrated by care givers in the absence of care and love and where these early experiences are compounded by subsequent abusive relationships in adulthood.

But the oppression of women in the 'private' sphere of family and community life is a reflection of gender inequality in society which can be seen as being reinforced by dominant ideologies (about, for example, how men and women are supposed to behave). This might suggest that SMD women are likely to be those who have been most relentlessly exposed to ideologies and myths that justify their abuse, exploitation and place in the world, and who have had few safe and meaningful conversations that challenge this. Instead their

'Stereotypes about gender norms of behaviour mean that public and service cannot 'cope' with aggression from women therefore they are responded to differently in support services and the criminal justice system'

'Reasons for claiming asylum differ: for men it tends to be extreme violence from the state; women more likely to flee violence from partners. Services cater better for the needs of male asylum seekers'

'We see a medicalisation of mental health issues when women are simply responding normally to life events/trauma. Some behaviours are actually signs of resilience or survival strategies – but they sometimes get women a borderline personality disorder label.'

'Male bias in interventions. Disadvantage starts early and services need to be gender aware. Many service providers think that equal opportunities means 'treating everyone the same' so they fail to recognise/ameliorate gendered disadvantage. Gender neutrality can mean no-one gets a good service.'

interactions and observations tell them that they are worthless, asking for it, to blame, needing to be punished, inadequate, and so forth. This is likely to include girls and women abused in highly controlling families and controlling cultures, along with those who have been groomed, have been sex trafficked, who are socially isolated because of poverty, have disabilities, are poorly educated, as well as those who are migrants (including those who have had few opportunities to learn the language of the host culture).

Conversely, those girls and women who are able to 'see through the oppressive myths' are more likely to claim a positive identity for themselves, to access support and make choices that support their wellbeing. The women who took part in our consultations were clear about the importance of women's spaces, relationship based support from other women and staff they could trust.

Inequalities are also reinforced by social institutions which primarily serve the interests of the privileged at the expense of the disadvantaged. Girls and women facing SMD are likely to include those who have been in sustained contact with social institutions which are not informed by an understanding of the working and impact of social inequalities. These institutions de-contextualise needs and behaviour and typically blame the individual for their predicament and any unwillingness to change. Those girls and women who have experienced support from those informed by understanding of inequalities may be better placed to endure and recover from extreme difficulties. The women we spoke to provided numerous examples of how their status as women affected whether and how they accessed services, and how they were received by services.

Within social hierarchies, dominant groups secure a disproportionate share of the good things in life (e.g. power, money, good education, valued work, housing, own transport, holidays and leisure) at the expense of subordinate groups. The most severely and multiply disadvantaged girls and women are likely to be found in the intersection of groups most disadvantaged in these respects e.g. women who have

'Get women's voices heard; encourage women to share their experiences and views; emphasise the legitimacy of these; use confidence building workshops'

'The women's centre - women's spaces – provides real honest communication, trust, at right speed, peer support'

'A family of women who belong and share is a substitute – share what learn and confidence to believe in self'

'The most vulnerable are those who've had most contact with services. Women get shoehorned into programmes designed for men.'

'More broadly, as a society we need to challenge men's behaviour; acknowledge that working with women (alone) won't solve the disadvantages the face.'

experienced exploitation and discrimination arising from their gender compounded by lifelong hardship associated with restricted access to resources and opportunities.

Gender is only one dimension of inequality and the most severely and multiply disadvantaged women will be those who are also members of other oppressed groups. Developing a profile of SMD using this approach would involve identifying these groups. Some inequalities are formally recognised by law such as age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation. Others may need to be identified via policy and research literature, campaign groups and dialogue with experts including those with lived experience. Examples which emerged during our consultations included:

- Young women who may be affected by both gendered and age power relations.
- Older women with long histories of disadvantage may find that ageing adds a further dimension to their oppression, particularly if they are part of cultures and societies where ageing is associated with a loss of status.
- BME women whose disadvantage will be compounded by inequalities associated with race, ethnicity and nationality.
- Women with mental health problems who do not fare well in current mental health diagnostic and treatment systems.
- Women with disabilities including learning disabilities.
- Women migrants without secure immigration status who may be subject to domestic violence in the context of marriage, employment and trafficking, and/or have no recourse to public funds;
- Women in extreme poverty, especially those with sole responsibility for children;
- Women offenders and those who are homeless;
- Women involved in sexual exploitation and substance use.

## 1.6. A rights based approach

This approach to conceptualising SMD can be seen as deriving from the social inequalities perspective outlined above. It would involve starting with a definition of people's rights and define SMD according to the circumstances in which those rights are most undermined or threatened. We might, for example, begin from a feminist analysis which emphasises the rights of women to enjoy<sup>10</sup>:

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<sup>10</sup> These derive from the seven demands of the Women's Liberation Movement. The first set of demands were established at the first WLM Conference in Oxford in 1970. In 1978 the final national WLM conference was held in Birmingham and a final demand was added to the first six: Freedom for all women from intimidation by the threat or use of violence or sexual coercion regardless of marital status; and an end to the laws, assumptions and institutions which perpetuate male dominance and aggression to women. See more at British Library: <http://www.bl.uk/sisterhood/timeline#sthash.He7mpzgj.dpuf>

- Financial independence.
- Control over life choices.
- Freedom of movement.
- Freedom from male violence and fear of violence.
- Sexual and reproductive choice.
- Shared responsibility for children.
- Equal access to education and employment.
- Freedom from gendered expectations.

Using such an approach, the most extensively disadvantaged women would be those able to exercise the fewest of these rights. Women who were themselves, or had partners who were homeless, drug dependent or involved with the criminal justice system would be particularly unlikely to enjoy these rights, but so would women such as asylum seekers, trafficked women and traveller/Roma women – and some of those living within ostensibly law-abiding families rather than on the social margins.

**Advantages** of conceptualising SMD in this way are:

- It is a fundamentally more inclusive approach which take account of structural inequalities
- A profile of SMD generated in this way would include hidden groups which do not presently feature in most analyses
- It can be applied at different stages of the life-course.

**Disadvantages** of conceptualising SMD in this way are:

- Defining rights and what constitute serious threats to those rights would be a major challenge;
- It is difficult to measure the presence and absence of rights and individuals' abilities to exercise them in a way that is quantifiable.

As part of our consultations with women we conducted an exercise which asked women to identify the most important rights (as defined above) for them. We did this by giving each woman three post-it notes numbered 1,2 and 3 and asking her to attach these to the above rights according to her first, second and third priorities. We are not making any great 'scientific' claims for this exercise – it was mainly a way of stimulating discussion, but the resulting 'scores' are interesting. The table below shows the composite scores for each group with the first, second and third priorities highlighted.

The right to be free from male violence and fear of violence was the top priority for the Yorkshire and Glasgow groups and equal first for one of the London groups. This and the

other London group also gave top priority to the right to equal access to education and employment. The London 1 group was composed of migrant women for whom education, freedom from violence and freedom of movement were their top three priorities.

The second London group was drawn from a range of BME (Bengali, Somali, Vietnamese and African Caribbean) with some White women. These women were largely part of families and communities and had talked a lot about their responsibilities for caring for children and others, often experiencing oppressive relationships and limited access to education and work. Access to education and employment was their top priority by a wide margin followed by control over life choices and financial independence.

The Yorkshire group was drawn from a range of groups held at the Women’s Centre (composed of White, Asian and Black women). Their interests in particular rights was more diverse but they were united in identifying freedom from violence as their top priority, well ahead of any of the others.

They shared this view with the Glasgow group who again overwhelmingly identified freedom from violence as their first priority.

Control over life choices was in the top three for all the groups. Some women explained that this was the overarching right for them – that if they had that, others would follow.

The lowest priority overall was the right to have shared responsibility for children. This perhaps suggests that for many women, despite the disadvantages of having the main caring role in families, the prospect of sharing this with their men is still not very appealing.

	Yorks	Glasgow	London	London
Number of women in group:	(21)	(20)	(16)	(38)
Financial independence	16	7	11	32
Equal access to education and employment	12	17	23	91
Freedom from male violence and fear of violence	30	42	23	13
Control over life choices	15	17	14	41
Freedom from gendered expectations	15	18	8	18
Freedom of movement	7	0	21	22
Sexual and reproductive choice	10	9	0	8
Shared responsibility for children	2	0	4	20

Most important right

Second most important

Third most important

## 1.7. A capabilities approach

A rights based approach shares some core features with our final conceptual framework, the capabilities approach. This approach to conceptualising SMD draws on some of the original thinking by Amartya Sen<sup>11</sup> and developed by Martha Nussbaum.<sup>12</sup> Central to the approach is a focus on human freedoms to enjoy a good life or to flourish. The approach is summed up by Burchardt and Vizard (2007)<sup>13</sup> as follows:

*Capabilities are substantive human freedoms or real opportunities (such as the ability to avoid premature mortality, to be adequately nourished, to have access to adequate health, social services and education, to participate in and influence public life, and to enjoy self-respect) that people value and have reasons to value. The capability approach is an analytical framework for examining the achievement (and lack of achievement) of basic human freedoms of this type. (2007:16)*

They go on to argue that the capability approach provides an overarching structure for understanding and measuring equality which is attractive because it:

- Focuses on what matters to people.
- Recognises diversity in needs.
- Places emphasis on barriers, constraints, structures and processes.
- Recognises diversity in goals.

Sen himself has eschewed the development of a definitive list of core capabilities but Nussbaum (2003) built on his work to develop a list of ten central capabilities that, she argues, all humans value and require to live a good life, these being: life; bodily health; bodily integrity; senses, imagination and thought; emotions; practical reason; affiliations; other species; play; and control over one's environment.

A number of writers have developed this thinking, particularly in the fields of international development and education.<sup>14</sup> In the UK, Vizard and Burchardt (2007) carried out work for the Equalities and Human Rights Commission to develop ten domains of capability as follows, including the capability:

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<sup>11</sup> See for example Sen, Amartya K. (1992), *Inequality Re-examined*, Oxford: Clarendon Press.

<sup>12</sup> See for example Nussbaum, M. C. (2003), .Capabilities as Fundamental Entitlement: Sen and Social Justice, *Feminist Economics*, 9(2-3), 33-59.

<sup>13</sup> Vizard, P. & Burchardt, T. (2007) Developing a Capability List: Final Recommendations of the Equalities Review Steering Group on Measurement (London, CASE 121, London School of Economics).

<sup>14</sup> For an overview of these see David Clark's ERSC working paper - The Capability Approach: Its Development, Critiques and Recent Advances

GPRG-WPS-032 <http://www.gprg.org/pubs/workingpapers/pdfs/gprg-wps-032.pdf>

- to be alive
- to live in physical security
- to be healthy
- to be knowledgeable, to understand and reason, and to have the skills to participate in society
- to enjoy a comfortable standard of living, with independence and security
- to engage in productive and valued activities
- to enjoy individual, family and social life
- to participate in decision-making, have a voice and influence
- of being and expressing yourself, and having self-respect
- of knowing you will be protected and treated fairly by the law

Vizard and Burchardt argue that the capability approach has the following **advantages**:

- It focuses attention on intrinsically valuable **ends**, rather than instrumentally valuable **means** (such as income and resources).
- It focuses on the central and valuable things that people can actually do and be (rather than on subjective wellbeing, happiness and preference-satisfaction).
- It focuses on what it is actually *feasible* for a person to do and be and recognises the importance of a broad range of *constraints* for the analysis of individual freedom.
- It can be adopted as an analytical framework to evaluate the substantive freedoms enjoyed by individuals and groups.

The **disadvantages** are:

- Measuring the extent of people's capabilities is a challenge and attaching capabilities to currently available data even more so. Existing data is unlikely to provide an account of people's preferences, for example, making it extremely difficult (if not impossible) to determine whether someone is being denied a capability due to structural or other barriers or simply choosing not to exercise it.
- It is not an easy set of concepts to communicate. The language of capabilities is easily open to misinterpretation.

Burchardt and Vizard recognised this second disadvantage and proposed two parallel definitions of the capability approach, one technical and one in 'plain English', as follows:

*Technical:*

*An equal society protects and promotes equality of valuable capabilities – the central and important things that people are able to do and to be – so that*

*everyone has the substantive freedom to live in ways that they value and choose (and have reason to value and choose). An equal society recognises the diverse needs, situations and goals of individuals, and seeks to expand their capabilities by removing discrimination and prejudice and tackling the economic, political, legal, social and physical conditions that constrain people's achievements and limit their substantive freedom.*

*Plain English:*

*A society which protects and promotes equality is one in which everyone can flourish. It seeks equality in the valuable things that people can do or be, so that everyone has the real freedom to live in ways that they value.*

*An equal society recognises the diverse needs, situations and goals of individuals, removes discrimination and prejudice, and tackles the economic, political, legal, social and physical barriers that limit what people can do and be.*

It follows that a profile of SMD based on such a list would include those individuals whose capabilities were most compromised. We suggest that a person's capability in any given domain can be seen as being composed of three interacting elements:

- The **opportunity** to enjoy the capability: does the opportunity exist? Does the person have an entitlement to the opportunity? Is the opportunity accessible to them?
- The **economic and social resources** available to enable them to do so: Does the person have the time, money, education, employment and social networks which enable them to enjoy the capability?
- The **personal capacities** to exercise the capability: does the person have the psychological resources necessary, e.g. the confidence, self-esteem, sense of entitlement

The important thing about a capabilities approach is that it cannot be reduced to any one of the above elements: each is significant. In this regard the capabilities approach connects to feminist approaches to inequality. As Robeyns (2003) puts it:

*It is immediately clear that the capability approach has enormous potential for addressing feminist concerns and questions. Ever since its inception, the women's movement has focused on many issues that are not reducible to financial welfare, such as reproductive health, voting rights, political power, domestic violence, education, and women's social status.<sup>15</sup>*

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<sup>15</sup> Ingrid Robeyns (2003) Sen's Capability Approach and Gender Inequality: Selecting relevant capabilities; *Feminist Economics* 9(2 – 3), 2003, 61 – 92  
<https://csde.washington.edu/~scurran/files/readings/April28/recommended/SelectingRelevantCapabilities.pdf>  
[fts](#)

In addition, Robeyns concurs with Sen that there should not be a definitive universal list of capabilities, but within the overall framework, such lists should be generated in ways which involve people in accordance with the context and purposes for which they are to be employed. As Sen argues:

*Taking people seriously as agents entails giving them a chance to be heard, and to be involved in collective evaluations and decisions.*

Robeyns goes on to propose a list of capabilities for the conceptualization of gender inequality in post-industrialized Western societies, as follows:

1. Life and physical health: being able to be physically healthy and enjoy a life of normal length.
2. Mental well-being: being able to be mentally healthy.
3. Bodily integrity and safety: being able to be protected from violence of any sort.
4. Social relations: being able to be part of social networks and to give and receive social support.
5. Political empowerment: being able to participate in and have a fair share of influence on political decision-making.
6. Education and knowledge: being able to be educated and to use and produce knowledge.
7. Domestic work and nonmarket care: being able to raise children and to take care of others.
8. Paid work and other projects: being able to work in the labour market or to undertake projects, including artistic ones.
9. Shelter and environment: being able to be sheltered and to live in a safe and pleasant environment.
10. Mobility: being able to be mobile.
11. Leisure activities: being able to engage in leisure activities.
12. Time-autonomy: being able to exercise autonomy in allocating one's time.
13. Respect: being able to be respected and treated with dignity.
14. Religion: being able to choose to live or not to live according to a religion.

The above list has much in common with the issues and priorities identified by women in our consultation exercises. The process we have undertaken, although on a very small scale, is largely consistent with the principles and processes advocated by Sen as appropriate to generating sets of capabilities which are relevant to particular groups and contexts. If we were to translate what women said to us into a set of capabilities for SMD women and girls, the list might look similar to the above.

The key challenge is how to measure such a list of capabilities. A framework for doing this was proposed by Burchardt and Vizard<sup>16</sup> for the Equalities Review<sup>17</sup> which recommended an approach for the measurement of inequality, summarised below:

**Objective:** to measure the extent of inequality in substantive freedoms/capabilities to achieve valuable outcomes

**Outcomes** Selected indicators within each dimension by gender, disability, ethnicity, age, religion and belief, sexual orientation and transgender, or combinations of these

**Autonomy** Indicators of choice and control in obtaining the outcome within each dimension by gender, disability, ethnicity, age, religion and belief, sexual orientation and transgender

**Process** Indicators of unequal treatment and discriminatory practices

## 1.8. Implications of these approaches

All of the conceptual frameworks considered here can enhance our understanding of SMD for women and girls when they are viewed through a gendered lens.

Our consultations in relation to generating a set of **defined categories** of women who are SMD give rise to several implications:

- There are a number of groups which women agree are likely to experience SMD, but a consensus across all groups was that women who experience greatest disadvantage are those who have a multiplicity of such factors in their lives.
- A profile of SMD would require data sources on all these groups/factors and identify those who appeared in one or more.
- The range of configurations would be quite extensive e.g. women with learning disabilities who had been sexually exploited and are isolated or migrant women with mental health problems who are in insecure housing.
- These configurations may well lead to different groups of women, all of whom could be reasonably judged to be experiencing SMD – but who would be found in different places.
- It would be difficult to develop a profile of women facing SMD using service data alone.

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<sup>16</sup> Tania Burchardt and Polly Vizard (2007) Definition of equality and framework for measurement: Final Recommendations of the Equalities Review Steering Group on Measurement  
[http://eprints.lse.ac.uk/6218/1/Definition\\_of\\_equality\\_and\\_framework\\_for\\_measurement.pdf](http://eprints.lse.ac.uk/6218/1/Definition_of_equality_and_framework_for_measurement.pdf)

<sup>17</sup> Fairness and Freedom: The Final Report of the Equalities Review 2007  
[http://webarchive.nationalarchives.gov.uk/20100807034701/http://archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/equality\\_review.pdf](http://webarchive.nationalarchives.gov.uk/20100807034701/http://archive.cabinetoffice.gov.uk/equalitiesreview/upload/assets/www.theequalitiesreview.org.uk/equality_review.pdf)

An understanding of **risk factors** for women and girls and the way that these interact with gendered expectations identifies groups who are more likely to experience SMD across the life-course.

- Extensive experience of violence and abuse is a key risk factor in their disadvantage and gendered pathways mean they are more likely to become visible as clients of mental health, violence and abuse and children's services.
- Amongst those women who do fall into the drugs/crime/ homelessness categories, experiences of interpersonal violence/abuse and mental health issues are likely to be of significance and particular gendered experiences (e.g. having been sexually exploited and having children taken into care) are likely to feature.
- Risk factors are inextricably linked to social inequalities – of gender, class, ethnicity, disability and membership of other oppressed groups (including being categorised and labelled as users of welfare, mental health and criminal justice systems).

There is extensive research on risk factors and we have good evidence about the groups of women and girls who are at risk of disadvantage. However, measuring risk (whilst important for planning interventions to prevent or divert people from disadvantage) does not equate to measuring actual SMD. Identifying those at greatest risk of SMD will still result in a number of 'false positives' – women, who despite having multiple risk factors in their lives, do not become severely and multiply disadvantaged.

Taking a **social inequalities** perspective, women and girls who experience SMD will be those who have experienced the most relentless and toxic interpersonal consequences of the gender system. These will be women:

- whose significant relationships since childhood have been characterised by violence and abuse;
- who have experienced additional vulnerability over their lifetime because of their membership of additional disadvantaged social groups;
- who may have had high levels of contact with social institutions and services that support social inequalities at the expense of meeting the needs of individuals;
- who have experienced lifelong hardship, exploitation and discrimination arising from their gender, and being part of other disadvantaged social groups compounded by poverty and restricted access to resources and opportunities.

A social inequalities perspective has much to contribute to our understanding of why some groups of women face SMD and how their experiences are compounded by gender and other inequalities. However, it is less useful as a means of developing a statistical profile.

Women and girls with experience of SMD will also be found among those who have the fewest **human rights**.

- Women who are themselves drug dependent or involved with the criminal justice system are particularly unlikely to enjoy these rights but so are women such as asylum seekers, trafficked women and traveller/Roma women – and some of those living in restrictive families and communities rather than on the social margins.

Applying a **capabilities framework**, women and girls with experience of SMD will be those whose capabilities are most compromised. These will be women:

- Who have the least entitlement to opportunities to enjoy capabilities or the most restricted access to such opportunities
- Whose capabilities are severely constrained by a lack of economic and social resources
- Whose capabilities are undermined by limited personal capacities as a consequence of their life experiences and circumstances

Each of these approaches present opportunities and challenges for developing a profile of SMD. The next chapter explores the application of these frameworks and the feasibility of profiling women and girls facing SMD through a range of existing datasets.

## Chapter 2: Feasibility study on developing a profile of women and girls facing SMD

### 2.1. Introduction

Having considered possible approaches to defining ‘severe and multiple disadvantage’ in relation to women and girls, this chapter assesses whether it would be feasible to build up a statistical profile of women and girls experiencing severe and multiple disadvantage (SMD) using existing datasets and considers the practicalities involved in doing so. The chapter begins with a presentation of the aim and methods utilised for this purpose, before proceeding to a systematic consideration of each research question and datasets of potential use.

#### 2.1.1. Aims of the feasibility study

This chapter addresses the feasibility of answering the following research questions:

- 1) How many girls and women are experiencing SMD?
- 2) How many women live with partners who are affected by SMD?
- 3) How many girls live in households where one or both parents are affected by SMD?
- 4) What are the overlaps between SMD domains in the case of women and girls?
- 5) What are the risk factors associated with SMD for women and girls?
- 6) What is the quality of life of women affected by SMD?

The feasibility study is directly linked to Chapter 1 in that it attempts to answer the question of feasibility not only for the ‘defined categories’ approach (which is easier to accommodate quantitatively than other approaches) but also for the rights and capabilities approaches to defining SMD.

We have come to the conclusion that the ‘social inequalities’ approach is, in practice, not conducive to the task of estimating the number of women and girls experiencing SMD and building their statistical profile. The strength of the ‘social inequalities’ approach undoubtedly lies in its explanatory potential (particularly its emphasis on ‘hidden’ power and intersectionality as causal mechanisms) and its sensitivity to changes to social context over time: inequalities may be different in 25 years’ time and this approach allows for the definition to be ‘sensitive’ in this respect. (Changes to the character of ‘severe and multiple disadvantage’ over time are clearly a challenge to all approaches but particularly to the ‘defined categories’ approach). The inequalities approach is, however, less useful at identifying cases of SMD in practice. Counting those women and girls who are at the ‘intersections’ of social inequalities would produce an over-estimate of SMD as not all

women disadvantaged in this way necessarily end up lacking resources or suffering from abuse or exploitation. On the flip side, there are women who are not at the intersections of disadvantage but who anyway end up experiencing SMD for other reasons. There is no satisfactory way of addressing these difficulties statistically. Considering cases on a case-by-case basis is possible within a small-scale qualitative study but not a quantitative one. Alternatively, switching the attention from 'social inequalities' to the 'lack of resources' would effectively mean the abandonment of the starting platform and would render it unclear what the difference is between this approach and the one that simply points at the 'severe and multiple' lack of resources (or extreme poverty) as the definition of SMD.

We have also concluded that a 'risk factors' approach is not appropriate for generating statistical profiles of those experiencing SMD. There is extensive research on risk factors and we have good evidence about the groups of women and girls who are at risk of disadvantage. However, measuring risk (whilst important for planning interventions to prevent or divert people from disadvantage) does not equate to measuring actual SMD. Identifying those at greatest risk of SMD will result in a number of 'false positives' – identifying women, who despite having multiple risk factors in their lives, do not become severely and multiply disadvantaged.

With regard to the 'defined categories' approach to defining SMD, the earlier part of the report highlighted a number of categories which were not included in the original 'Hard Edges' study. The two most prominent categories are (a) being a victim of abuse and violence; and (b) having poor mental health. Other categories include: being a lone mother, being a migrant (particularly when compounded by poor English skills), being a Traveller, being isolated, living in poor quality accommodation, having a physical disability, being involved in sex work and having lost children to the care system. The feasibility study has taken all of these categories into account, in addition to the three categories defined by the 'Hard Edges' study (homelessness, substance misuse and offending).

The conceptual paper suggests that women and girls affected by SMD may experience certain configurations of domains (for example, women with learning disabilities who are sexually exploited and isolated; migrant women with mental health problems affected by domestic violence), but does not attempt to develop an exhaustive or prescriptive list of potential configurations. This feasibility study therefore considers the sheer *number* of domains rather than their particular configurations. Datasets rich in information on a number of domains<sup>18</sup> were therefore deemed more useful than datasets with information on a small number of domains.

It is important to spell out what this feasibility study did *not* attempt to achieve or to be. Firstly, it was not designed to carry out actual calculations of the prevalence of SMD or

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<sup>18</sup> Particularly the five key domains: being a victim of abuse or violence; homelessness; mental ill-health; substance misuse and offending.

profile those experiencing SMD. Secondly, it has focused solely on severe and *multiple* disadvantage and therefore it did not attempt to identify which data sources would be most suitable to estimate the prevalence of any single domain (e.g. how many girls and women are experiencing abuse or violence). Thirdly, the feasibility study is not a review of already existing published research, although the researchers have familiarised themselves with existing research. Lastly, only data sources regarding the UK population rather than international databases have been examined.

### **2.1.2. Methodology**

The feasibility study has examined three types of data: survey data; administrative client-level data generated by authorities; and organisational client data generated by non-statutory services. A 'long list' of potential data sources was initially created by searching the UK Data Service, ADLS and by conducting online searches. Where descriptions of datasets indicated the presence of themes relevant to this study, data dictionaries and other documents were interrogated to check what relevant variables exist and to gather information about the size of and other key information about the dataset. Based on the results of this exercise a 'short list' was created. Subsequently, a pro-forma was completed for short-listed datasets and datasets were downloaded where possible. Finally, all forms were cross-examined and a decision was taken regarding which dataset or datasets would be the most suitable to answer a given research question about the scale or nature of SMD affecting women and girls. The long list and the short list are provided in Appendices 2 and 3.

Given interest in SMD trends, as well as the situation at a particular point of time, a decision has been made to attach additional significance to data sources which are continuous or periodically refreshed. However, one-off studies have still been included in the review of data sources. For the same reason a decision has been made to review data sources which are in development and look very promising for the future.

Data linkage possibilities have also been investigated as far as possible. It should be noted that a full assessment of data linkage opportunities would require the acquisition of permission and/or bespoke analysis from various government departments. This can be an immensely time-consuming process and relies upon the cooperation of the relevant government body, which of course cannot be guaranteed.

### **2.1.3. Considerations regarding data sources**

The feasibility study examined a wide range of data sources, including: state-generated administrative client data; organisational client data produced by non-statutory bodies; large-scale surveys of general population; surveys of specific populations (such as prisoners or children who are looked after); longitudinal surveys of the general population; and longitudinal surveys of specific populations. This strategy of pursuing various types of data sources was adopted because different types of data sources have different strengths and

weaknesses: some will lend themselves better to answering a certain type of questions while others are likely to be better for answering other types of questions. Of particular importance here is that:

- Generally speaking, cross-sectional data is better for answering questions about the national population size and any patterns of overlaps between SMD categories, while longitudinal birth cohort studies are better for identifying risk factors and outcomes in later life. (Longitudinal birth cohort studies revisit respondents at certain ages – for example, 8, 11, 14, 16 and 25 – which means that it is not possible to make statements about respondents' characteristics in between these 'sweeps', for example when they were 13 or 15).
- Datasets with the largest samples are likely to be the most suitable for answering the question of scale, while datasets providing information about many SMD domains/issues are likely to lend themselves particularly well to answering the question of overlaps.
- It would not be productive to rely only on service data alone as it misses those who are experiencing SMD but who do not contact services (this is particularly the case with mental ill-health).
- Service data is often of poorer quality than survey data produced by research organisations – because staff are (quite understandably) focused on service delivery rather than record-keeping.
- Some administrative and service data sources are biased towards multiple disadvantage and therefore one needs to be careful when making conclusions regarding overlaps. An example of this is the Family Monitoring Dataset (data collected for the original Troubled Families Programme): due to eligibility criteria for the TFP it is likely that there are disproportionately many families there experiencing many domains of SMD relative to families with a few SMD domains. What this means is that general population surveys may provide a more valid picture of the overlaps between SMD domains (and the *balance between them*).
- However, one should not over-rely on general population studies either: while they capture those who do not use services, the risk of under-reporting is arguably higher in them than in service data (service data is particularly strong where the data form is filled in by a member of service staff who has worked with the client for a period of time and is very familiar with the client's situation).
- Surveys of general population usually cover only private households. In order not to completely miss the part of the population which are not in private households, it is therefore necessary to complement survey data with administrative or service data covering non-private households (those with 'no fixed abode' incl. rough sleepers,

sofa-surfers and mobile Travellers, and those living in 'communal establishments' i.e. managed residential accommodation such as hostels, children's homes, prisons etc).

- Previous research has indicated that specific groups may be at higher risk of experiencing SMD (for example, children who are looked after) or may have a distinct SMD profile (for example, long-term rough sleepers). Where designated datasets regarding such specific groups exist it makes sense to make use of them rather than relying on data sources regarding the wider population.

In essence, where possible, there is a need for inspecting both general population data and administrative / service data and then for making an informed decision. Depending on the circumstances, the decision may be to prioritise the source which suggests a higher prevalence of SMD than other sources or it may be to triangulate estimates from two or more sources.

It needs to be remembered that if a decision is made to combine data regarding private households with data on non-private households, the result may be a slight overestimate for a given year. This is because someone could be staying in a homeless hostel or a prison in the first half of the year (and has a record in an admin/service dataset) but then he/she may get their own accommodation and participate in one of the surveys of private households. However, in our view it is better to have this slight overestimate than to exclude one type of household altogether.

## **2.2. Women Experiencing SMD – the 'defined categories' approach**

### **2.2.1. How many women in the UK are experiencing SMD?**

The possible options for answering this research question include one service-generated dataset and three general population surveys. A comprehensive overview of the scope and relevance of each is provided in boxes below.

Supporting People (SP) appears to offer the best service data on SMD among women in the sense that it is rich in SMD indicators, has a large number of cases and covers those in non-private households (according to our own calculations, approximately half of the females in the dataset do not live in private households). While datasets generated by other (non-housing-related) services have also been taken into consideration, they do not appear to be useful for this purpose. In particular, the National Drug Treatment management System (NDTMS) is low on indicators of SMD and the Offender Assessment System (OASys) does not have many records of female clients and misses those who have offended but did not get caught. The disadvantage of SP is that grossing up is somewhat tricky and imprecise due to it being impossible to know exactly which records without ID are duplicates (therefore the reduction of duplicates can at best only be crude). Also, the data collection has been

stopped in March 2015 meaning that while it is a useful data source now, it will gradually become a source of historical data as time passes.

Among survey data, the main options are the Adult Psychiatric Morbidity Survey (APMS), Crime Survey for England and Wales (CSEW, adult module) and the Poverty and Social Exclusion Survey (PSE). As long as APMS 2014 retains the richness of SMD information that characterised APMS 2007 (the content is not yet known but is likely to be very similar for comparison purposes), APMS 2014 will be a clear first-choice. CSEW provides a current picture and has a much larger sample than APMS but is not as strong on SMD as it particularly lacks indicators of homelessness / poor housing, being a migrant and some other less key indicators. PSE is relatively recent but lacks indicators of substance misuse which is a big drawback.

With regards to specific groups, the Combined Homelessness and Information Network (CHAIN) dataset can provide details regarding rough sleeping women affected by SMD in London.

### **Supporting People (Client Records and Short-Term Outcomes), 2003/04-2014/15**

Since 2003, funding for housing-related floating support for vulnerable adults and accommodation-related homelessness services has largely been provided through the Supporting People programme.

Funding and coordination of these services is undertaken through local government, although actual service delivery rests primarily with voluntary sector bodies, particularly the major providers of services for single homeless but also services focusing particularly on substance misuse, the rehabilitation of offenders, mental health support and support to other particularly vulnerable groups.

The funding was provided by the Department of Communities and Local Government's (DCLG) until April 2011. From 2011-12, Supporting People funding was rolled into the Formula Grant – a single grant given by central government to local authorities. There is now no specific budget allocation for Supporting People services as it is part of this single grant. It is now a wholly decentralised programme, administered through 152 top-tier authorities which have complete discretion over where to direct their funding best to meet local needs.

The *Supporting People Client Records and Outcomes* dataset comprises information about clients who entered and left housing support services that were in receipt of Supporting People funding (until April 2011) or housing-related funding from Local Authorities (from April 2011).

DCLG ended the requirement that local authorities collect or submit client data from April 2011, although most authorities and providers continued to submit their data to the Centre for Housing Research based at the University of St Andrews until the 2014/15 financial year (inclusive). From April 2015 the data is no longer centrally collected by CHR or another organisation, although individual Administering Authorities may carry on

collecting data in the same format.

The data provide information about the routes by which services were accessed, the personal characteristics of service users, and outcomes for clients matched against their identified needs.

While Client Records and Short-Term Outcomes client data runs from 2003/04, of particular use is post-2006/07 data, as since that time a majority but not all of SP clients have unique IDs. This permits linkage of client to outcome records and the elimination of 'duplicates' within years ('duplicates' are mainly cases using more than one service or having more than one episode).

The dataset covers clients aged 16 and over. There is information on other members of the household but only those who were receiving support under the same plan.

The data covers England. There are geographical codes for the Administering Authority and the postcode of accommodation occupied by the client immediately prior to receiving the support service.

The dataset covers those living in private households, those living in communal establishments and those with 'no fixed abode'.

#### **Dataset size**

2010/11 (last full year):

Client Records: 231,167

Short-Term Outcomes: 113,302

2014/15:

Client Records: 112,304

Short-Term Outcomes: 94,251

#### **SMD indicators**

Supporting People (Client Records) dataset provides a rich amount of information on homelessness and medium amount of information on mental health, offending and being a victim of abuse or violence. It also has basic indicators of substance misuse. Additionally there are flags for being physically disabled, being a refugee, being a Traveller and being a teenage parent. The Outcomes dataset contains proxy indicators of being isolated. There is no data on past risk factors.

The Outcomes dataset contains some indicators of the client's current quality of life, such as economic status, being in debt, self-harming, etc.

#### **Data Access**

Supporting People datasets covering 2003/04-2010/11 are available from the UK Data Service. Datasets stripped of geographical data are available on a 'Standard Access' basis. A more detailed version of the Supporting People Client Records and Outcomes dataset, containing finer-level geographic data and information on service providers, is available

but subject to Special Licence Access conditions.

Until August 2015 datasets covering 2011/12-2014/15 were not available for download but the Centre for Housing Research based at the University of St Andrews (which holds the data) provided bespoke data analyses subject to a charge. From September 2015 this service is no longer available and therefore access would need to be negotiated with CHR.

#### **Relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=7005&type=Data%20catalogue>

<https://supportingpeople.st-andrews.ac.uk/>

## **Adult Psychiatric Morbidity Survey 2007 & 2014**

### **Outline**

The Adult Psychiatric Morbidity Survey (APMS) provides data on poor mental health among adults aged 16 and over living in private households in England. The survey is carried out every 7 years. The first two surveys were conducted in 1993 and 2000 and covered England, Scotland and Wales. The third (2007) and fourth (2014) surveys covered England. The data from the 2014 survey is expected to be publicly available in September 2016.

While the variables of the 2014 survey are not available online, it is likely that there is going to be a very high degree of overlap in relation to 2007 APMS. This is because in the past consistent instruments have been used across the series to allow for comparison over time.

The 2007 dataset has 7,403 records, including 4,206 women of which 62 were aged 16-17.

There is data on household grid and geographical codes for the Government Office Region.

### **SMD indicators**

APMS 2007 covers all five key domains of SMD (with rich information on being a victim of abuse/violence, mental health and substance misuse, as well as basic information on offending and homelessness). It also has indicators of being a migrant (proxy), being isolated, living in overcrowded or poor quality accommodation and being involved in sex work (since the age of 15).

The dataset is rich in indicators of past risk factors such as being expelled from school; being bullied; being homeless; running away from home; sex work; substance misuse; past problem with the police involving court appearance; having been into care; and having parents separated. There are also indicators of the current quality of life, including gambling; eating disorders; social support; social capital; being a perpetrator of domestic violence; being a perpetrator of child abuse; living in material deprivation; income and

benefits; being discriminated against; and the perception of the neighbourhood.

#### **Data Access**

The 2007 dataset is deposited on the UK Data Service. Standard access procedures apply: only user and project registration through the UK Data Service is required.

#### **Relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=6379&type=Data%20catalogue>

<http://www.natcen.ac.uk/our-research/research/adult-psychiatric-morbidity-survey/>

## **Crime Survey for England and Wales (CSEW)**

CSEW is an annual survey of private households with an adult module (16+) and a young person module (10-15). In the 2013/14 dataset there are nearly 19,000 women aged 18 and over, 233 girls aged 16-17 and 1,400 girls aged 10-15.

The adult module contains rich self-reported information on being a victim of abuse /violence, on substance misuse and on offending. It also has medium amount of information on mental health and basic information on homelessness. It also has indicators of being a migrant, proxy indicators of having no or poor English, being a Traveller and for having lost a child to the care system (but only if the child is still under 16). Other data include neighbourhood perception, employment, income and benefits data.

A potential disadvantage of CSEW is that perhaps respondents may be less inclined to reveal their own offending behaviour (particularly if it has been undetected by the police) in a crime-related survey than in a survey focused on other topics such as mental health or housing.

The dataset provides less information about children aged 10-15. It covers being a victim of abuse /violence (apart from being a victim of sexual offences), substance misuse (medium amount of information) and offending (only proxy indicators: carrying a knife, being a member of a gang, having been stopped and searched by the police). There is no data on the child's mental health or homelessness (e.g. episodes of running away; staying in B&B etc.). However, there is some information on truancy, being a victim of bullying, or having a friend/sibling who is a gang member.

#### **Data access**

The data is deposited on the UK Data Service. Children's data is held under Special Licence access conditions. For adults, SMD-related information is available only under Secure Access conditions. This requires accreditation by the UK Statistics Authority as an Approved Researcher, completion of face-to-face half-day training course (held fortnightly in London and occasionally at the University of Essex), and agreement to the Secure Access User Agreement and the Licence Compliance Policy. Secure Access data is

accessed via the Secure Lab. Applications are screened by the UK Data Archive and the Office for National Statistics, and access is only granted to those researchers requiring data for statistical research purposes and who can justify their need for the data. Users who obtain access to these data are required to read and follow the Microdata Handling and Security: Guide to Good Practice.

Access to the Secure Lab is currently only available to researchers based at a UK academic institution or an ESRC-funded research centre.

### **Most relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=7280&type=Data%20catalogue>

<http://ukdataservice.ac.uk/get-data/how-to-access/accessecurelab/train>

## **Combined Homelessness and Information Network (CHAIN)**

CHAIN is a multi-agency database recording information about rough sleepers and the wider street population in London. The system is commissioned and funded by the Mayor of London and managed by St Mungo's Broadway. CHAIN allows users to share information about work done with rough sleepers and about their needs, ensuring that they receive the most appropriate support and that efforts are not duplicated. Reports from the system are used at an operational level by commissioning bodies to monitor the effectiveness of their services, and at a more strategic level by policy makers to gather intelligence about trends within the rough sleeping population and to identify emerging needs.

Information is recorded on CHAIN about the following groups of people:

- People who have been seen rough sleeping by outreach workers - often referred to as 'verified rough sleepers'
- People who have a 'street lifestyle' such as street drinking or begging - often referred to as 'wider street population'. Many people who have a street lifestyle are also rough sleepers, but a minority are not

CHAIN does not cover 'hidden homeless' groups, such as those who are squatting or staying in places which are inaccessible to outreach workers.

CHAIN data goes back to late 1990's. The 2013/14 dataset has 837 female client records.

### **SMD indicators**

Apart from rich data on homelessness, CHAIN has basic indicators of substance misuse, offending, mental health and being a victim of abuse/violence. There is also a flag for being a migrant and being a Traveller.

There is some information on the client's past and present circumstances, including

having been into care; having been in armed forces; loss of job; financial problems; and being a perpetrator of domestic violence.

#### **Data Access**

Organisations seeking to use data from CHAIN for policy or research studies will not be given direct access to the system. However, data holders can supply aggregate data from the system. In exceptional circumstances they may also consider supplying limited amounts of anonymised raw data. Organisations requiring access to CHAIN data for research purposes should contact the CHAIN Team to discuss their request.

#### **Relevant links**

<http://www.mungosbroadway.org.uk/chain>

### **2.2.2. How many women live with partners affected by SMD?**

There are two ways of addressing this research question. The first option would be to find data sources which are rich in information about the respondent's SMD plus information about the household composition (household grid or 'living arrangements'). One could then select cases where the respondent is SMD and his/her female partner lives in the same household.

The second option would be to find data sources where there is SMD data on both partners (either the respondent has an opportunity to indicate that the partner is SMD or the Household Reference Person's partner fills in a separate questionnaire).

APMS and CSEW (adult module) can be employed in the 'inverted' way outlined in the first option. Ideally both would be analysed, as they have different strengths (APMS has an unrivalled amount of SMD-related information while CSEW has a much larger sample).

The Poverty and Social Exclusion Survey (PSE) can be used in both 'straight' and 'inverted' ways: either via the female HRP's partner indicating in a separate questionnaire that he/she is SMD, or via the HRP indicating that he/she is SMD and has a female partner living with him/her. However, PSE does not include information on substance misuse.

#### **Poverty and Social Exclusion Survey 2012**

The Poverty and Social Exclusion research project, funded by the Economic and Social Research Council, is the largest ever study of poverty conducted in the UK. It was a one-off study, although loosely connected to predecessor surveys, especially the Poverty and Social Exclusion survey in Britain in 1999, the Poverty and Social Exclusion survey in Northern Ireland in 2002/03 and the Breadline Britain surveys in 1983 and 1990.

The key element of PSE 2012, the Living Standards survey was carried out between March and December 2012 by the National Centre for Social Research (NatCen) in Britain and by

the Northern Ireland Statistics and Research Agency (NISRA) in Northern Ireland. The survey re-interviewed respondents to the 2010/11 Family Resources Survey (FRS) who said they could be contacted again. Every adult living at each address was interviewed.

The final sample size achieved was 5,193 households in which 12,097 people were living. While representative of the population living in private households, this survey omits those currently in institutional accommodation or with no fixed abode.

The minimum age for adult questionnaire was 16. There is a household grid and geographical codes for Government Office Region.

### **SMD indicators**

PSE has basic indicators of being a victim of violence/threats/sexual abuse from current partner as well as of poor mental health. There is also information on past experiences of offending and past experiences of homelessness (ever or last 5 years). There is no data on substance misuse. There is information on being a migrant, poor command of English, being a Traveller, being isolated, living in poor quality accommodation, having lost children to the care system, and being a victim of sexual abuse since the age of 16.

The respondent's quality of life can be examined through an array of poverty measures, particularly material deprivation based. The PSE dataset includes many variables carried forward from the FRS interviews.

### **Data Access**

Data is available for download from the UK data Service for registered users. No licence is required.

### **Relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=851607&type=Data%20catalogue>

<http://reshare.ukdataservice.ac.uk/851607/>

<http://poverty.ac.uk/>

### **2.2.3. What are the overlaps between SMD domains in the case of women?**

Unsurprisingly, some of the previously mentioned datasets would be good candidates for answering this research question. Among general population survey data, APMS is clearly the leading contender in terms of the amount of SMD information, which makes it the optimal choice. CSEW would be another alternative as regards this type of data source. PSE would not be a suitable source for this purpose due to its lack of information on substance misuse.

With regards to service-generated data covering those not living in private households, Supporting People would be the obvious choice once again. However, it is not strong on less key variables such as being a migrant.

Although not generated by services but being a small survey of service users instead, the Multiple Exclusion Homelessness (MEH) survey dataset could be used for exploring overlaps. The sample is too small for grossing up but the richness of SMD information lends itself well to exploring overlaps. Also MEH's advantage is that it covers both private households and those not living in private households.

With regards to overlaps among specific groups, CHAIN can be analysed to provide SMD profile among rough sleeping women in London, while the Offender Assessment System (OASys) can provide such a profile for women in prison or on probation.

### **Multiple Exclusion Homelessness survey 2010**

This study, supported by the ESRC, involved a multi-stage survey. First, with the assistance of local voluntary sector partners, researchers identified all agencies in seven urban locations that offered 'low threshold' support services to people experiencing deep social exclusion, including homelessness, substance misuse, ex-offenders, and street sex work, with six randomly selected services chosen in each city.

The second stage of fieldwork involved a 'census' questionnaire survey undertaken with the users of these low threshold services over a two-week 'time window'. 1,286 census survey questionnaires were returned (52% response rate), including 227 females. The youngest respondent was 16 years old.

Third, and finally, 'extended interviews' were conducted with users of low threshold services whose census responses indicated that they had experienced MEH, and who consented to be contacted for this next stage of the study. The structured questionnaire used was designed to generate detailed information on the characteristics and life experiences of these MEH service users. The interviews were conducted face-to-face, using Computer Assisted Personal Interviewing technology. A self-completion section contained particularly sensitive questions relating to violence and sexual matters. In total, 452 extended interviews were achieved (51% response rate) including interviews with 93 females.

The study was UK-wide. There is a code for the city in which the questionnaire was completed. There is no household grid but the 'extended interview' dataset has information on 'living arrangements'.

The study captured both those in private households and those with no fixed abode / living in communal establishments.

### **SMD indicators**

The 'census' dataset contains data on homelessness, mental ill-health (severe only), offending and substance misuse (severe only).

The 'extended interview' dataset has rich data on all five key domains of SMD as well as risk factors going back to childhood.

### **Data Access**

UK Data Service registration is required and standard conditions of use apply.

### **Relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=6899&type=Data%20catalogue>

## **Offender Assessment System (OASys)**

The Offender Assessment System has been developed by the National Offender Management Service (NOMS) as a systematic data recording system at the level of individual offenders within the criminal justice system, primarily as a means of predicting the risk of reoffending.

The data covers (with varying degrees of detail) most non-custodial cases subject to supervision, most prisoners with longer sentences and young adult (18-20) prisoners, but only a minority of prisoners on shorter sentences.

The OASys dataset had around 48,500 unique individual assessments per year between 2006 and 2012 (both genders).

### **SMD indicators**

OASys contains indicators of all five key SMD domains (only limited indicators of being a victim of abuse/violence) as well as data on past risk factors.

### **Data Access**

Standard NOMS application procedure applies (see the link below). It is likely to take a long time to successfully negotiate access.

### **Relevant links**

<https://www.gov.uk/government/organisations/national-offender-management-service/about/research>

### **2.3. What are the risk factors associated with SMD among women?**

Apart from being rich in SMD-related information, APMS is also very strong on the existence of risk factors and as such would be the best choice for answering this research question.

MEH would be the second-best choice although its advantages - the richness of data and the inclusion of those not in private households - are undermined by a relatively small sample size. PSE is the most detailed of sources with regards to past and present material situation and as such may be particularly useful for exploring the role of growing up in poverty among respondents affected by SMD.

If one was interested in 'risk factors' among *parents* affected by SMD, the Avon Longitudinal Study of Parents and Children (ALSPAC, see page 65) would be an excellent data source. For women in prison or on probation, OASys provides a large amount of information about 'risk factors' present in a respondent's past.

## 2.4. What is the quality of life of women affected by SMD?

For our purposes, the domains that fall under the 'quality of life' heading include:

- Employment, income and material situation
- Health
- Social relationships and support

Constitutive elements of SMD are not part of the 'quality of life' indicators as they are by definition present among women affected by SMD.

Among general population survey data, APMS is the richest source of information on the quality of life among women affected by SMD. PSE would be the natural choice if one was only interested in the quality of material situation among such women.

Among service-generated data Supporting People (Outcomes of Short-term Services) is the richest source of information. While the advantage is that it includes women who are not in private households, it is not nearly as rich in relevant data as APMS.

## 2.5. Women experiencing SMD – the rights and capabilities approaches

We have also looked for datasets rich in information indicating the respondent's capabilities and exercise of rights, including financial independence; control over life choices; shared responsibility for children; physical security; being healthy; engaging in activities; social life; participation in decision-making; and self-respect.

While no dataset covers all of these, the Understanding Society Survey (USS) provides the widest coverage of such topics. The PSE survey also provides a wide coverage but has a smaller sample than USS and is not continuous (it is repeated roughly once a decade). The advantage of PSE over USS, however, is that it provides data on both SMD defined as 'categories' and SMD defined as rights or capabilities, therefore potentially allowing for comparison between two SMD groups defined in different ways.

The disadvantage is that these two datasets only cover women who are in private households, thus completely missing a section of the population which is potentially the most affected by SMD (that is, those who are not in private households).

If one was interested only in *parents*, the Millennium Cohort Study (MCS) would be a good alternative to analysing parents only within USS or PSE.

It needs to be stressed that the discussion here focuses only on women and not girls. Given that the rights and capabilities of children and adults are clearly not identical, a specific definition of children's rights and capabilities would need to be provided for the feasibility study to provide insight into what data sources could be used.

## The Understanding Society Survey, 2009-present

As a multi-topic household survey, the purpose of *Understanding Society* is to understand social and economic change in the UK at the household and individual levels. It is anticipated that over time the study will permit examination of short- and long-term effects of social and economic change, including policy interventions, on the general well-being of the UK population with a strong emphasis on domains of family and social ties, work, financial resources, and health. The study is an annual survey of each adult member of a nationally representative sample. The same individuals are re-interviewed in each wave. One person completes the household questionnaire. Each person aged 16 or older answers the individual adult interview and self-completion questionnaire. Young people aged 10-15 years are asked to respond to a paper self-completion questionnaire.

Participants in Wave 1 were sampled from private households. This included those living in institutions that would otherwise be resident. In further waves attempts have been made to interview those participants who have moved into an institution or with no fixed abode.

### Dataset size

Wave 1: 30,169 households, 50,994 adults and 4,899 young people aged 10-15 years. Wave 4: 31,447 households, 51,579 adults and 4,049 young people aged 10-15.

### SMD indicators

USS (adult module) has several indicators of the extent to which the respondent is able to exercise his/her rights and possesses capabilities, including: physical security; self-respect; being healthy; control over things at home; shared responsibility for children; gender attitudes; parenting styles; social networks; organisations; activities; and financial independence.

### Data Access

There are two versions of the main *Understanding Society* data. One is available under the standard End User Licence (EUL) agreement, and the other is a Special Licence (SL) version. The SL version contains month and year of birth variables instead of just age, more detailed country and occupation coding for a number of variables and various income variables have not been top-coded (see the documentation available with the SL version for more detail on

the differences). Users are advised to first obtain the standard EUL version of the data to see if they are sufficient for their research requirements. The SL data have more restrictive access conditions; prospective users of the SL version will need to complete an extra application form and demonstrate to the data owners exactly why they need access to the additional variables in order to get permission to use that version.

#### Relevant links

<http://discover.ukdataservice.ac.uk/catalogue/?sn=6614&type=Data%20catalogue>

## Poverty and Social Exclusion 2012 survey: rights and capabilities

PSE has quite a lot of relevant information, including on how financial decisions are shared, participation in child/education related activities, experience of 'harms', health conditions, general subjective wellbeing, social support, social networks, social activities, civic participation and feelings about political engagement.

### 2.6. Girls Experiencing SMD

This section explores SMD among girls who are under 18 years of age. In practice, we have mostly limited the discussion to 10-17 year olds. This is for two reasons:

- 1) There are fewer sources of SMD-related data about children under 10 than about young people. This seems to result from the fact that research designers do not anticipate issues such as substance misuse or offending to be a problem among under-10s, and therefore do not include relevant questions in questionnaires.
- 2) When information is given by parents on behalf of the child (a common practice for under-10s), data is not particularly reliable as parents are unlikely to admit to abusing their own children or to reveal that the child has, for example, offended – fearing that they risk attracting the attention of children's services if they do so.

Linked to the first point above, it can be argued that the younger the child is the less prevalent and therefore the more irrelevant indicators of 'adult' SMD become – particularly offending, substance misuse and mental ill-health. This raises two questions: firstly, how should SMD be defined in relation to children under-10? While in the light of Chapter 1 'being a victim of abuse/violence' should undoubtedly be part of the definition, would other conditions need to be met, for example living in severe material disadvantage? Secondly, it is not obvious what constitutes 'homelessness' among children. While it is obvious that children being part of families staying for example in B&Bs are themselves homeless, the case of the family staying in temporary self-contained accommodation is less obvious (unlike their parents, children may feel that this is their home). Furthermore, some cases of running

away from home could be seen as situations of homelessness, particularly if episodes are repeated and stretching over a period of time rather than just a couple of nights.

### 2.6.1. How many girls in the UK are experiencing SMD?

The review of data sources has pointed at six datasets which could potentially be used to answer this research question, two of them being administrative in character and four survey-based. Key features of each may be summarised as follows:

- The 'Children in Need' census (CiN): a large administrative dataset with records of individual children referred to Children's Social Care Services as well as records of episodes of care. It encompasses children in private households and children who are in care homes or other residential accommodation. There were 180,140 female children in need on 31 March 2014 (46% of all children in need in the dataset).
- Supporting People (SP): another large administrative dataset containing individual records of people aged 16 and over. SP is particularly focused on housing need and homelessness. For this exercise, records of girls aged 16-17 could be analysed. There are 2,800 girls of this age in the latest dataset (CR 2014-15).
- Mental Health of Children & Young People (MHCYP): a nationally representative survey of children aged 5-16 in private households conducted in 2004. There are 3,866 girls in the dataset including 1,992 aged 10-15 and 295 aged 16.
- Crime Survey for England and Wales (CSEW): an annual survey of private households with an adult module (16+) and a young person module (10-15). In the 2013/14 dataset, there were 233 girls aged 16-17 and 1,400 girls aged 10-15.
- Adult Psychiatric Morbidity Survey (APMS) – a nationally representative survey of people aged 16+ conducted in 2007. Only individuals in private households were surveyed. As with SP, for this exercise records of girls aged 16-17 could be analysed. The sample was however very small: only 62 girls of this age.
- The Children's Society 'Young Runaways' 2005 survey – a survey of 10,700 children aged 14-16 (of which 48% were female) administered in secondary schools. Through its focus was on running away, this survey is a rich source of data on homelessness among this age group: there is information on the number of episodes, their length and where the child stayed while away from home (e.g. sofa-surfing, rough sleeping).

Considering the obvious advantages of CiN over the other datasets – particularly its size and the coverage of both private and non-private households - a defensible case could be made for analysing just CiN and not the others.

An alternative although more challenging approach would be to combine the analysis of CiN with other datasets, given that:

- As not all girls experiencing SMD are referred to Children's Social Care, it should not be ruled out *a priori* that another source (particularly a survey of the general population) may provide a higher estimate than CiN.

- CiN lacks indicators of homelessness. While homelessness is more of an issue for young adults than under-18s, nevertheless it is a problem for some 16/17 year olds (as own homelessness or through being part of a homeless family) and to some extent for even younger children (through being part of a homeless family or through longer periods of running away).

If a decision was made to combine the analysis of CiN with other datasets, we suggest splitting the analysis into two groups: children aged 10-15 and 16-17.

For the age group 16-17, APMS cannot be used due to the very small sample covering that age group<sup>19</sup>. This is unfortunate as APMS is very rich in SMD-related information. The sample of girls aged 16-17 in CSEW 2013/14 (233) is also relatively small. However, as CSEW is an annual survey it is possible to pool samples from two or three years of CSEW to decrease the margin of error.

An analysis of CSEW would provide a national estimate of girls aged 16-17 living in private households experiencing SMD. The analysis would then need to be complemented with an estimate of 16-17 year olds not living in private households. Here, ideally we would want to examine data on 16-17 year old girls presenting as homeless. As there is no such individual-level English data however, Supporting People is the obvious choice due to its focus on homelessness and considerable size<sup>20</sup>.

For children younger than 16, there are two alternatives to CiN. The first one is to use The Children's Society 'Young Runaways' 2005 survey, which is the best source of data on this aspect of homelessness among 14-15 year olds. Like CiN, it encompasses children living in private households and those who are not.

The second option would be to use either CSEW (the 'young person' module, 10-15) or the Mental Health of Children & Young People 2004 survey. While the advantage of CSEW is that the data is much more recent, MHCYP is richer in SMD information than CSEW and had a bigger sample.

The disadvantage of this second option is that it would only provide an estimate of the scale of SMD among children aged 10-15 living in private households, thus missing those in residential accommodation.

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<sup>19</sup> This was the case with APMS 2007 and is likely to be the case with APMS 2014.

<sup>20</sup> The only considerable survey of homeless 16/17 year olds did not explore SMD (Pleace et al, 2008: *Statutory Homelessness in England: The Experience of Families and 16-17 Year Olds*. York: Centre for Housing Policy, University of York).

Summing up, we therefore suggest that - depending on the resources available to researchers - the study should investigate the following datasets, in decreasing order of priority:

- 1) CiN
- 2) CSEW and SP for 16-17 year olds; 'Young Runaways 2005' for 10-15 year olds
- 3) MHCYP 2004
- 4) CSEW (young person module)

We have also looked into two other datasets which, upon closer examination, appeared to be less useful:

- The Looked After Children dataset is an administrative dataset of children who are looked after by local authorities in England. Children who are looked after are however already included in CiN/National Pupil Database.
- SafeLives (formerly CAADA) Children's Insights dataset 2011-13 is a service-generated dataset containing records of children of women using SafeLives services. Although the dataset is rich in SMD-related information, it is unfortunately very small (183 teenagers of both genders).

## **The Children in Need census dataset**

This is a large administrative dataset with records of individual children referred to Children's Social Care Services as well as records of episodes of care. It encompasses children in private households and children who are in care homes or other residential accommodation. The dataset contained 427,000 records in 2013/14, of which 46% (180,140) were female.

### **SMD indicators**

The dataset contains information on several domains indicating that the child is experiencing SMD. This includes rich information on being a victim of abuse / exploitation / neglect, a medium amount of information on mental health and substance misuse, and basic amount of information on offending. (The two indicators of the latter being that the referral to Social Services is made by the police – which is about 25% of all referrals - and the flag for 'socially unacceptable behaviour'). There is no information on homelessness (rough sleeping, sofa-surfing, staying in a B&B or a hostel) but there is an indication of the child being looked after or in residential accommodation. There are also flags for the child being an Unaccompanied Asylum Seeking Child or a trafficked child as well as for child sexual exploitation.

Several variables of key interest to us were only introduced in the 2013-14 CIN census

(under the banner of 'factors identified at the end of the assessment'). However, they have not been made available by data holders. The contact person responsible for CiN-related enquiries has given the following explanation:

"In 2013-14 many local authorities moved from carrying out initial and core assessments to carrying out continuous assessments part way through the year, therefore the data on factors was not collected from all local authorities and for those that did supply data, the data was often incomplete. Due to concerns with the quality of the data it was published at a national level and an extract of this data at local authority level is unavailable. Now that the data item is in the second year of collection we are hoping the quality will be much improved and intend to publish at local authority level for 2014-15 (this will be published in October 2015). Data extracts for the 2014-15 factors identified at assessment can be requested after this publication in late October".

The dataset contains records of children who have been referred by a person or organisation concerned about the child's needs or welfare. (Children with a disability are automatically included in CiN). It therefore misses cases where the child experiences SMD but this is not reported to Social Services by parents/carers and not spotted by the school and other services (or not reported when identified).

The data refers to England and has been compiled over a period of time. The Department for Education has been collecting the Children in Need census from local authorities since 2008-09. Whilst prior to that there was a periodic children in need collection, the latest covering a week in February 2005, it was carried out on a very different basis to the current CiN census and so the figures are not directly comparable.

Geographical codes are included.

Other data include: age, gender, ethnic group, disability, whether the child is on a child protection plan, gang involvement (from 2014/15).

#### **Data access**

CiN data can be accessed as a data extract from the National Pupil Database. A request for SMD-related data will be categorised as Tier 1 request (Identifying or Highly Sensitive information). Such requests are dealt with by the Data Management Advisory Panel (DMAP). It is a departmental group consisting of senior members of staff from across the department.

Users requesting access to any pupil level data from the NPD must complete and return the application form and information security questionnaire. These forms are available on the department's website or from the NPD Data Request Team at [NPD.REQUESTS@education.gsi.gov.uk](mailto:NPD.REQUESTS@education.gsi.gov.uk)

People requesting access also need to demonstrate they will comply with all the relevant requirements of the Data Protection Act 1998. They will need to demonstrate and sign an agreement to confirm that they (or their organisation):

- are registered with the Information Commissioner's Office to process personal data or fall

within an appropriate exemption.

- Have appropriate security arrangements in place to process the data.
- Intend to use the data only for the specified purpose.
- Will keep the data only for the specified length of time.
- Will not further disclose, publish or pass on the data without the prior written approval of the department.

Anyone requesting access to sensitive data in tiers 1 and 2 will be required to explain on a field by field basis why each item is required and why the same outcome cannot be achieved by using less sensitive data. In addition, they need to provide evidence in the information security questionnaire that they have adequate physical and technical security arrangements in place for handling the data.

### **Data linkage**

CiN data can be linked to other datasets within the NPD via The Pupil Matching Reference (PMR) which uniquely identifies each pupil in the dataset. The PMR gives each pupil an identifier which is unique to them and allows matching across datasets without giving away their identity. In this way, for example, CiN data can be linked to information about the child's Free School Meals eligibility (which is a proxy for low-income household).

CiN data can also be linked to some other official datasets which are not part of the NPD via the Unique Pupil Number.

### **Most relevant links**

NPD User Guide: <https://www.gov.uk/government/publications/national-pupil-database-user-guide-and-supporting-information>

DfE website: <https://www.gov.uk/government/publications/national-pupil-database-user-guide-and-supporting-information>

## **The Mental Health of Children & Young People 2004 survey**

MHCYP was a nationally representative survey of children aged 5-16 conducted in 2004. Only people in private households were surveyed. It was a repeat of the 1999 survey (*Mental Health of Children and Adolescents in Great Britain, 1999*). This earlier survey covered children aged 5-15.

The survey consisted of parent/carer interview (face-to-face), young person interview (only those aged 11-16; self-completion questionnaire) and teacher interview (surveyed by post).

There are 3,866 girls in the dataset including 1,992 aged 10-15 and 295 aged 16.

There is a household grid. The survey covered Great Britain with geographical codes for the Government Office Regions (England), Scotland and Wales.

### **SMD indicators**

MHCYP is naturally very rich in information about the child's mental health but also has a medium amount of information on offending, substance misuse and being a victim of abuse or violence. It is weaker on homelessness, with the only indicator being a positive answer to the question 'have you run away from home or stayed away all night without parents' permission?' – which unfortunately potentially conflates homelessness and boundary-testing.

MHCYP does not allow for identifying 'risk factors' going back to a few years before the interview (one can only know if something took place more than six months before the survey, which means that it cannot be sure whether a factor really pre-dated SMD or co-occurred with it). However it is rich in information on factors occurring within half a year prior to the interview, such as conduct problems; truancy; self-harm; eating disorders; fighting; bullying others; social support etc.

### **Data Access**

The dataset is deposited on the UK Data Service. Standard access procedures apply: only user and project registration through the UK Data Service is required.

### **Relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=5269&type=Data%20catalogue>

## **The Children's Society 'National Survey of Young Runaways' 2005**

The Children's Society has undertaken three surveys of the prevalence of running away among young persons: in 1999, 2005 and 2011. The 2005 was undertaken in partnership with the University of York and is of particular relevance to this feasibility study as it contained indicators of substance misuse and offending.

The survey collected information from 10,716 young people aged 14-16 (year 10 and 11 of school) of which 87.5% were aged 14-15 and the remaining 12.5% aged 16. The proportion of females was 48.1%.

The data was gathered using self-completed questionnaires issued through mainstream schools, special schools and pupil referral units, in 25 areas of England representing a range in terms of ethnic diversity, population density and economic prosperity.

The survey captured young people living in private households and in residential accommodation.

There is no household grid but there is information on family structure (parents only). There are geographical codes for areas covered by the study.

### **SMD indicators**

The dataset has rich information on episodes of running away, including their number and length as well as information on where the respondent stayed (including rough sleeping). The dataset also has basic indicators of offending and substance misuse. It is weaker with regards to mental health (respondents were asked a few questions about subjective well-being including depression) and does not have data on being a victim of abuse or violence. There is a flag for being non-UK born.

While there is no information on past risk factors, there is a range of data on currently present factors. This includes: Quality of relationship with parents/carers; problems with school attendance; school exclusion; being bullied at school; Type of area (rural, suburban, urban); low/high prosperity area; disability; sexual orientation; ethnicity; family structure (parents only); being in foster care or a children's home; FSM eligibility; and the number of adults in the household with a paid job.

### **Data Access**

The data can be accessed via The Children's Society.

### **Relevant links**

[http://www.childrenssociety.org.uk/sites/default/files/tcs/research\\_docs/Still%20running%202020-%20Findings%20from%20the%20second%20national%20survey%20of%20young%20runaways.pdf](http://www.childrenssociety.org.uk/sites/default/files/tcs/research_docs/Still%20running%202020-%20Findings%20from%20the%20second%20national%20survey%20of%20young%20runaways.pdf)

## **2.6.2. How many girls live with parents/carers affected by SMD? How many girls have parents/carers affected by SMD?**

Here we are particularly interested in datasets on adults where there is information on SMD for adult respondents and the household grid, or datasets on children where there is information on there being SMD among parents.

There is no administrative dataset which would be a good choice here. This makes it difficult to answer the second research question above (How many girls *have* parents/carers affected by SMD). However, there is survey data which can be used to shed light on the first research question (How many girls live with parents/carers affected by SMD).

The choice for researchers here would be to either choose from the three best candidates, or to analyse all three and see which one gives the highest estimate.

The three candidates are:

**CSEW** (adult module): as mentioned above, this is a rich source of data on SMD benefiting from a large sample size. The disadvantage is that it is low on indicators of homelessness (and has no indicators of living in poor quality accommodation).

**APMS** – this survey is unrivalled by other surveys when it comes to the richness of SMD-related information. In particular, it has a lot more information on homelessness than CSEW. However, the 2007 sample was not as big as in the case of CSEW (4,150 adult women versus 19,000) and it is likely to be the case with APMS 2014. This last limitation is amplified by the fact that APMS sample had relatively more women aged 50 or over than would be nationally proportionate.

**PSE** – a nationally representative survey of the UK population (18+) in private households, carried out in 2012. It benefits from a slightly bigger sample than APMS 2007 (4,900 adult women versus 4,150). However, it has a major disadvantage in this context as it has no indicators of substance misuse. Such trade-off may not be worth making.

We have also considered a few other datasets but ruled them out. These include:

**CiN** – from 2013/14 CiN has some indicators of parental SMD. However, it is not known which of the parents exhibits SMD characteristics – and therefore it may be that SMD is split between the parents (e.g. the father is affected by substance misuse while the mother has poor mental health and is a victim of abuse). Furthermore, CiN does not contain data on parental offending or an indicator of them being migrants.

**Children Looked After (CLA)** – no information on SMD among parents.

**Troubled Families Programme (Family Monitoring Data)** – while this dataset has very valuable data on SMD among children and parents/carers, there is no information on gender of either children or parents/carers.

### 2.6.3. What are the overlaps between SMD domains in the case of girls?

As mentioned earlier, it should not be taken for granted that datasets which are deemed most suitable for grossing up will also be the best for estimating the overlaps between SMD domains. It may well be that a dataset with a smaller sample (although still sufficiently large) but very rich in SMD-related information will be better suited for exploring the overlaps.

Similarly, the age of the dataset is arguably less of an issue here than in the case of estimating the scale of SMD, in that the profile of overlaps is probably more stable over time than the scale of SMD.

We believe that this is the case here in that while CiN is preferable for estimating the totals due to its substantial size, for the current purpose there may be better choices particularly for the 16-17 age group. This is because CiN does not have indicators of homelessness (which is more common among 16-17 year olds than younger children) and is relatively thin on indicators of offending.

Therefore for exploring overlaps among 10-15 year olds we suggest starting off by analyzing CiN data but to subsequently strengthen the analysis by looking at other datasets as well. Four datasets would be particularly suitable here:

- The Children's Society 'Young Runaways' 2005 survey – which is a rich source of information on homelessness among 14-15 year olds (as well as on other key SMD domains);
- The Mental Health Children and Young People 2004 survey – which is very strong on the coverage of SMD (mental health, offending, substance misuse, being a victim of abuse; less strong on homelessness);
- Avon Longitudinal Study of Parents and Children (ALSPAC) - Age 14 sweep dataset has more textured SMD information than CiN (apart from homelessness);
- The Millennium Cohort Study (MCS) - Age 11 sweep of MCS was strong on indicators of offending, mental health and substance misuse; it was however weaker on being a victim of abuse or violence and experiences of homelessness. This may however change with Age 14 sweep which is being conducted in 2015. Unfortunately the questionnaires and data dictionaries are not available to the public yet.

With regards to the 16-17 age group, findings from CiN could be supplemented with the analysis of either Supporting People or CSEW (adult module) or MHCYP. The first benefits from a large population (1,650<sup>21</sup> girls aged 16-17) while CSEW is nationally representative (and the sample size - although apparently small (233 in 2013/14) - is still large enough to allow for 3% margin of error at 95% confidence level. Samples from 2-3 years of CSEW may also be pooled to improve the margin of error and/or the confidence level). MHCYP is strong on coverage of SMD but could only be used for calculating overlaps for 16 year olds (it has a bigger sample of 16 year old girls than CSEW but it did not capture 17 year olds).

A number of other datasets have also been taken into consideration but ruled out:

MEH – a 2010 survey of users of low-threshold support services in England, aged 16+. While it is very rich in SMD information, there are not enough 16/17 year old girls in the dataset to allow for the analysis.

APMS 2007 or 2014 – the 2007 dataset is excellent in terms of SMD indicators but there are not enough girls aged 16/17 (62 girls) to allow for the analysis. This is likely to also be true of APMS 2014.

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<sup>21</sup> While the total number of girls of this age in the latest (2014/15) SP Client Records dataset is 2,800, our own calculations suggest that around 1,650 records are usable (after excluding duplicates and records with no ID).

CAADA Children's Insights – a rich service-based source of information on SMD but the number of cases is small. Also it refers to a single specific group - only children whose mothers are victims of domestic abuse are in the dataset.

It also needs to be mentioned that if one is interested specifically in SMD among children who are looked after, the CLA dataset is a good source of information on overlaps among this group.

## **Avon Longitudinal Study of Parents and Children, 1991-present**

The *Avon Longitudinal Study of Parents and Children* (ALSPAC, and also known as the 'Children of the 90s' study), which is based at the University of Bristol, is an ongoing longitudinal study of a population of children born to mothers resident in one geographic area in England (the Avon Health Authority). The overall objectives of the study are to understand the ways in which the physical and social environments interact over time with genetic inheritance to affect health, behaviour and development in infancy, childhood and then into adulthood. Information has been collected at regular and frequent intervals from pregnancy and throughout childhood concerning the child's physical environments, parental characteristics (including economic and educational indicators), social circumstances, and family relationships. ALSPAC recruited more than 14,000 pregnant women with estimated dates of delivery between April 1991 and December 1992 to take part in the study. These women, the children arising from the index pregnancy and the women's partners have been followed up since then and detailed data collected throughout childhood.

Household grid is provided.

### **SMD indicators**

ALSPAC is very strong on the key five domains of SMD for both adults and children. In the case of adults (both parents/carers were asked to fill in separate questionnaires), there is rich information on mental health; medium amount of information on substance misuse, homelessness and being a victim of abuse/violence; and basic information on offending. For children, there is rich information on mental health and substance misuse; medium amount of information on offending; and basic information on being a victim of abuse /violence as well as homelessness (have you ever run away from home; how many times in the past 6 months).

ALSPAC also has other indicators of SMD such as being a migrant (proxy only), being isolated or living in overcrowded or poor quality accommodation.

There is rich data on risk factors in parents' own past, including: being physically/emotionally abused by own parent; being sexually abused; truancy; in trouble with the police before age 17; expelled or suspended from school; having been into care; staying in a hostel before the age of 18; living in material deprivation; difficulty in affording food/clothing/heating/accommodation/things for the baby; amount spend on food/rent; financial help from relatives; employment; and experience of 'stressful life events' such as separation or a friend's death.

There are some indicators of the current quality of life for adult respondents, particularly financial difficulties.

There is also data regarding 'risk factors' in the child's past, including having run away; being bullied; being a gang member; eating disorders; school exclusion/suspension; truancy; and conduct misbehaviour.

#### **Data Access**

Researchers are required to complete an online proposal form. This proposal should have clearly stated aims and hypotheses and describe the relevant exposure, outcome and confounders that will be considered, justifying the data you require.

All researchers accessing ALSPAC data will be charged on a cost recovery basis: This cost will vary depending on the amount and type of data. Costs will be determined on a project-by-project basis.

Standard fee (includes up to 50 variables) is £1,180 +VAT. Every additional 100 variables cost £85 +VAT.

#### **Relevant links**

<http://www.bristol.ac.uk/alspac/>

<http://www.bristol.ac.uk/media-library/sites/alspac/documents/Access%20Policy.pdf>

## **The Millennium Cohort Study, 2000-present**

The Millennium Cohort Study (MCS) is a multi-disciplinary research project following the lives of around 19,000 children born in the UK in 2000-01. It is the most recent of Britain's world-renowned national longitudinal birth cohort studies. The study has been tracking the Millennium children through their early childhood years and plans to follow them into adulthood. It collects information on the children's siblings and parents. MCS's field of enquiry covers such diverse topics as parenting; childcare; school choice; child behaviour and cognitive development; child and parental health; parents' employment and education; income and poverty; housing, neighbourhood and residential mobility; and social capital and ethnicity.

The study is core funded by the Economic and Social Research Council (ESRC) and a consortium of Government departments.

Five surveys of MCS cohort members have been completed so far – at age nine months, three, five, seven and eleven years. The Age 11 Survey took place in 2012 and resulted in 13,287 productive interviews. The Age 14 Survey fieldwork is under way. The next survey is planned for 2018 when participants will be 17 years old.

#### **SMD indicators**

The exact content of Age 14 Survey is not going to be publicly available until the fieldwork is completed. However, the draft materials available online indicate that there is going to be rich information on substance misuse and offending as well as medium amount of information on mental health. While it does not seem likely that there is going to be child-level information on being a victim of abuse or violence, it is possible that this can be inferred from adults' responses (where one or both parents/carers indicate that they themselves are currently experiencing abuse/violence). Similarly, data on homelessness can be inferred from adults' responses. It also seems that there is going to be rich data on 'risky behaviours'.

As for information about parents/carers, so far MCS has provided basic indicators of substance misuse, mental ill-health, homelessness and being a victim of abuse or violence. There is no adult data on offending.

#### **Data Access**

This data is available to download from the UK Data Service. Standard access rules apply.

#### **Relevant links**

<http://discover.ukdataservice.ac.uk/catalogue/?sn=7464&type=Data%20catalogue>

<http://www.cls.ioe.ac.uk/page.aspx?&sitesectionid=851>

## **Children Looked After (CLA) dataset**

Data on Looked After Children is collected annually from local authorities in England via the SSDA903 return. It regards children aged 0-18 and from 2013/14 also young people who have turned 19, 20 or 21 in a given year who were previously looked after.

There were 68,840 looked after children at 31 March 2014, of which 38,800 were female (45%). 30,430 children started to be looked after during the year ending 31 March 2014.

#### **SMD indicators**

CLA has basic indicators of substance misuse, offending, mental health, being a victim of abuse / violence and homelessness (for care leavers only). It also has flag for an unaccompanied asylum-seeking child.

There is no data on the child's parents/carers or on past risk factors.

LAC data is part of the National Pupil Database and therefore can be linked to other information included in NPD.

#### **Data Access**

Our request for information regarding access to the data has not been responded to. However, as CLA is part of the National Pupil Database we would expect the requirements to be the same as for Children in Need data (see pages 58-59).

#### **Relevant links**

<https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption--2>

#### **2.6.4. What are the risk factors associated with SMD among girls?**

Three strategies can be employed to address this research question.

The first option would be to only look at girls aged 16/17 and use adult datasets (where respondents are aged 16 and over) which are rich in information about the respondent's past as well as current SMD. However, the two datasets which are rich in such information – MEH and APMS - do not have a sufficiently high number of girls aged 16/17.

The second option would be to analyse longitudinal studies. Here again ALSPAC (Age 14 sweep) appears to be the best choice while MCS (Age 14 sweep) may be a possibility depending on the exact content.

The last option would be to look at cross-sectional surveys of children and young people (under 18) which again are rich in information about the occurrence of 'risk factors' in the past as well as SMD. There is no ideal data source here but the Mental Health of Children and Young People survey (2004) is a reasonable candidate. The disadvantage, apart from the data being quite old now, is a relatively small number of girls aged 16 (295) and lack of girls aged 17. (Unfortunately it is not possible to pool data for girls aged 16 from the 2004 survey with data from the 1999 survey as the latter had no girls aged 16).

Additionally, two datasets can be explored to gain a picture of risk factors for specific groups of children experiencing SMD who are not in private households. Firstly, the CLA dataset allows for identification of children who are affected by SMD but also due to its very nature can be used to shed light on the extent to which being looked after is a factor increasing the risk of SMD. Secondly, OASys could be used to analyse risk factors among young offenders: it has records of young people under 18 and allows for identification of SMD as well as for exploring past risk factors.

It seems likely that further in the future the Life Study (currently under development) will become the main source of data on risk factors. It is a birth cohort study with a sample of 80,000<sup>22</sup>.

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<sup>22</sup> <http://www.lifestudy.ac.uk>

## 2.7. Implications and recommendations

With regards to SMD among women, the feasibility study has resulted in identification of five datasets which could usefully be explored: Supporting People, Adult Psychiatric Morbidity Survey, Crime Survey for England and Wales, Poverty and Social Exclusion, and Multiple Exclusion Homelessness. With respect to specific populations known to suffer from high rates of SMD, CHAIN data could be analysed for rough sleeping women in London and OASys can be investigated for female offenders. Lastly, the Understanding Society Survey and PSE survey can be employed if a rights and/or capabilities approach is adopted.

For girls, six datasets have been identified, including Children in Need, Supporting People, Crime Survey for England and Wales, the 'Young Runaways' 2005 survey, Mental Health of Children & Young People 2004 survey and ALSPAC Age 14 Sweep (or MCS Age 14 Sweep if data is available in time for the study). The Looked After Children dataset could be used for exploring SMD among the specific population of children involved with the case system.

In terms of implications for resources, two points need to be stressed:

1) Access to some datasets may be time-consuming or otherwise difficult. Judging by the Heriot-Watt team's experience with the original 'Hard Edges' study, access to OASys is likely to be the most difficult. Accessing CSEW will require travelling to a Safe Room located in Essex and undertaking a half-day course in London. Access to post-2010 Supporting People datasets would need to be negotiated with the Centre for Housing Research. Access to the 'Young Runaways 2005' survey dataset may be problematic too (our inquiry regarding the remit of and access to the dataset has as yet not been responded to).

2) The analysis of longitudinal surveys is more complicated and time-consuming than the analysis of cross-sectional surveys. This needs to be borne in mind when a decision is taken to analyse ALSPAC or MCS.

With regards to APMS 2014, it does not appear to be a problem that the data is not going to be available until September 2016. In our view the study of SMD among women and girls would need to be at least a 12-month project. Considering that the start is not likely before January 2016, we anticipate that the study team would first lodge requests for access to datasets, then do the bulk of analysis over Spring/Summer 2016, and finally analyse APMS 2014 when the data is available in September 2016.

If a decision was taken to follow the rights and/or capabilities approaches, a significant consultation exercise would need to be carried out first regarding the operationalisation of SMD. The feasibility study has usefully found that one of the datasets – PSE – can be used for both 'defined categories' approach and rights/capabilities approach, thus allowing for a comparative investigation of two SMD populations defined in two different ways.

Lastly, it would be possible to carry out a gendered comparison of SMD among women/girls and men/boys but such a project would require a proper conceptualisation of SMD for

men/boys to be carried out (equivalent to Chapter 1 in this report conceptualising SMD for women and girls). In terms of the datasets used for analysing SMD among men/boys, all the key datasets identified in this feasibility study would also be employed with the only modification being that OASys would play a prime role.



## Appendix 1: Additional gender analysis of Heriot-Watt SMD profile data

OASYS data	Women (%)			Men (%)		
	SMD1	SMD2	SMD3	SMD1	SMD2	SMD3
Receiving medication for mental health problems	22	29	30	14	19	23
No qualifications	42	49	55	35	43	48
Significant financial problems	16	31	48	12	24	43
Significant family relationship problems	14	23	37	10	17	32
Some/significant partner relationship problems	33	45	53	29	37	43
Significant adverse childhood experiences	40	45	56	25	32	42
Victims of DV	60	65	71	8	10	12
Perpetrators of DV	13	16	21	41	45	51
Childhood psychiatric problems	15	21	27	19	28	35
Have parenting responsibilities	39	27	22	36	29	25

NDTMS data	Women (%)				Men (%)			
	Sub only	Sub+H	Sub+Off	All 3	Sub only	Sub+H	Sub+Off	All 3
Dual diagnosis	19	23	16	20	15	18	10	13
Contact with children:								
a) parent living with own children	36	22	26	12	18	7	16	6
b) Other child contact - living with children	11	19	17	24	13	19	16	21
c) Other child contact - parent not living with children	16	23	22	30	20	27	22	29
d) Not a parent / no child contact	38	36	35	34	50	47	46	44

## Appendix 2. Long list of data sources investigated in some detail.

1958 National Child Development Study (NCDS)  
1970 British Cohort Study  
Adult Psychiatric Morbidity Survey 2007 (APMS)  
Attendance and Absence in Scottish Schools Survey  
Avon Longitudinal Study of Parents & Children  
British Household Panel Survey (BHPS)  
CAADA - Children's Insights Dataset  
CAADA - Insights National Dataset  
CAADA - Young people and interpersonal violence survey  
CAFCASS  
Child Exploitation and Online Protection (CEOP) Centre data  
Child Trafficking Advice Centre (CTAC) referral data  
Children in Need (CIN) Census  
Combined Homelessness and Information Network (CHAIN)  
Crime Survey of England and Wales (CSEW)  
DDV Concessions  
Destitution in the UK survey (Heriot-Watt/JRF)  
Effective Pre-School, Primary & Secondary Education (EPPSE)  
English homelessness and prevention data (P1E form)  
English rough sleeping LA data  
European Social Fund (ESF) Support for Families with Multiple Problems  
Exclusions from Scottish Schools Survey  
Families and Children Study (FACS)  
General Household Survey  
Growing Up in Scotland  
Households Below Average Income / Family Resources Survey  
Health Survey for England  
HES (Hospital Episode Statistics) Data Interrogation System (HDIS)  
Scottish homelessness data (HL1, HL2, HL3)  
Home Office asylum data  
Homeless Link (In:Form)  
Looked After Children (England ) (SSDA903)  
MARAC data  
Mental Health of Children and Young People in Great Britain, 2004  
Mental Health of Young People Looked After by Local Authorities in Great Britain, 2001-2002  
Millennium Cohort Study  
Multiple Exclusion Homelessness (MEH)  
National Case Review Repository  
National Drug Treatment Monitoring System (NDTMS)  
National Pupil Database  
National Referral Mechanism

National survey of young people's well-being (2008)  
Next Steps (Longitudinal Study of Young People in England - LSYPE)  
NRPF Connect  
NSPCC Prevalence study 2011  
Offender Assessment System (OASys)  
Offender Management Community Cohort Study (OMCCS)  
Offending, Crime and Justice Survey, 2003-2006  
ONS Longitudinal Study  
Our Future (Longitudinal Study of Young People in England 2 – LSYPE2)  
Partner exploitation and violence in teenage intimate relationships (University of Bristol)  
Peterborough Adolescent and Young Adult Development Study (PADS+)  
Police National Computer  
Poverty and Social Exclusion (PSE)  
Scottish homelessness prevention / Housing Options data (PREVENT1)  
Pupil Referral Unit Census  
Pupils in Scotland Census  
Safe Lives - Insights Idva national dataset 2013–14  
Safe Lives - Insights outreach national dataset 2013–14 (Adult outreach Services)  
Safeguarding Board Statistics on Section 42 investigations  
Scottish Drug Misuse Database (SDMD)  
Scottish Longitudinal Study  
Scottish School Leavers Survey  
Scottish Schools Adolescent Lifestyle and Substance Use Survey, 2013 (SALSUS)  
Scottish Welfare Fund (SWF)  
Section 25 Welfare Orders (Secure Accommodation Orders)  
Smoking, Drinking and Drug Use among Young People  
Supporting People  
Survey of New Refugees 2005-2009  
Surveying Prisoner Crime Reduction (SPCR) longitudinal survey  
The Children's Society 'Young Runaways' surveys (1999, 2005, 2011)  
The Edinburgh study of youth transitions and crime (ESYTC)  
The Life Study  
Troubled Families Programme  
Trussell Trust  
Understanding Society Survey  
What About Youth Study (previously the Local Health and Wellbeing Survey for Younger People)  
Women's Aid annual survey of services  
Youth Cohort Study  
Youth Custody data  
Youth Justice data  
Youth Offending Teams (YOTs) data

### **Appendix 3. Short list of data sources investigated in full detail.**

Adult Psychiatric Morbidity Survey 2007 (APMS)  
Avon Longitudinal Study of Parents & Children  
CAADA - Children's Insights Dataset  
CAADA - Insights National Dataset  
CAFCASS  
Children in Need (CIN) Census  
Combined Homelessness and Information Network (CHAIN)  
Crime Survey of England and Wales (CSEW)  
Looked After Children (England ) (SSDA903)  
Mental Health of Children and Young People in Great Britain, 2004  
Millennium Cohort Study  
Multiple Exclusion Homelessness (MEH)  
National Drug Treatment Monitoring System (NDTMS)  
Next Steps (Longitudinal Study of Young People in England - LSYPE)  
Offender Assessment System (OASys)  
Offending, Crime and Justice Survey, 2003-2006  
Poverty and Social Exclusion (PSE)  
Scottish homelessness prevention / Housing Options data (PREVENT1)  
Safe Lives - Insights Idva national dataset 2013–14  
Safe Lives - Insights outreach national dataset 2013–14 (Adult outreach Services)  
Scottish Welfare Fund (SWF)  
Supporting People  
The Children's Society 'Young Runaways' surveys (1999, 2005, 2011)  
Troubled Families Programme  
Understanding Society Survey

## APPENDIX 4: What is Severe and Multiple Disadvantage for Women and Girls?

### Report on consultations with women affected by disadvantage

To inform the development of our thinking about severe and multiple disadvantage (SMD) for women and girls, we convened five consultation events as follows:

**West Yorkshire:** This group was hosted by Women's Centre, Huddersfield and was attended by 21 women with 4 staff. Women had a range of involvement with the centre including being part of a young women's group, a migrant women's group and a group for women who had lost their children to care.

**Glasgow:** 20 attendees included representatives from Up-2-Us, Argyle and Bute Rape Crisis, Quarriers, Centre for Youth and Criminal Justice, Scottish Consortium for Learning Disabilities, SAY Women, Cyrenians, Circle, Wise Women, Ivy Project, TARA, Routes Out/Base 75, Turning Point Scotland, Violence Against Women Partnership.

**London:** Two groups were held in London:

One was hosted by Praxis in East London and was attended by 16 migrant women from Africa, South/ SE Asia and Latin America. All were refugees or asylum seekers and/or women who had been trafficked – all survivors of gender-based violence. This is a group which has been meeting together for the past five years.

The second London group was hosted by Women's Health and Family Services (WHFS) in Tower Hamlets and was attended by 38 women in total, composed of 13 Bengali women (+ 2 Bengali workers & 2 volunteers), 11 Somali women (+ 1 Somali worker); 6 Vietnamese women (+ 1 Vietnamese worker); 8 Black African/ Caribbean and White UK women (plus 2 workers).

**Suffolk:** This was a small group of four women hosted by One Voice 4 Travellers. This included a worker who is also from a Traveller background.

Prior to each session, the host organization was provided with a briefing paper (see appendix) explaining the purpose of the consultation in order to inform their recruitment of participants and enable them to prepare women in advance. This was particularly helpful in ensuring that the majority of women that attended sessions knew why they were there and had actively chosen to participate.

Host organisations were given a modest payment to help reimburse the costs of their time in

recruiting women and towards the cost of the venue. We also provided funding for the provision of lunch for participants at the beginning or end of each group. We gave each woman who attended a £20 shopping voucher as a thank you for their participation.

Sessions were facilitated slightly differently depending on the size and composition of the group e.g. the small group of Gypsy and traveller women was run as an informal conversation whereas the larger sessions were run as workshops with participants split into smaller discussions which then fed back to the whole group. We had a minimum of two facilitators for each session which enabled us to both facilitate and take notes. (We opted not to tape record sessions as initial feedback from host organisations suggested that some women would not be comfortable with this). For the larger groups we had 3 or 4 facilitators and some staff from host organisations also helped by facilitating and/or note taking in the small group discussions. Host organisations also provided interpretation where required.

Each session was introduced with the background and purpose of the consultation i.e. to gain a better understanding of severe and multiple disadvantage for women and girls.

We then took each group through a set of questions which were broadly linked with the main approaches outlined in the draft conceptual framework. In order to identify which categories of women participants thought faced the worst SMD (the defined categories approach) we asked:

### **Who are the most severely and multiply disadvantaged women?**

#### ***Prompts***

- Thinking about the women in your community, who are those have the most difficult lives?
- What are their lives like? What sorts of situations are they living in? What issues do they face?
- How are their lives different to that of men who are disadvantaged?
- The most severely & multiply disadvantaged men have been identified as those affected by homelessness, drugs, and involvement with the criminal justice system. Many also suffer from mental ill health. Those facing the worst SMD have all of these factors in their lives.
- To what extent is this also the case (or not) for women?
- Are there other issues that are more likely to affect women and lead to them facing SMD?

In order to obtain participants' views on the key risks that result in women facing SMD (the risk factors approach), we asked:

### **What leads to the worst disadvantage?**

### **Prompts:**

- Are there particular life events/things that happen that disadvantage women?
- What are the childhood experiences that can lead to later difficulties?
- Pathways – does one thing lead to another?
- Are there things that interact to make things worse?
- What are the biggest risks for women?
- Are the risks different for women than for men (e.g. as children, growing up, as adults)
- Are there things that affect women worse or differently?

In order to gauge views on how social inequalities and access to rights impact on women we asked:

### **How do social inequalities affect women and add to their disadvantage?**

#### **Prompts:**

- How do gender inequalities (being a woman, being a man) impact on SMD?
- What effect do gendered expectations have on women and men?
- How do other inequalities affect women?
- Poverty?
- Race and ethnicity?
- Disability?
- Sexuality?
- Age?
- Are there other characteristics which make some women less equal (e.g. being married; not being married)

In addition we asked women to identify the rights that were most important to them. We did this by giving each woman three post it notes numbered 1, 2 and 3 and asking them to attach them to flipcharts on the wall which had the following rights on them:

### **How important are the following rights to you?**

- Financial independence
- Control over life choices
- Freedom of movement
- Freedom from male violence and fear of violence
- Sexual and reproductive choice
- Shared responsibility for children
- Equal access to education and employment
- Freedom from gendered expectations

We followed this exercise with a whole group discussion on why participants had chosen their 3 most important rights.

The final part of the consultation focused on what would help women who face SMD or to prevent women from experiencing SMD. We asked:

### What would (or does) help women:

- To prevent them becoming disadvantaged?
- To get them out of disadvantage?
- To make their lives better?
- Are there gender differences in the support needed?
- In your own experience, what are the things that have been most difficult for you to deal with? What are the things you have found hardest to get help with?

## Overview of responses

### Who are the most severely and multiply disadvantaged women?

There were some common themes in the groups identified across all the consultations. Women with experience of homelessness, drug/substance misuse and prison all came up in most of the groups. The following groups of women were also raised in most of the consultations:

**Women experiencing mental ill-health** was a group identified across all the consultation events. In several of the discussions, women described mental illness as still taboo in their communities:

*People hide it and don't seek help so they suffer more.*

Mental ill health was also seen as a consequence of, or compounded by, other problems in women's lives.

**Lone mothers**, especially those living in poverty and with a range of other problems. For example a group of Somali women talked about the difficulties faced by:

*Single mums raising children without support from family or from services – this is hard from the earliest days, once Health Visitor input is over – there can be post-natal depression, everything is new and you don't know what to do, language barriers mean you are isolated and cannot ask for help, as children get older you do not understand the education system and children end up staying at home.*

A migrant woman who is a lone mother gave an account of a time when she had broken her leg and was alone with her children in a flat. One day there was a suspected gas leak in the block of flats and everyone evacuated the building – everyone except her and her children because she couldn't walk and her English was not good enough to enable her to ask for help. She described taking her children to bed with her and hiding under the covers – terrified in case there was an explosion.

**Migrant women.** Several groups talked about migrant women being particularly likely to face SMD. They highlighted a range of factors contributing to this: poverty – particularly for those women who have no recourse to public funds, the generally poor accommodation many migrant women live in, negative public attitudes and the day to day struggles of communicating in a foreign language.

*Migrant women – don't know the system, lack of language, no clue how to deal with the system. No funding – horrendous poverty. Women end up taking responsibility for families. Worse for women because men are more independent. Issue isn't just money – they're not integrated. ... I was living for years with no status. I am refugee now but still living with difficult lives. Women left holding the background of the culture. Feel not accepted by society. Whatever knowledge or intelligence you have is not respected.*

Those with no recourse to public funds were identified as a particularly disadvantaged group:

*Asylum seekers are often simultaneously suffering from trauma and lack of access to support because they're ineligible. Rates of female destitution very high for this group e.g. even if she's pregnant an asylum seeking woman cannot get help until she's at 8 months.*

A woman in one of our groups cried as she recalled her experiences of trying to survive with no money or support. She fed herself and her child by going through rubbish bins.

These experiences are often added to life histories characterized by horrendous abuse prior to migration followed by further experience of violence and abuse after entry to the UK. In one of our consultation groups:

*Two women revealed that they had been raped as children and talked of the pain and fear and isolation they felt. Neither had previously told this to the group (who knew each other well having been meeting for 5 years). One woman talked of feeling ashamed all her life – or having 'a secret inside me I could not share'. It had*

*affected her all her life, affected her marriage and was still in her head. She could not forget. The other woman talked of the pain of the physical act and of rejection by her family and feelings of worthlessness. The man was 'still in her head'. She wanted to study, to learn English but the memories in her head and feelings made it very difficult.*

**Women who do not speak English.** Language barriers were a major issue for many of the women in the consultations. They described how difficult it was for them to understand the system and to access health and social care services.

*Women do not get the help they are entitled to because they don't know it is there*

Being unable to communicate with a GP was a particular concern for many. Language issues also act as a barrier to women's access to education and employment opportunities.

Some women talked about how hard it was not to be able to communicate about their lives – not having their experiences acknowledged and understood or considered as relevant and important.

Many migrant women talked vividly about the difficulties they had not speaking English: one woman didn't go out for 4 years, another lived in a hostel for 6 years, in part because she didn't have the language skills to find somewhere else. They also talked about the impact of past trauma on their ability to learn:

*Your mind cannot be still to learn. I try to stay positive and to learn, but it's hard.*

Several women had tried over years to learn English, sometimes feeling they were improving and other times losing confidence because they felt they weren't getting any better. They expressed frustration at not being better at the language despite years of living here and trying to learn. They were distressed at the attitudes of people in authority who seemed to think that learning English was a simple thing and they just weren't trying.

**Young women.** Several of the discussion groups raised concerns about younger women. People talked about the challenges and pressures of being a teenage girl, their vulnerability to mental health issues and a lack of support available.

*People fall through the net between 16 & 18 especially those with mental health issues. It's virtually impossible to get help for teenagers in schools... Many young women almost but don't quite meet criteria for mental health services.*

When young women do not have support from their families, they were thought to be

additionally vulnerable. For example:

*Young homeless women are often seeking emotional connection/support and will look for this in an intimate relationship which makes them very susceptible to exploitation.*

**Older women.** Some groups talked about the challenges faced by older women including those living in poverty and with little support. They were described as ‘invisible’. Older women within minority communities were thought to be particularly disadvantaged, especially where they spoke little English.

Older women are more likely to experience poverty and people gave examples of finding it harder to find work as an older woman and not being seen as a priority for housing or support. One woman described having lost her child and her husband and as a result spending years in a hostel unable to get anywhere better to live. She was distressed at living alongside drugs and prostitution.

People also spoke about the pressures on older women to continue caring for others:

*Women never retire – they carry on caring and being responsible.*

The level of **caring responsibilities** that women often have in their lives was a recurring theme in the consultations. This included women with children and with elderly or sick relatives. There were several examples of women spending most of their time looking after other people on top of their paid jobs. This was mostly thought to be entirely taken for granted.

**Those who are isolated.** Isolation was one of the difficulties identified for older people, but it was also viewed as an issue for other women including those without children (or who had lost children) who were seen as not having a place or any status in some communities. Some groups described the circumstances of women whose movements were restricted to within her family and immediate community. Again, women with little English were felt to be particularly disadvantaged, but Traveler women could also find themselves in this situation.

*Women can be isolated within their own families and lack access to any kind of support. You are dependent on family for support and that’s alright when everything is alright but not when it wasn’t.*

A group of Vietnamese women described their sense of loss for the country of origin and the isolation they experienced moving to a strange country:

*They found the life completely strange. They had no English and no education and no support. They had no idea about the future and felt very frightened and worried. One spoke of not knowing how to count the money and just holding out her hand for people to take it. They didn't know where to get help. Isolation was a big problem and many felt depressed – and wherever they went they were called 'Boat People'*

**Disabled women and those with learning disabilities** were mentioned particularly in the context of being more vulnerable to abusive relationships. People highlighted the lack of information available to women and girls with learning disabilities and gave examples of young women experiencing abuse and not being believed because of their learning disability.

*Young women with learning disabilities get less information about what to expect from and how to manage relationships. For example, in our rural area young women with learning disabilities are regularly asked to perform sexual favours in exchange for a lift – and the young women don't have the knowledge and confidence to refuse.*

**Women who have lost their children to the care system.** In one of our consultation events there were several women who are part of a support group for those who have lost their children to care. They were very articulate about the pain and grief they faced, the stigma attached to their situation and the negative attitudes of other people.

*There's not much understanding for women who have lost their kids – including from other women.*

**Those in poor, overcrowded and temporary housing.** Homelessness was mentioned by several groups along with those women who have accommodation but of a poor or unsuitable kind:

*One woman described living with her 8 children in a 2 bedroom flat on the 9<sup>th</sup> floor with nowhere for the children to play – this leads to noise and disputes with neighbours who then complain about her. This causes her huge stress and worry about losing the property and also about social services becoming involved (and their lack of cultural sensitivity to understand her situation).*

Some of the women in the groups raised concerns about housing policy and shortages resulting in them being housed a long way from their communities and support networks.

**Traveller women.** The women in the Gypsy, Roma and Traveller group were clear that the

most disadvantaged women in their community were those travelling 'on the side of the road' (around a quarter of the community). The circumstances of women were described as very difficult:

*They don't know where they will be the next day - could have to move on at any time because people won't let you stay. They have no access to medical help if they need it – you can take a sick child to the doctors in one place then be 40 miles away the next day. And your only community is your family – you are with them 24/7 - which is OK when everything is alright, but not if anything happens and you need help.*

However, things can also be difficult for travellers who settle. One woman explained that she'd moved into a house because her partner was disabled. The people on the road had a meeting when they heard about her moving in and put up a sign - 'No Gypsies Allowed Here'.

*I've lived here for 10 years now and no-one in the cul-de-sac speaks to me. Whenever I see a neighbour I raise my hand and say hello in the hope that one day someone will reply. You can feel very isolated but you just have to close it off and get on with your life.*

The women we spoke to in this group described the public attitudes to them as:

*The last acceptable form of racism. Even people who wouldn't dream of being racist against anyone Black doesn't think twice about saying things about gypsies and travellers...You go through being hurt, then sad, then bored – and eventually you just cut off, blank the situation out'*

### **Women with multiple issues in their lives**

Although each of the consultation groups provided examples of categories of women they thought were most disadvantaged, what was clear from all the group discussions was that the most disadvantaged women were thought to be those experiencing an accumulation of bad experiences: women who had experienced abusive and neglected childhoods, then abusive relationships as adults combined with poverty culminating in poor mental health, low self-esteem, often accompanied by substance misuse and other bad experiences such as homelessness or insecure accommodation.

*Women who have lots of things going on – poverty and when you've had bad childhood there's a domino effect – it's a vicious cycle. My parents had same problems as me.*

When we asked women what life was like for those with SMD, responses did not tend to focus on the practical, physical hardships of life (it was as though these were taken for granted). There was much more emphasis given to the emotional impacts: recurring words and phrases were low self-esteem, lack of confidence, depression, anxiety, fear, exhaustion, no motivation, loss of pride and dignity. The responses of other people were also recurring themes: being judged, feeling blamed, getting labelled and being let down, loss of trust.

*People let you down – partner, family, parents, services – they all let you down*

## What leads to SMD for women?

We asked groups of women what they thought led to SMD – what experiences or life events meant women were more likely to face SMD. Again, women did not tend to dwell so much on the practical challenges that face women at risk of SMD. Lack of money, loss of benefits, eviction – these were all mentioned, but much more prominent in the discussions were things that happen to women in relationship to others. Poor family relationships and trauma from abuse in childhood were viewed as setting girls on the path to later disadvantage.

*What happens in childhood – I lost my child because of my childhood.*

Some of the groups talked about the impact of abusive family relationships on young women whose escape from abuse can leave them with few sources of support – and more vulnerable to abuse by others.

*Sometimes the only way for young women to secure their safety is to sever ties with family because they are not believed re abuse. Sometimes ties have to be severed from an entire community. The prospect of ‘rocking a community’ and being excluded is a heavy burden to bear.... Sometimes women see securing new relationships as the only way to safety.*

And as adult women, it was their continued experiences in abusive relationships with men which was the most dominant discourse across all the groups. Many women were explicit about what they saw as a clear thread linking what happened to them as children (in abusive relationships within their families) to what happened to them as adults (in abusive relationships with partners) and how these experiences were connected to the circumstances they were in e.g. their experiences of mental health problems, substance misuse, sexual exploitation and/or involvement with the criminal justice system.

Women’s experiences differed but the themes were similar. For example, some migrant women talked about escaping male violence in their countries of origin only to find themselves in abusive situations in the UK.

*One woman talked of being trafficked to this country and spending 7 years in one place as a captive, not knowing where she was or even what country she was in. She could speak no English. She eventually escaped and ran to a church where people helped her. She said you could not see because she was clothed but her body bore the scars of what had happened to her.*

A group of gypsy, Roma and traveller women talked about the prevalence of domestic violence in their community and the additional difficulties faced by women who are largely enclosed within their family and community.

*I asked one woman about her black eye and she told me she'd got a Crown Derby plate for that. Every time her husband hit her he tried to make up by giving her Crown Derby. She told me she's got the whole tea set.*

They described some of the cultural norms which can make it almost impossible for women to escape a violence relationship: girls often marry young and there's an expectation that it's for life – divorce is very uncommon. There's a culture of not interfering in someone's marriage unless you're asked – even if you know/suspect violence. The close knit community which can provide excellent support for women, can also make it harder to escape. In practical terms, women are frequently 'under the surveillance' of their families, and in emotional terms, leaving a violent relationship would usually entail leaving the community:

*Women who are treated very badly are still there because of their children. There is very little option for women but to stay. Theoretically, you could leave and go to a safe house with your children – but you would have to cut all communication with your family and leave the community entirely because otherwise your whereabouts would get round by word of mouth and your husband would find you.*

In addition, the traveller community's generally poor relationship with the police means that domestic violence is rarely reported.

This group of women also commented on the impact of psychological abuse:

*If you have scars you can say: this is what he's done - but no-one can see what he's done to your head.*

These themes were echoed by other groups of women. For example, a group of Vietnamese women talked about their husbands taking other wives: they feel very lonely and

disappointed as they have already spent their whole life with this man. Sometimes the second young wife lives in the family home but mostly the husband takes his new wife and moves out of the house with her, leaving the children with their mother.

*The older woman is left on her own to look after the children. The man doesn't help...It affects the whole family as the children see there is a problem between their mother and father and they feel angry with their father.*

When asked if attitudes were changing against this practice, the women said no – it was getting worse:

*The men can go home to the poorer country and tempt young women to come with money and stories of how wealthy they are in the UK.*

This group of women described how much worse it is for them if they only have girl children:

*Families must have a son because the son carries the name to the next generation – so if the family has only daughters it will be 'cut' as there is no-one to take the family name forward...Women who do not give birth to a boy feel very unhappy and depressed. The husband may threaten divorce and it is another excuse for the man to go and get another wife. They may feel suicidal.*

## How are the experiences of women different to those of men?

There were a number of recurring themes in women's responses to this question. Several of the discussions highlighted the greater freedom experienced by men.

*Men have more free time to get out; women are much more trapped than men.*

*Men also have hard lives but women's lives can be much harder if not supported by their husbands. Men work hard but can go out to meet friends. Women work even harder – often have two jobs.*

Women also discussed differences in the amount of power and control enjoyed by men and women – for example, they pointed out that even within very disadvantaged families, men often have greater financial control over the available resources.

*For example if they are on benefits when the money is collected he takes it all and only gives the woman perhaps £20 to buy food for the family for the whole week.*

And, however disadvantaged men themselves are, they are often able to exert power over the women in their lives.

*The husband goes out gambling and drinking then comes home demanding sex and beating the woman if she does not comply or threatening to tell other people if she won't give it to him. So the woman just lets him do what he wants – but she is very depressed and has to take anti-depressants and go out to work to earn money for the family. She wants to commit suicide – but the need to care for her children stops her.*

*The majority of Gypsy/ Roma/ Traveller families are very traditional. The men go out and work and earn the money – and have the last say; the women stay on site and look after the family. The women can have a say over their children – but only up to a point. Big decisions will be made by the man. There's a lot of protection and surveillance of girls.*

Several of the discussion groups talked about the risks for women who did try to take control.

*If women try to take control they're seen as wrong and it can lead to domestic violence.*

A further theme raised in the groups was the different expectations placed on men and women. One of the greatest expectations on women is that they will keep going in order to look after others.

*There's an expectation on women to keep the family together.*

This was not necessarily seen as a bad thing – for example, women talked about the need to look after their children as the main thing that kept them strong. However, the imperative to care for children comes with risks. They may tolerate violent relationships or avoid services which might help them:

*Women will put up with domestic violence because of the kids. In the end I only left cos I knew otherwise I'd be coming out in a straitjacket or a body bag*

*Women don't go to services cos they're frightened of losing their kids – or can't go because of the kids.*

*Women fight to keep their children even when they don't have the emotional and other resources to cope; there's less stigma for dads to walk away.*

Given the expectations on women of caring for their children, the cost of 'failure' can be very high. Some women who had lost children to the care system were distressed and angry that the men they saw as contributing to their loss could get involved with another partner and have more children, while they felt labelled for life as 'bad mothers.':

*I've had four bad relationships all involving domestic violence and drugs. But it's women who pay the consequences for bad decisions – men can just walk off. When women have kids taken off them, men can walk away and have as many as he wants. Women are watched like a hawk. Sometimes I wish I wasn't a woman.*

Women also highlighted widely held gendered expectations about the behaviour and demeanour of women. They described the pressure on women to have particular kinds of passive, non-assertive personality traits, to have particular kinds of body shapes and to be sexual in particular ways. They talked about the sexualisation of women starting at a very early age.

*Women have to be a certain way. It's 2015 – but the pressure on women hasn't moved on much.*

And they talked about the ways in which these expectations shaped the way women and men respond to adversity.

*It's how women deal with trauma that differentiates their experiences from those of men. Men (especially young men) get status by acting out – their image is important and they're more likely to be involved with gangs etc. Women gain status through relationships. Women are also more likely to internalise issues and are at greater risk of self-medicating and/or self-harming.... Men tend to take it out on others; women take it out on themselves.*

*Women are more likely to take these experiences to heart than men and keep it inside them, damaging them even more.*

*Young women often self-harm by cutting themselves in visible places e.g. arms (and this is often perceived as 'attention-seeking' by professionals); young men often self-harm by seeking out fights they know they cannot win.*

Some women suggested that the prevalence of intimate violence and abuse in young women's lives meant that they had less support when things went wrong:

*Young women tend to be more disaffected from family therefore have weaker (or no) support networks to return to when coming out of prison, for example. Many young women end up in homeless hostels when young men would return to family. Severed family ties makes young women 'doubly disadvantaged'*

There was also some discussion of how women are treated differently by services:

*Stereotypes about gender norms of behaviour mean that public and services cannot 'cope' with aggression from women therefore they are responded to differently in support services and the criminal justice system.*

*Reasons for claiming asylum differ: for men it tends to be extreme violence from the state; women more likely to flee violence from partners. Services cater better for the needs of male asylum seekers*

*We see a medicalisation of mental health issues when women are simply responding normally to life events/trauma. Some behaviours are actually signs of resilience or survival strategies – but they sometimes get women a borderline personality disorder label.*

## **What are the most important rights for women?**

As part of our consultations with women we conducted an exercise which asked women to identify the most important rights for them. We did this by giving each woman three post-it notes numbered 1,2 and 3 and asking her to attach these to the above rights according to her first, second and third priorities. We are not making any great 'scientific' claims for this exercise – it was mainly a way of stimulating discussion, but the resulting 'scores' are interesting. The table below shows the composite scores for each group with the first, second and third priorities highlighted.

The right to be free from male violence and fear of violence was the top priority for the Yorkshire and Glasgow groups and equal first for one of the London groups. This and the other London group also gave top priority to the right to equal access to education and employment. The London 1 group was composed of migrant women for whom education, freedom from violence and freedom of movement were their top three priorities.

The second London group was drawn from a range of BME (Bengali, Somali, Vietnamese and African Caribbean) with some white women. These women were largely part of families and communities and had talked a lot about their responsibilities for caring for children and others, often experiencing oppressive relationships and limited access to education and

work. Access to education and employment was their top priority by a wide margin followed by control over life choices and financial independence.

The Yorkshire group was drawn from a range of groups held at the Women’s Centre (composed of white, Asian and Black women). Their interests in particular rights was therefore more diverse but they were united in identifying freedom from violence as their top priority, well ahead of any of the others.

They shared this view with the Glasgow group who again overwhelmingly identified freedom from violence as their first priority.

Control over life choices was in the top three for all the groups. Some women explained that this was the overarching right for them – that if they had that, others would follow.

The lowest priority overall was the right to have shared responsibility for children. This perhaps suggests that for many women, despite the disadvantages of having the main caring role in families, the prospect of sharing this with their men is still not very appealing.

	Yorks (21)	Glasgow (20)	London (16)	London (38)
Financial independence	16	7	11	32
Equal access to education and employment	12	17	23	91
Freedom from male violence and fear of violence	30	42	23	13
Control over life choices	15	17	14	41
Freedom from gendered expectations	15	18	8	18
Freedom of movement	7	0	21	22
Sexual and reproductive choice	10	9	0	8
Shared responsibility for children	2	0	4	20

(Number of women in each group appears in brackets)

Most important right

2<sup>nd</sup> most important right

3<sup>rd</sup> most important right

## What does or would help?

There were a number of recurring themes in what women said helped them now or would help them and other women if available:

**Timely and accessible support:** Women spoke about the need to access help quickly and the difficulties they faced due to waiting lists and delays.

*Sometimes support comes too late, isn't there, or doesn't come until it's too late.*

*Need services to be flexible and well-resourced enough to enable response at first point of disclosure re a need i.e. so that women don't need to repeat their story over and over.*

*Services need to go to SMD women (i.e. provide services in their homes/communities), not expect them to attend appointments elsewhere*

Women wanted support which lasted over the longer term and which did leave them stranded with their issues after a few short weeks of help. They also talked about the need to overcome the barriers to accessing support, including taking rurality into account:

*If we really want to provide proper and dignified access to services there's a need to take seriously things like childcare costs, travel costs, cost of interpreters; i.e a need to resource things adequately*

*Improve services in rural areas; don't assume SMD is an urban phenomenon (e.g. trafficking occurs in rural areas too and isn't necessarily less hidden)*

**Preventive support and education:** Women talked about how they would have valued earlier support before issues became entrenched and identified the importance of prevention and education for girls and boys today.

*Education for children on what healthy relationships look like & for girls to know they can be on their own and for boys to deal with anger so they don't become violent men*

**Support for women themselves – not just as mothers:** Some women talked about only feeling visible to services as mothers, not as people in their own right.

*Many young women go unnoticed by services until they appear in children's services as a parent*

Women who had lost their children to care felt particularly abandoned.

*There are services for families but when children removed nothing for mum*

*Support for women at risk of losing their kids – think of mother first and give her support and information.*

**Gender informed services:** Women valued support provided in women's spaces and wanted more separate services for boys and girls, men and women.

*More gender responsive services; i.e. better acknowledgement that women's needs are different from men's (and that there is great variability amongst women too, of course).*

They appreciated support from other women in a safe, trusted environment which included peer as well as staff support:

*The women's centre - women's spaces – provides real honest communication, trust, at right speed, peer support*

*A family of women who belong and share is a substitute – share what learn and confidence to believe in self*

*Get women's voices heard; encourage women to share their experiences and views; emphasise the legitimacy of these; use confidence building workshops*

Several people talked about the need to provide support to women which is based around relationships:

*What women need is people (i.e. positive relationships with genuinely supportive staff etc) not 'new projects'*

The importance of relational support for women was felt to be overlooked by many services with the result that existing services often have a male bias and there is insufficient investment in the kinds of support that works for women:

*Supporting women 'costs more' /requires more investment coz they require time to build relationships and genuine sense of safety. It's often 'cheaper' to get outcomes with men.*

*Male bias in interventions. Disadvantage starts early and services need to be gender aware. Many service providers think that equal opportunities means 'treating everyone the same' so they fail to recognise/ameliorate gendered disadvantage. Gender neutrality can mean no-one gets a good service.*

*Lack of investment in specialist/tailored services for women coz numbers too small. The resources needed to support women are primarily 'human' in nature (i.e. recovery comes from relationships rather than 'stuff'/initiatives).*

Some women felt that services were not merely unhelpful but could be positively damaging to women:

*The most vulnerable are those who've had most contact with services. Women get shoehorned into programmes designed for men.*

Services also need to be well informed about other inequalities which intersect with gender:

*Professionals are not immune from racism/ignorance: e.g. "that domestic violence is what happens in those families"*

The importance of gender-informed services for men was also highlighted:

*More broadly, as a society we need to challenge men's behaviour; acknowledge that working with women (alone) won't solve the disadvantages they face.*

**Empowering women to have a voice:** Groups talked about the importance of women developing the confidence to speak out on their own behalf:

*Groups of women having space to come together regularly to raise all the issues and then having a representative to speak to policy makers on their behalf*

**Education for women:** Some groups of women identified specific services which would help. More support and tutoring for women with limited English was highlighted. This needs to take account of the pace of learning and the experience of many women that trauma blocks their ability to learn and the level of education that some women start with:

*Many women not even literate in Somali – need someone who understands, from the community to help them take the steps to learn English*

*Language barriers also lead to a lack of other skills as you can't 'better yourself' and take advantage of opportunities for education and training*

Many women saw education as a route to better lives:

*The community helps but people will only help you for a short time so you have to educate yourself for the long term. Some things you can't control but if you get knowledge you can do the best you can.*

*The traveller community needs more education. The drop out of school after primary is very high. Boys have to work and girls are kept at home to look after the house and other children...but most Gipsy and Traveller Education Units are mostly now closed or drastically cut, even in those areas which have the largest traveller populations.*

**Jobs and the benefits system:** Several groups highlighted a number of ways in which the current system disadvantages women, particularly those with children:

*Austerity measures have disproportionate impact on women (eg lone parent obligations).*

*Current benefit arrangements allow no time for women to recover from trauma before being pushed back into work*

*Provision of more jobs that are 16hrs that women with caring responsibilities can realistically manage*

*Benefits system: better understanding of the impact that medication has on people's wellbeing on a day-to-day basis and their capacity to work*



# Lankelly Chase

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