The core components of a gender sensitive service for women experiencing multiple disadvantage:

A review of the literature

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Introduction

The report '*Women and Girls at risk: evidence across the life course*' (McNeish & Scott 2014) was pivotal in shining the spotlight on the vast range of harms faced by many women over the course of their lifetimes. The authors highlight how women entering services are often viewed through a lens of what is wrong with them, i.e. having substance use problems, offending behaviour or mental health difficulties, rather than through the lens of what has happened to them. A gendered perspective means recognising the importance of the social context, particularly the social inequalities impacting on women's lives. Without this, service approaches fail to meet the needs of women facing multiple life stressors and disadvantages over the course of their lives.

This literature review continues where the W*omen at Risk* report left off, encompassing the same five areas of disadvantage faced by women:

- contact with the criminal justice system
- homelessness
- involvement in prostitution or sexual exploitation
- experiencing severe mental health problems
- experiencing serious drug and/or alcohol problems.

The definition of disadvantage is also extended to include wider forms of violence against women[1] to encompass harms related to all forms of sexual violence, intimate partner violence (IPV), so called 'honour based' violence, trafficking and female genital mutilation.

The *Women at Risk* report highlights service approaches that are better suited to women facing multiple forms of these disadvantages. Within mental health, for example, this requires services to promote safety, respect and take the complexity of women's lives seriously and to be provided in a holistic, integrated and seamless manner. Services delivered by staff with an understanding of gendered violence and abuse and which provide women with a sense of control, particularly for survivors of abuse who have been the subject of controlling behaviour, are also important. Women praise those groups, programmes and services that share the core elements of providing safe contacts with others, helping to understand commonality of experiences, inspiring people with what others have achieved, allowing people to move forward at their own pace and enabling others to 'give back'. The authors

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[1] The UK government has adopted the United Nations definition of violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life." See https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118150/vawg-paper.pdf

highlight how women may be more likely to respond to an 'emotionally intelligent' approach to their needs (Covington 2001).

The authors also refer to 'nine lessons for good practice' with women offenders in the community, underpinned by 1) women-only provision, 2) integration with non-offenders, 3) fostering of women's empowerment, self-esteem and problem-solving abilities, 4) holistic and practical services, 5) links with other agencies, especially health, housing and employment, 6) flexibility to allow women to return for 'top up' support, 7) arrangements for personal support on leaving the project, and practical support such as transport and encouragement to re-establish links with children (McNeish & Scott 2014). A number of women's community centres in the UK delivering services to women involved in or at risk of being involved the criminal justice system, operate around these exact principles (Jones, Duffy & Hyde 2011; Radcliffe *et al* 2013).

This review aims to further flesh out the core components of a 'gender-sensitive' service for women experiencing multiple disadvantage, regardless of which sector the service may be based in. This is in recognition that service provision within health and social care still continues to operate in silos and often fails to address the full range of needs of women. However, it is also recognised that single-issue services (e.g. substance misuse, mental health) have developed some excellent gender-sensitive approaches, offering useful lessons for others. This supplements the numerous evaluations and reviews of women's community centres currently in the public domain.

It is hoped this review will ultimately provide a foundation from which a minimum threshold can be operationalized into an assessment tool in order to support a national service mapping.

Background

There is a myriad of good practice guidance, standards and assessment frameworks developed within a non-gender specific context that currently inform the delivery of services to all people accessing health and social care services. For example, the Care Quality Commission, the independent regulator for health and social care ask five questions of services in their inspections: are they safe, effective, caring, responsive to people's needs, and well led? The Royal College of Psychiatrists' College Centre for Quality Improvement Enabling Environments Award is a quality mark that assesses against ten domains: Belonging, Boundaries, Communication, Development, Involvement, Safety, Structure, Empowerment, Leadership, Openness (Royal College of Psychiatrists 2013).
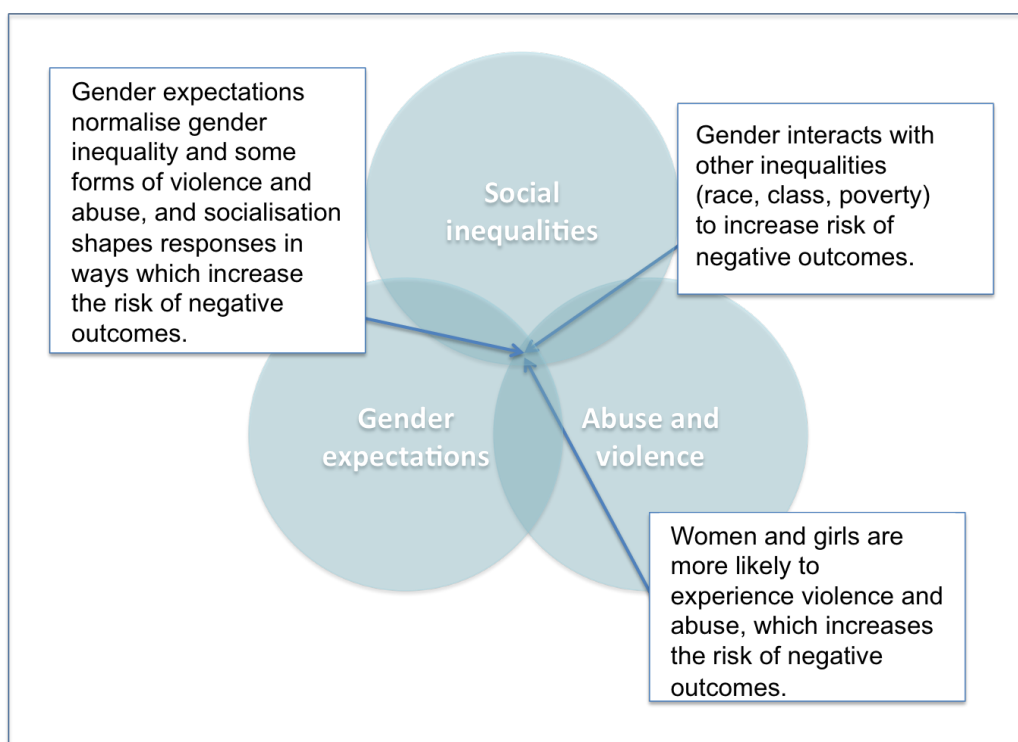
More specifically, Victim Support (2016) have recently published *Responding sensitively to survivors of child sexual abuse,* which describes the importance of creating safety for survivors based on respect, rapport, taking time, keeping survivors informed about sharing information, sharing control, respecting boundaries, understanding non-linear processes of healing, fostering mutual learning and demonstrate knowledge and understanding of intimate partner violence.

The initiative to promote 'Psychologically Informed Environments' (PIE) within homelessness services (Department for Communities and Local Government 2012) acknowledges the high proportion of complex trauma found amongst people facing homelessness and aims to "take into account the psychological makeup – the thinking, emotions, personalities and past experience - of its participants in the way that it operates". PIE has five elements - relationships, support and training, physical environment and social spaces, psychological framework, evidence generating practice. Assessment tools and guidance have also been created (Solutions Ltd 2015). However both the framework and guidance is gender neutral. St Mungo's, in their development of gender-specific services as part of the PIE initiative, highlighted the need for a gender specific approach that we hope to explore further in this review: "*We know from our own clients that women who come to our emergency shelters, hostels or into our supported housing have a complex mix of problems. We need to look deeper and try different approaches*" (St Mungo's 2015a).

Similarly, the work of the Making Every Adult Matters Coalition (MEAM) has established local projects with the aim of improving outcomes for the most excluded and disadvantaged adults. The projects aim to take a person-centred approach through redesigning services to address individual need as well as helping individuals to reconnect to family and social networks (Young 2016). Following the MEAM pilot projects, however, it became apparent that a more gender-responsive approach was needed to ensure that women

experiencing multiple disadvantage were effectively identified and engaged with the subsequent Fulfilling Lives programme. For example, as pointed out in the Women and Girls at Risk Report, the social context in which women live (see Figure 1) increases the risks faced by women and girls and therefore should be factored into service delivery.

Figure 1: Social context which increases risk to women and girls (McNeish and Scott 2014)

Gender expectations normalise gender inequality and some forms of violence and abuse, and socialisation shapes responses in ways which increase the risk of negative outcomes.

Gender interacts with other inequalities (race, class, poverty) to increase risk of negative outcomes.

Social inequalities

Gender expectations

Abuse and violence

Women and girls are more likely to experience violence and abuse, which increases the risk of negative outcomes.

Research shows that regardless of which sector the service is based, women present with a myriad of support needs. For example, of women accessing domestic violence services as part of a national trial for psychological informed advocacy, at least 70% recorded clinical levels of psychological distress with 77% meeting thresholds for a diagnosis of post-traumatic stress (PTS), 15% reported excessive drinking and 24% reported smoking cannabis in the previous year (Ferrari *et al* 2014). Of 313 women accessing a London based women only counselling service to address all forms of gender based violence, 25% were self harming, 25% reported suicidal ideation, 15% problematic substance misuse and 6% psychosis when they arrived (Bailey 2013). A project to support vulnerable women in pregnancy recorded the following experiences of the women using the service; 58% had injected drugs; 52% have never been employed; 18% were homeless; 21% had previously been in prison; and 30% had outstanding court cases (Leggate 2008).

In 2011, the All Party Parliamentary Group on Women in the Penal System published a report on statistics gathered from women's community projects that were set up in the wake of the Corston report (Home Office 2007). The data shows that almost half of the women referred to the projects have needs in more than four areas: 48% have drug or alcohol problems, 40% have experienced domestic violence, sexual abuse or rape and 8% are involved in prostitution.

Moreover, the *Rebuilding Shattered Lives* report highlights how women tend to enter homelessness services and other support services at a later stage than men, when problems have escalated significantly and where they may be less ready to begin their recovery journey. The report also demonstrates how the prevalence of disadvantages relating to childhood abuse, domestic violence, and mental health among their female service users are significantly higher than amongst male service users. In addition, women face further issues relating to trauma from having children removed and involvement in prostitution (St Mungo's 2015). This constellation of disadvantage is echoed in other research. For example, authors of an evaluation of a community living space initiative in the USA state: "*[t]he triple challenge of homelessness, behavioral health problems, and intimate partner violence may complicate women's access to resources, as the literature indicates that women with any one or two of these disadvantages have difficulty connecting with and benefitting from services*" (Ponce *et al* 2014).

Despite data showing the multiple forms of life stressors experienced by women accessing health and social care services, dominant service delivery models do not address the complexity of the challenges many women face. Within the health sector, for example. definitions of 'integrated care' are often based on the traditional 'medical model' (Imkaan, Positively UK & Rape Crisis England Wales 2014). Therefore, although groups such as those with long term health conditions are readily identified as needing support, victims of violence against women are often not considered as having complex needs or requiring access to 'person-centred, coordinated care' in the form of acute and long-term support to address the impact on their health (Imkaan, Positively UK & Rape Crisis England Wales 2014). This is despite the publication of the Department of Health's Women's Mental Health Strategy back in 2003 which aimed to respond to what women told them in focus groups, that is to say "a 'whole-person' approach to their care, treatment and rehabilitation, to value their strengths and abilities and to recognise their potential for recovery, in the context of holistic assessment and care planning" (Department of Health 2003).

The overwhelming majority of substance misuse services in the UK are mixed gender services. A UK survey undertaken to review services for women involved in prostitution found that less than half offered any women-only sessions within their service (Drugscope & AVA 2013). US research has shown that mixed-gender services are less likely to address women's barriers to treatment, such as childcare needs and financial concerns (Greenfield & Pirard 2009).

However, it is also important to point out that services that are gender-specific and women-only do not necessarily meet the needs of women experiencing co-occurring forms of disadvantage, for example, relating to substance misuse or mental health. A survey of London refuge providers found that while only two London boroughs operated blanket exclusions on women with problematic substance use and/or mental health, almost all excluded women with more serious substance use relating to opiate use or serious mental health conditions such schizophrenia, autism spectrum disorder or dementia (Holly *et al* 2014). Solace Women's Aid, who operate refuges and community services across London, are currently undergoing a programme of work to make their services more psychologically informed in recognition of the need to better address the impact of trauma on psychological and emotional level.

Methodology

The search strategy was designed to mirror the nature of current service delivery. Search terms comprised free text and database index headings for synonyms relating to 'women' AND 'services' OR 'treatment' in the areas of 'intimate partner violence' OR 'sexual violence' OR 'prostitution' OR 'trafficking' OR 'homeless' OR 'criminal justice system' OR "substance misuse' OR 'mental health' OR 'complex needs' OR 'multiple disadvantage' OR 'vulnerable.'

Inclusion criteria:

- Discusses service delivery for women (18yrs+) addressing *one or more* issue relating to homelessness, substance use, criminal justice system, mental health, prostitution, violence and abuse.

- Discusses service delivery for women in terms of any of the following:
    1. Organisation values/service philosophy (includes core principles)
    2. Service environment
    3. Staff skills and competences
    4. Programme components.

- Qualitative, process evaluations, effectiveness studies if they contain process evaluation or qualitative component, literature reviews, personal accounts of women with lived experience, materials produced by specialist organisations or health and social care practitioners, policy docs, service audit/assessment tools.

- Peer reviewed, non peer-reviewed publications, grey literature and material produced online, published and unpublished material.

- National material and international material from high-income countries in English.

Exclusion criteria

- Discussed only a specific intervention (e.g. counselling, groupwork) rather than focus on wider service/organisation and systems level in which the intervention is delivered.

- Does not contain a qualitative or process evaluation component.

● Dissertations, conference proceedings.

● Relates to service delivery in Low and Middle Income countries.

Table 1: Search locations

Databases/search engines	Websites
Psych-Info	togetherwomen.org
SCIE Database – Social Care Online	onesmallthing.org.uk
CINAHL	thewomensresourcecentre.org.uk
Google	womeninprison.org.uk
	homeless.org.uk
	rebuildingshatteredlives.org
	womenatwish.org.uk
	imkaan.org.uk
	thegriffinsociety.org
	trust-london.com
	refugeewomen.co.uk
	beds.ac.uk
	revolving-doors.org.uk
	prisonreformtrust.org.uk
	whec.org.uk
	avaproject.org.uk
	rapecrisis.org.uk
	womensaid.org.uk

	clinks.org
	womensbreakout.org.uk
	artsincriminaljustice.org.uk
	cteg.org.uk
	wenwales.org.uk
	walesassemblyofwomen.co.uk

In line with feminist methodologies, inclusion of a wide range of research methodologies can serve to raise the voices of people who are traditionally marginalised (Oakley 1998; Skinner *et al* 2005). This can also serve to explore questions of why and how something is working for a particular group of people (Pawson & Tilley 1997).

Limitations

This literature was commissioned on a limited budget and is therefore small scale in nature. Exhaustive search criteria to cover terms and synonyms for all forms of multiple disadvantage were not used. Even though a systematic search strategy was employed it does not amount to a systematic review as the grade and quality of studies was not undertaken to ascertain level of robustness or scientific accuracy.

Ascertaining the 'effectiveness' of different forms of interventions by analysing quantitative and outcome data is not the focus of this literature review. The identified literature that reports on outcomes was found to embrace a range of methods aligning to various levels of academic rigour. Most rely on pre- and post-outcomes from non-controlled studies using distance-travelled tools, employing a variety of validated and non-validated assessments. Rather, this review draws on the qualitative research and other forms of implementation data associated with these studies, alongside other practitioner knowledge and user testimony in order to answer the research question.

Whilst some documents were published in peer review journals, the majority were found in the 'grey literature', that is to say is not published via the normal commercial publication channels, and is often not peer reviewed.

Findings

Fourteen articles met the inclusion criteria from the academic databases and a further 55 documents were found elsewhere. The identified documents span a wide range of research knowledge such as mixed method evaluations including social return on investment (SROI), service reviews and qualitative research. Other literature comprises guidance documents, assessment tools and national service standards. A large part of the literature involves testimony from women accessing services or with lived experience of multiple forms of life stressors accessed through interviews or focus groups.

Regardless of the sector in which the services were based or the thematic focus of the research or guidance documents, a clear message was apparent. That is to say, any definition of 'core components' of a model of intervention for this group of women must go beyond *what* is delivered to encompass *how* it is delivered.

The philosophical approach underpinning a 'gender-sensitive' intervention

The values and approaches underpinning the delivery of the different service components are as important as the service delivery itself. It is the explicit value system, underpinned by understanding the reality of women's needs and lives, which drives a gender responsive service model. For example, an organisational approach that understands how gender based violence is so pervasive in society and the way women are made to feel invisible, inferior or irrelevant in male dominated environments, drives the understanding of the need for women-only environments. This is highlighted well within the description of the 'WomenCentre' approach underpinning the network of Women's Community Centres that were originally set up to support women involved in or at risk of offending. They are designed to *stand aside women* in the everyday struggles for increased safety and wellbeing (Jones, n.d.).

Covington & Surrey (1997) suggest that relational theory, with its emphasis on the role of personal relationships within women's use of substances and recovery, provides a useful framework for planning and implementing appropriate support services for women offenders. Moreover, Herman (1997) in her seminal text describes the destruction to the concept of the self and personal relationships caused by experiencing interpersonal violence as a child or from an intimate partner. She explains that because of this, "*[r]ecovery can take place only within the context of relationships; it cannot occur in isolation. In her renewed connection with other people, the survivor re-creates the psychological facilities that were damaged or deformed by the*

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traumatic experience. These faculties include the basic operations of trust, autonomy, initiative, competence, identity, and intimacy" (Herman, 1997).

The *Why Women?* report published almost ten years ago provides compelling evidence for the need for women-only service provision and highlights the role of specialist Black and Minority Ethnic (BME) led services in reaching women across communities who often face additional marginalisation due to racism and discrimination (WRC 2007). When aiming to address structural inequality due to gender, this cannot operate in isolation from practice that understands how other forms of oppression and discrimination intersect with gender inequality. Service standards across the violence against women and girls sector similar emphasise the importance of addressing the specific barriers to accessing services for women facing additional inequalities dues to race, sexual orientation, age or physical abilities.

Moreover, Imkaan's national service standards, whilst aimed at specialist BME led services, also hold relevance for any service hoping to meaningfully engage diverse communities. Their standards point to the importance of ethno-cultural relevance. Service provision should recognise "*the implications and impact of patriarchy and colonisation and demonstrate an "understanding of the impact of racism and discrimination in the lives of women and girls within the context of violence"* (Imkaan 2014).

Such understandings also lead to the acknowledgement of the importance of 'women-centred representatives' being present at a policy level to inform strategic decision making, planning and commissioning. Therefore advocacy goes beyond the individual to enable women's voices to be heard at the wider political and strategic spheres of influence. The mission statement of a Women's Community Centre, sums up nicely how such understandings form core business: "*... Anawim seeks to work with partners and other agencies to challenge that which degrades and diminishes women"* (Anderson 2011).

The nature of the relationships established between staff and the women with whom they work

Quality relationships based on trust

Non-judgmental attitudes by staff was a re-occurring theme identified by both service users and practitioners as being important for building trust and successful relationships (Dawson, Jackson & Cleary 2013; Imkaan, Positively UK & Rape Crisis 2014; Holly & Scalbrino 2012; Johnson *et al* 2014; Penn *et al* 2002; Plechowisz 2009; Wahab *et al* 2014). In the evaluation of a women's

only substance misuse service (LaFave *et al* 2008), one woman explained what helped her build a strong relationship with the service:

> *"I like the way you handle it when people say they've used. You don't judge them and you don't yell at them like you're their mother, you don't send them down the road....'Cause if I had...told you guys that I smoked a joint, and somebody had gotten on me about it I wouldn't have come back."*

Participants involved in a peer led intervention in the U.S. for survivors of intimate partner violence experiencing depression highlighted the importance of providing opportunities to talk individually, with someone they could trust, drawing on wisdoms of the African-American community. Staff use of motivational interviewing helped to make women feel understood, respected, accepted and listened to: "*Being able to express anything I wanted to the way I wanted to. Not being feeling judged or feeling like OK I can't say this because this person's going to, you know, feel this way.*" (Wahab *et al* 2014)

Women using homelessness services in the UK stated that they preferred practitioners who treated them as human beings, genuinely listened to them, and took the time to build meaningful and trusting relationships. Where these relationships existed, clients felt supported to begin to take control of their own lives (Williamson 2013).

A process evaluation of Anawim's prison and outreach service described the core ethos of its 'one-stop shop' model as '*welcoming, nurturing and supportive'* (McDonald *et al* 2014). Staff members described how ultimately all aspects of their work relates to the quality of the personal relationship and providing individualized, needs led support for however long it is required. "*Our policy is that you support women as long as they need it. We still have women in their fifties"* (McDonald *et al* 2014).

Similarly, women involved in Cardiff's Women's Turnaround Project described the importance of key workers in a way that suggests they act as a secure base (for attachment). They all describe a consistent, reliable source of support that they can turn to when they are anxious, scared or upset. Cases are never closed but 'shelved' providing the message that service is there for them as long as they need them (Plechowisz 2009).

These themes are echoed in an evaluation of a community project to support pregnant women who had recently been released from HMP Holloway, women who were at risk of detention or those with experiences of previous detention. The evaluation identified the following aspects as contributing to positive outcomes: a flexible service model which is underpinned by listening to women's needs and led by their concerns at their pace, focusing on mother

and not child; and quality relationships based on trust. Women described experiencing support that was beyond the immediate practical input but had symbolic meaning built on gestures of kindness (Clewett & Pinfold 2015).

A report by the Institute of Criminal Policy Research (ICPR) at Birkbeck College is particularly compelling because it reviews the evidence base of sixteen mixed methods evaluations of Women's Community Services (WCS) conducted between 2004-2011 and combines this with evaluations of a further six services. Two common themes emerge from the sixteen evaluations involving qualitative research with service beneficiaries (Radcliffe *et al* 2013). Echoing the findings described above, the authors highlight the importance of the relationships established, attitudes of staff and ethos of WCSs: the quality of relationships is what women often value most in the provision of services. The development of trusting relationships is provided through non judgmental emotional support and 'be-friending' where women's needs remains the focus over and above their offending behavior.

Working from a strengths-based empowerment model

> "*An empowerment model incorporates those elements of a helping relationship that can increase the client's power in personal, interpersonal, and political spheres.*" (Gutierrez, Parsons, & Cox, 1998)

The adoption of a collaborative, strengths-based model of working with women requires that the relationships formed go beyond that of 'helping'; service delivery is more than something that is 'done to' or 'for' women. Women accessing a women-only substance misuse programme emphasised the importance of this approach when interviewed. They describe the significance of having choices and staff trying not to control behaviour (LaFave *et al* 2008). The programme evaluators also highlight the importance of collaboration in the form of women's involvement in defining the outcomes against which progress is measured (LaFave *et al* 2008).

The avoidance of behaviours that may replicate those of an abuser are particularly important for women who have experienced controlling relationships from family members, intimate partners or pimps. Grella (2008) further argues that this is important for women experiencing co-occurring issues of problematic substance use, trauma exposure and psychological distress in order to enhance their sense of competency and self-efficacy. However, this is not necessarily common practice across substance misuse services: *"Traditional substance abuse treatment programs, by attempting to control the behavior of participants, reinforce the idea that it is possible and*

appropriate to control another's behavior" (LaFave *et al* 2008).

Similar sentiments have been echoed in evaluations of women-only substance misuse programmes in the UK. Strengths-based approaches, being treated like equals and service delivery within a safe programme environment were highlighted as enabling factors for women to engage with Brighton Oasis Project, a women-only substance misuse service in England (NEF 2015). An evaluation of the Nelson Trust's residential substance misuse treatment (Tompkins *et al* 2015) emphasised the value of consistent nurturing approaches that are encouraging and empowering, combined with more direct approaches that challenge certain behaviours. As one staff member notes, *"[r]elational communication seeks to find equality and shared goals. Maintaining valued relationships is generally seen as more important than exerting influence and control over others"* (Tate 2016).

Participants of focus groups with African-American IPV survivors stressed the importance of community-based, culturally specific services, and expressed great interest in programmes that would increase their ability to take control of their depression and enable them to advocate for themselves within the health system. They cited a particular mistrust in healthcare services, framing the problems as lack of cultural understanding to outright discrimination (Wahab *et al* 2014). This feedback informed the development of a model of intervention for IPV survivors with depression comprising the use of motivational interviewing delivered by trained peers embedded within active case management (Wahab *et al* 2014). Evaluation of this intervention posited relationships based on partnership working as key to its success. As one woman explains "*even if [the IPV advocate] had her opinion on something, she would say her thoughts, you know, and allow me to feel differently; she never forced her, her thoughts or her opinions on me. And always asked if she could ask a question. Always asked. She always put me in, and one thing she always said was, 'You always have a choice,' you know. So [she] made me feel comfortable*" (Wahab *et al* 2014).

A comprehensive review of the work of a Women's Community Centre in Calderdale and Kirklees also highlights 'relationships' as one of the three core dimensions key to the success of their work (Duffy & Hyde 2011). The authors of the report explain that the development of these relationships goes much further than just 'delivering a service'. A 'woman to woman connection' involves an empowering, and highly skilled, bond of trust with each woman who uses its services. This empowering relationship is not limited by reference to any specialism – it is pragmatic and multi–faceted (Duffy & Hyde 2011). Staff do not act as brokers of other services but rather as a guide or mentor in order to help women get to the right services and feel in control. The overall approach staff take seems to be central to the success of WomenCentre: *"It is...that another woman is prepared to believe in you, to*

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stick with you - even when you might make some of the same old mistakes" (Duffy & Hyde 2011).

Progress is also facilitated by relationships built on a sense of faith in the positive possibilities that lie inside each woman. As the authors highlight, this is particularly important because of the unusually heavy burdens of fear, shame and misery carried by women accessing the service: *"These burdens make solving day-to-day problems hard and they make thinking positively about the future almost impossible. The very fabric of their lives constantly undermines their sense of self-belief and their faith in the future"* (Duffy & Hyde 2011).

Belief in ability to change and providing a renewed sense of meaning and purpose are identified as key elements to reducing re-offending in the theory of change presented by the New Economics Foundation in their evaluation of Women's Community Services (NEF 2012). Their theory of change also argues that optimism and autonomy, i.e. fostering self-efficacy, is particularly important in two areas of health behaviour relevant to vulnerable women – managing addiction and avoiding risky sexual behaviour. As women are provided with a safer environment and supported to assert more control over their lives, they can begin to see alternative choices are available and within their attainment (NEF 2012).

Similarly in evaluating the impacts of rape crisis counselling on the health and wellbeing of survivors, Westmarland & Alderson (2013) argue that in terms of reducing distress, perceived control over the recovery process appears to be key in facilitating recovery. They refer to research that demonstrates survivors of sexual assault who reported higher levels of perceived control over their recovery process were less depressed and had lower levels of posttraumatic stress. They also highlight research demonstrating that control was associated with less binge drinking, less feelings of distress about the trauma, and lower levels of general distress. Furthermore, in a review of barriers and facilitators for engaging women in substance misuse treatment who have a history of involvement in prostitution, the authors highlight how creating a sense of hope, reassurance and belonging combats de-humanisation of prostitution, restores sense of self and fosters self-esteem (Griffin Society 2015).

The emphasis on empowerment is all the more critical for women with serious mental health conditions living in secure environments: *"In environments where they are surrounded by the distress of others, and where they are controlled by disciplined regimes influenced by the custodial aspects of secure hospitals, the affective vulnerability, lack of self-identity and sense of*

powerlessness experienced by women with BPD will be exaggerated" (WISH 1991).

The importance of co-collaboration is noted to be a key component of any service that aims to empower (Jones, n.d.; Women's Aid Federation England 2015). This should extend beyond the 1:1 relationships and involve women in the design and delivery of services (Bindel 2006; Coy *et al* 2007; Drugscope & AVA 2013; Griffin Society 2015; Ponce *et al* 2014; St Mungo's 2015; Women's Aid Federation England 2015). Women's Aid Federation England national service standards (2015) acknowledge that barriers for women facing inequalities of race, sexual orientation, ability and age are more effectively removed or reduced by services led by women facing similar barriers and inequalities. Such peer support seems to be highly valued by women in the roles of both peer mentors and mentees:

> *"There's nothing better than engaging with someone who has a shared experience."* (Holly & Scalabrino 2012)

> "*I'm their support now 'cause I'm actually mentoring one lady at the moment. The tables have turned a little bit, if you understand what I mean? I've become more of the supporter than needing supporting.*" (Radcliffe *et al* 2013)

Provision of women only space as a base to offer needs led and holistic support

The value of needs led/holistic support is the second overarching theme identified from the ICPR review (Radcliffe *et al* 2013). In fact, when assessing the literature what is quickly apparent is that empowerment based approaches that build on women's strength, give women control and a sense of self-efficacy go hand in hand with practical service delivery which is holistic, addresses the multiple needs of women and offered in a woman only space.

Establishing safety

The term 'safety' appears throughout the literature. Emotional safety can only be fostered when physical safety is provided. For example, national service standards created within the violence against women and girls sector all emphasise the need to create a sense of safety and security first and foremost (Imkaan 2014; Rape Crisis England & Wales and Rape Crisis Scotland 2012; Women's Aid Federation England 2015): "*The rebuilding of stability, resilience and autonomy for women survivors is facilitated in women-*

only spaces and environments of mutual respect" (Women's Aid federation England 2015).

For women who have experienced violence and abuse, the male-dominated nature of day centres and mixed gender substance treatment services makes them frightening, threatening and generally places they do not want to be. Women-only space is deemed crucial to facilitate safety on both an emotional and physical level (Anderson 2011; Bindel 2006; Drugscope & AVA 2013; Griffin Society 2015; Kuo *et al* 2013; NOMS Wales, n.d; Radcliffe *et al* 2013; St Mungo's 2015; Williamson 2013; WRC 2007). For example, in the ICPR review (Radcliffe *et al* 2013) many women stated they preferred attending a women's centre rather than a probation office because of the sense of safety established and the ability to avoid others with whom they had used drugs or gone drinking with in the past. The authors conclude that: *"The provision of a women-only space is thus central to the provision of a non-stigmatising, safe environment where women offenders who may have a history of sexual and physical violence can feel positive about taking part in group learning activities"* (Radcliffe *et al* 2013).

More recent evaluations of programmes for women offenders or those deemed at risk of offending only serve to corroborate the findings of the ICPR review, for example: *" it was a lot better (that it was run by women at the women's centre). As part of my agoraphobia I'm quite afraid of men so it really helped that it was run by women......."* (Codd 2016).

Women interviewed as part of research into services for women with problematic substance use and involvement in prostitution said similar things. For example, *"[s]ome men are not there to get well, they are there because they want a new relationship and if you say something, that makes you a bit vulnerable" (*Drugscope and AVA 2013*).* Women in residential drug service described how in mixed gender services they experience the same judgment as from punters, receiving *"inappropriate comments, advances and intrigue from males"* (Griffin Society 2015). The women stated that the greatest barrier to disclosing their histories of involvement in prostitution is having to disclose to men. Furthermore, the evaluation of Nelson's Trust residential service also found that staff who did not work within the women-only service did not always fully understand the specific needs of women and this made it sometimes difficult to safely involve women in activities with other users of Nelson Trust services (Tompkins *et al* 2015).

In their evaluation of a women only substance misuse service, LaFave *et al* (2008) highlight the importance of providing a space for women to examine the roles they have been socialized into, within an environment free from competition that can occur in mixed-gender groups. It also allows for the ability to address issues that are not exclusively, but certainly more prominent

within women's lives such as reproductive health, parenting, gender socialisation which emphasises passivity, dependence and excessive valuing of appearance and youth among women. Furthermore, in a comparison of mixed gender and women only substance misuse treatment in the U.S., the authors found that mixed gender programmes were less likely to address women's barriers to treatment, such as childcare needs and financial concerns (Greenfield & Pirard 2009).

EACH Counselling and Support works with diverse communities across West London providing specialist services to individuals and their families to address alcohol, drug, mental health and domestic violence concerns. It is important to note that as part of EACH's holistic service, they provide onsite domestic violence services and the need to address physical safety is built into care-planning (EACH 2009). Their women's group for women recovering from problematic substance use meets in a women-only space to foster and enable service users to build trust and feel safe. Issues relating to the complex interrelations with domestic violence, substance use and mental health are addressed within the group. In a recent qualitative evaluation, the importance of providing a safe place to address these concerns, which could not be addressed in mixed-gender settings, was highlighted as key elements of success of the programme (EACH and Cambridge Policy Consultants 2016).

Similarly, a review of a mental health pilot project delivered within a women's community service concluded that the fact it was delivered in a safe, women only space using a strengths based and recovery approach, was one of the critical success factors (Anderson 2011). Social return on investment (SROI) evaluations of a diverse range of women's organisations have come to similar conclusions: being 'women-only' was key to the success of their outcomes (MacDonald *et al* 2014a; MacDonald *et al* 2014b; NEF 2012; WRC 2011;).

The authors of the review of WomenCentre at Calderdale and Kirklees describe how the development of the relationship actually begins with trying to help women be as safe as possible, recognising that no work can be done until a woman is safe. This often begins with finding a safe place to live (Duffy & Hyde 2011). Certainly for many specialist domestic violence services, offering access to safe accommodation is a crucial component of their work. A summary report on the partnership work between Anawim and local housing provider Midland Heart was produced within the context of an EU funded project to explore how a more integrated approach to housing provision and social support can reduce the threat of violence against women. Therefore, unsurprisingly the authors stress *" [a] safe and secure environment of accessible, appropriate and affordable accommodation is crucial before a woman can start to deal with social needs both practical, such as dealing with*

financial difficulties, and health needs, including addiction, mental health, self-harm and Post Traumatic Stress Disorder (PTSD)" (MacDonald *et al* 2014b).

Holistic and needs-led interventions

A particular strength of Women's Community Centres are that – unlike most service access points – women do not have to identify and isolate specific issues to receive a service. The 'whole woman' approach embraces all aspects of a woman's life, whether practical, physical, mental, emotional or more deeply personal and spiritual (Jones, n.d.). As one service describes, *"[w]e fill a gap really: if you take a drug agency for example, they will only support around the drug issues: we offer much more holistic support. The emotional support is important because a lot of our women are extremely chaotic: they come here, sit and have a cup of coffee and feel safe"* (MacDonald *et al* 2014a).

Whilst the majority of services working with women are not set up in this way, a gender-sensitive service should embrace the use of comprehensive and holistic assessments which reflect the full range of life stressors affecting women (Holly & Horvath 2012; Jones, n.d; Leggate 2008; Williamson 2013). Within the mental health setting this means assessing the needs of women not only in respect of their individual 'pathology' but also to take account of the social and economic context of their psychological distress, offending and behavior (WISH 1991): *"If you have these things - like I don't know, rape, sexual abuse, bi polar, transgender, PTSD - they don't want to know, they can't deal with all. I am like an onion - I have eating disorders too - I am more than one thing...If I was just X with an eating disorder it would be fine, there's help with that and off I go but I have more than one thing."* (Imkaan, Positively UK & Rape Crisis England Wales 2014)

Within a service operating predominately with single issues, this may require conducting assessments with specialists from other services in order to develop holistic packages of care and joint support from multiple sources (Holly & Horvath 2012).

Staff with the skills to work with multiple issues, advocate for women and undertake partnership working

Given the heterogeneity of women's lives, experiences and needs, it is unsurprising that holistic service provision may mean different things to different women and therefore should be tailored appropriately (Anderson 2011; Bindel 2006; Dawson & Cleary 2013; Imkaan, Positively UK and Rape

Crisis England and Wales 2014; Jones, n.d; MacDonald 2014a; Ponce *et al* 2014; Women's Health and Equality Consortium 2016). The range of 'interventions' may be as far ranging as the provision of immediate intensive casework and crisis support to the provision of opportunities for women to develop skills and experience which enable them to reconnect with the community and reclaim their identities (Table 1).

Table 1: Range of interventions provided for women

Service component	
Assigned keyworker and individual casework	Johnson et al 2014; Radcliffe et al 2013; Drugscope & AVA 2013; Williamson 2013; Duffy & Hyde 2011; Leggate 2008; Jones, n.d; NOMS Wales.
Provision of information about and access to a range of services relating to health, social care, housing, welfare rights and immigration	Coy et al 2007; Holly & Horvath 2012; Duffy & Clyde 2011; Jones, ,n.d; Dawson & Cleary 2013
Provision of immediate crisis support **(e.g. domestic and sexual violence, trafficking, mental health)**	Women's Health & Equality Consortium 2016; Drugscope & AVA 2013; Penn et al 2002; Coy et al 2007; Women's Aid Federation England and Wales 2015
Support around parenting and social service involvement, including provision of childcare	Penn 2002; St Mungo's 2012, St Mungo's 2015; Bindel 2006, WRC 2007, NEF 2015; Holly & Scalabrino 2012
Individual and group counseling including those which address trauma, substance use and mental health in an integrated way	Morrissey et al 2005, Elliot et al 2005, Penn 2002, Coy et al 2007, St Mungo's 2012, Johnson et al 2014, Tompkins et al 2015
Psycho-education groupwork to address issues of self-esteem, confidence and assertiveness	S Mungo's 2015; Penn et al 2002, NOMS Wales; Duffy & Clyde 2011
Ongoing support and aftercare	Drugscope & AVA 2013; Imkaan, Positively UK and Rape Crisis 2014; Williamson 2013; Bindel 2006; Coy et al 2007
Structured activities to reduce social isolation	Imkaan, Positively UK and Rape Crisis, 2014; WHEC 2016, St Mungo's 2015, Coy et al 2007; NOMS Wales; St Mungo's 2012; Tompkins et al 2015; Jones, n.d
Opportunities to undertaken education and training, including voluntary work	Bindel 2006, NOMS Wales; Coy et al 2007; Duffy & Clyde 2011, WISH 1991, Radcliffe et al 2013

Unsurprisingly, collaborative and proactive working with a range of specialist organisations is required in order to provide this holistic provision (Bindel 2006; Holly & Horvath 2012; Jones, n.d; NEF 2012; NOMS Wales, n.d; Ponce *et al* 2014; Radcliffe *et al* 2013; Rape Crisis England and Wales 2012; St Mungo's 2015; Women's Aid Federation England 2015). For BME women, specialist BME led services are highly valued (Imkaan, Positively UK & Rape Crisis England and Wales 2014; WRC 2011) and should be a feature of a tailored support package for this group of women. Women also want staff to advocate for them whether it be with regard to child protection, health or housing services (Bindel 2006; Coy *et al* 2007; Duffy & Hyde 2011; Leggate 2008; Penn *et al* 2002).

Moreover, staff must be trained and supported appropriately to understand all the key issues featuring in a holistic assessment and how these issues are interrelated. This entails being aware that these relationships include individual, but also relational and social contexts. This includes having the cultural competency to understand the specific issues facing BME women, lesbian or bi-sexual women, as well as younger and older women and those with physical and learning difficulties. Staff must also possess the communication skills to undertake the assessment effectively. Staff should be trained on the impacts of trauma on the emotional, somatic, cognitive and behavioural levels and how to provide self-care and coping skills to women showing signs of post-traumatic stress (Elliot *et al* 2005; Holly & Horvath 2012; Jones, n.d; Ponce *et al* 2014; SAHMSA 2014; Solutions Ltd 2015; St Mungo's 2015; Tompkins *et al* 2015; Victim Support 2016). Motivational interviewing is a particularly good technique for developing empowering and collaborative relationships with women. Central to this approach is the idea that women are experts in their own lives, something which is also in keeping with a trauma-informed approach (Urquhart & Jaisura 2012; Wahab *et al* 2014) discussed further below. Finally, attention should be paid to staff wellbeing through the provision of regular supervision and self-care strategies (Ponce *et al* 2014; Tompkins *et al* 2015; Williamson 2013).

Working from a perspective of trauma-informed care

Trauma-informed care is described as a *"strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment"* (Hopper *et al* 2010).

The term is now well established in the lexicon of behavioural health services in North America, and the US Substance Abuse and Mental Health Services Administration (SAMHSA) has produced a Treatment Improvement Protocol (2014) that offers a detailed discussion of assessment, treatment planning strategies that support recovery, and building a trauma-informed care workforce. There are varying accompanying documents including a core competencies framework for addressing the needs of women and girls in mental health and substance use services. Similarly, in Canada the British Columbia Centre of Excellence for Women's Health and British Columbia Ministry of Health have issued the *Trauma Informed Practice Guide* (2013).

The language of trauma-informed care promoted in the treatment protocols is gender neutral much like the language of Psychological Informed Environments used here in the UK. The origins of this work and the development of this approach, however, came from the identified need to better respond to women with experiences of violence against women, serious mental health conditions and problematic substance use in health and social care services (Elliot *et al* 2005; Fallot & Harris 2002; Moses *et al* 2003) and women involved in the criminal justice system (Bloom, Owen & Covington 2003). Various toolkits and guidance documents are available but are all built on the five core principles first established by Harris and Fallot (2001): trauma awareness, safety, trustworthiness, choice and collaboration, and building of strength and skills. Trauma informed services work to integrate these principles at the service users, staff, agency and systems levels. Ultimately, akin with the ethos of women-centred working, the trauma-informed approach recognises the wider socio-political historical influences in women's lives (Urquhart & Jaisura 2012).

What is apparent when reviewing the principles outlined in Table 2 (overleaf) is the similarity with the dominant themes outlined earlier in the report and particularly with the women centred way of working epitomised by women's community centres (Jones, n.d). However, what this framework adds is an increased focus on the need to address the psychological impact of trauma in service delivery. Through appropriate training and support, non-specialist staff across substance misuse, violence against women, homelessness, women's community centres and health services can provide women with psycho-education about the impact of trauma on their emotional and physical selves, and help them to develop coping skills to address emotional regulation and other forms of psychological distress. The need for this approach was highlighted in the mental health service pilot conducted by Anawim (Anderson 2011). This Women's Centre now offers specialist trauma informed groupwork, including an integrated programme for women experiencing problematic substance use.

Table 2: Principles of trauma informed services (Elliot et al 2005)

Principle 1. Trauma-Informed Services Recognize the Impact of Violence and Victimization on Development and Coping Strategies

Principle 2. Trauma-Informed Services Identify Recovery From Trauma as a Primary Goal

Principle 3. Trauma-Informed Services Employ an Empowerment Model

Principle 4. Trauma-Informed Services Strive to Maximize a Woman's Choices and Control Over Her Recovery

Principle 5. Trauma-Informed Services Are Based in a Relational Collaboration

Principle 6. Trauma-Informed Services Create an Atmosphere That Is Respectful of Survivors' Need for Safety, Respect, and Acceptance

Principle 7. Trauma-Informed Services Emphasize Women's Strengths, Highlighting Adaptations Over Symptoms and Resilience Over Pathology

Principle 8: The Goal of Trauma-Informed Services Is to Minimize the Possibilities of Retraumatization

Principle 9. Trauma-Informed Services Strive to Be Culturally Competent and to Understand Each Woman in the Context of Her Life Experiences and Cultural Background

Principle 10. Trauma-Informed Agencies Solicit Consumer Input and Involve Consumers in Designing and Evaluating Services

Several other services identified in this review explicitly articulate a trauma-informed framework as the foundation for their work. For example, the evaluation of a women only residential substance misuse service operated by the Nelson Trust highlighted critical components of success as the combination of individual and group based trauma-informed treatment, which involves the provision of information about trauma, trauma responses and coping strategies to women (Tompkins *et al* 2015).

St Mungo's Women's Psychotherapy service (St Mungo's 2012) is delivered in a women-only hostel for women involved in prostitution and experiencing problematic substance use. The approach builds on the Psychologically

Informed Environments initiative by combining an explicitly gendered perspective into a trauma-informed model. Their model emphasizes the role of socialisation and expectations on women and the importance of being flexible in appointments, understanding dynamics of power and control in therapeutic relationships and how women are attuned to being criticised and judged, rather than empathised with and understood.

Women and Girls Network (WGN) aims to reduce the impact of historic or current gendered violence on individual women and enhance their mental, emotional, spiritual and physical wellbeing by providing specialised, comprehensive and culturally appropriate holistic therapeutic services to facilitate healing and recovery. Like St Mungo's they also work from a gendered and trauma-informed model that includes the delivery of evidenced based trauma-focused interventions and body therapies. Staff interviewed for an evaluation of their recovery project highlighted the body therapies and the trauma-focused counselling are areas of the service that worked well in helping women recover. For example, one counsellor stated: *"I think the body therapies are underestimated by the rest of the world, everyone in our organisation knows how key that is, it's so important, it makes such a massive change I think to the women, especially with trauma"* (Bailey 2013).

In addition to the above services, a programme of work is currently being rolled out across the women's prison estate by Stephanie Covington and supported by Public Health England. Furthermore, recommendations for implementing trauma informed care are expected to feature in the updated UK guidelines on clinical management of drug misuse and dependence. Therefore the approach of trauma-informed care provides another framework to assess whether services are meeting criteria for a gender-sensitive approach.

In 1998 SAMHSA launched the Women and Co-occurring Disorders and Violence Study (WCDVS), a five year, multi-site controlled trial to develop and evaluate integrated, holistic trauma informed services for women with histories of violence, problematic substance use and psychological distress. As well as evaluating effectiveness, a detailed level of implementation evaluation data was gathered generating useful lessons.

The comprehensive service package included: outreach and engagement; screening and assessment; individual, group or family therapy to address mental health, problematic substance use and trauma, parenting skills training, resource coordination and advocacy, trauma specific services and crisis intervention. Some of the lessons learned (Moses *et al* 2004) are particularly relevant to inform partnership and integrated working across UK services that are traditionally single focus:

- Co-facilitation of groups by staff from partner services and multi-disciplinary case conferencing was found to be an effective strategy to enhance integration at the service and system levels.

- In order to promote retention in services for women facing many competing demands, assistance with childcare and transportation and the placement of groups in convenient community locations was needed. Providing assistance with basic needs (housing, food, income etc.) and peer support services were other effective responses.

- The relational aspects of group-work were important to keeping women engaged in services and facilitating recovery.

- Women had a need for continuing services and support especially after graduation from the trauma-groups; follow on peer support was useful.

- Co-collaboration involving women with lived experiences of the issues made an immeasurable impact on the project to transform how services were designed, delivered and evaluated. However, the challenges faced with engaging women in this way required attention and support.

- Cross-training was essential for staff to become familiar with the philosophies and concepts of mental health, problematic substance use and trauma, and then create and implement an integrated response

- A trauma-integrated service requires on-going supervision, management and support of staff.

Conclusion

This review draws on the extensive body of evidence available about Women's Community Centres, many of which were originally set up to work with women offenders and then extended to work with women at risk of offending. This group of women and their families are often the most marginalised and must overcome a number of forms of disadvantage on a daily basis. Several authors have already consolidated the learning from evaluations of these Centres and outlined the critical elements of success, much of which is highlighted here. In addition, this review integrates learning from services based in other sectors that traditionally operate around single issues, but have adapted their service provision in an attempt to address the myriad of life stressors and disadvantages facing the women with whom they work.

In summary, the overarching message is clear – the *way* a service is delivered is as equally important as *what* is delivered. In fact the value system and philosophical approach underpinning a service is crucial for ensuring the requisite service components are present whether it be in the physical space (e.g. women-only safe environment) or staff competencies (e.g. understanding the impact of gender socialisation and the importance of relational theory in women's recovery). Furthermore, exploration of the wider literature has also highlighted, particularly within the substance misuse sector, the strength of trauma-informed services. Adopting this approach provides a more psychologically based framework for responding to women's needs and fits well with a gender-sensitive and intersectional approach. This review also identified several gender-sensitive service assessment tools whose adaptation may prove useful to inform the methodology for auditing services in the UK.

Appendix 1 – Frameworks and assessment tools for gender-responsive and trauma-informed services

1. Gender Specific Mentoring Guidance Tool (Together Women, n.d.)

Adapted from the Together Women's Gender Specific Mentoring Guidance Tool, the table below outlines the core elements of their framework.

Core Element		Examples of possible assessment domains
Woman Centered	Woman Centered is putting a woman at the core of her support, recognizing at all times that her needs are different because of her gender and the impact that her gender can have on her experiences.	The programme recognizes the difference between male and female services users and the need for different approaches. The facility is a safe, confidential and comfortable environment for women to attend. Staff build relationships based on relational theory where women are encouraged to build healthy and trustworthy relationships.
Holistic	Holistic is recognizing that women have various needs and that these needs are interrelated	The aims of the programme are based on a holistic model that addressed the social, emotional, cultural and environmental needs of women. Staff are trained to deliver assessments and support plans that explore needs through a holistic approach. The relationship is led by the needs as identified by the service user not the staff member or service.
Need responsive	Need responsive is responding to the needs of an individual and recognizing that needs change and support must be adapted to these changes.	The programme aims is designed in response to the women and their specific needs. Women are offered a female only space. Staff reflect the diversity of the female population. Child-care is provided or taken into account when engaging with a woman with children.

User Led	User led is an approach that ensures services are led by women, through design, development and delivery. User led is giving women a voice, a voice that has impact.	The policy and this tool are reviewed by female service users for feedback and input. Service users are involved in the recruitment and interviewing of staff. Staff use a motivational approach that encourages women to lead on their support and provide personal insight.

2. Six Domains of Trauma Informed-Services (adapted from Harris and Fallot 2003)

FIVE CORE VALUES	Example questions
Ensuring Physical and Emotional Safety	In making contact with women is there sensitivity to potentially unsafe situations (e.g. domestic violence?) Are staff attentive to signs of client discomfort or ease – does they understand these signs in a trauma-informed way?
Maximizing Trustworthiness through Task Clarity, Consistency and Interpersonal Boundaries	Does the programme provide clear information about what will be one, by whom, when, why, under what circumstances with what goals?
Maximising Client Choice and Control	Is the client informed about the choices and options available? Does the programme build in small choices that make a difference to survivors (e.g. when would you like me to call?)
Maximizing Collaboration and Sharing Power	Do providers communicate respect for the woman's life experiences and history, allowing the client to place them in context (recognizing women's strengths and skills?) Does the programme cultivate a model of doing 'with' rather than 'to' or 'for' clients?'
Prioritising Empowerment and Skill Building	How can each contact or service be focused on skill development or enhancement? Do survivor-advocates have significant advisory voice in the planning and evaluation of services?

3. Measurement domains of gender-responsive treatment (Grella, 2008)

Specifically relating to treatment for problematic substance use, the table below sets out the wide-ranging elements that enable services to be gender-responsive.

Domain	Variable
Treatment Orientation/Processes	Women as priority or target population, treatment model/approach (e.g. non-confrontational, empowerment, strengths-based, relational, developmental, trauma-informed), cultural competency, use of evidence-based approaches, planned treatment duration, use of written protocols or manuals
Administrator and Staff	Program director's gender, percent of female staff, staff education & training, staff beliefs and attitudes about treatment, staff competencies
Organizational Characteristics	Age of program, type of ownership, type of setting (e.g. stand-alone vs multimodality), program capacity, accreditation, client case-mix (e.g. percent of women clients), proximity to other service providers, formal & informal relationships with other providers (e.g. exchange of clients, funds, information), referral sources, MIS
Women's Services	Prenatal/postnatal services, women-only groups (in mixed-gender settings), parenting training/counselling, trauma/abuse counselling and/or groups, women's health services.
General Services	Gender-specific assessments, psychiatric consult or on-site mental health services, case management, medical, spiritual, educational, vocational, legal/CJS, social services, individual employment/vocational, 12-Step groups, transportation, after-care, housing, alumni groups
Children's Services	On-site child care, live-in accommodation for children (in residential settings), age and number rules regarding children's participation, assessment, counseling/mental health services, psycho-education, educational services, coordination with Child Welfare/Children's Protective Services
Physical Environment	Program environment, safety and security, child care area is clean and well designed, spatial layout, social/recreational spaces, community environment, access to public transportation

4. Gender Responsive Program Assessment Tool (Covington & Bloom 2008)

This tool acknowledges the fundamental elements of quality programming centered on the guiding principles from Gender-Responsive Strategies: Research, Practice and Guiding Principles for Women Offenders Report (Bloom, Owen & Covington 2003):

1. Gender: acknowledge that gender makes a difference.

2. Environment: create an environment based on safety, respect and dignity.

3. Relationships: develop policies, practice and programmes that are relationship and promote healthy connections to children, family, significant others and the community.

4. Services and Supervision: address substance use, trauma and mental health issues through comprehensive, integrated and culturally relevant services and appropriate supervision.

5. Socio-economic status: provide women with opportunities to improve their socio-economic conditions.

6. Community: establish a system of community supervision and re-entry with comprehensive, collaborative services.

An outline of the assessment tool is set out in the table below.

	Examples of assessment domains
Theoretical Foundation and Mission Statement	The theoretical foundation of the program is gender-responsive (i.e., it is grounded in research on gender differences, female socialization and psychological development, including relational-cultural theory). The program's foundation is based on the integration of the following theories: pathways, relational-cultural, trauma and addiction. The theoretical foundation of the program includes information on ethnic and cultural strengths and respect for differences.

Site and Facility	The facility is located at a safe site and near the communities the clients come from. The décor includes empowering images of females, including those of females from diverse ethnic and cultural groups.
Administration and Staff	All staff members receive training in gender-responsive programming for females, including differences between males and females, female psychosocial development (including relational–cultural theory), female needs and challenges, and female strengths. All staff members receive training on strengths based, trauma-informed, culturally competent therapeutic approaches Staff meetings are held regularly and include discussions that facilitate gender-responsive learning and practice
Programme Environment/Culture	Physical and psychological/emotional safety are clearly defined for staff members and clients and are include in programme practices and materials. Staff members focus on clients' strengths, teach clients alternatives to unsafe and ineffective behaviours (i.e coping skills and self-soothing skills), and give clients appropriate control and decision making opportunities individually and as a community
Treatment planning	Screening and assessment tools are gender responsive and culturally aware, they include attention to trauma, relationships, community connections, client's strengths, substance use and childcare responsibilities. Assessment is based on gender-responsive theory and practice (i.e it is designed to build a therapeutic relationships between the staff and clients that is characterized by mutuality, empowerment, respect and support.)

Programme Development	Female only groups are used for treatment
	Mental/emotional health, physical health services specifically designed for women are offered on site or by referral
	Education and vocational services are offered onsite or by referral
	Services for clients who are pregnancy or parenting are offered onsite or by referral

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