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ORIGINAL ARTICLE

Negotiating Multiple Stigmas: Substance Use in the Lives of Women Experiencing Homelessness

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Abstract

This paper explores the qualitative dimensions of stigma related to substance use for a sample of women experiencing homelessness in Brisbane, Australia. A secondary thematic analysis of ethnographic research data identified four key themes: (1) "Intersecting stigmas," including experiencing homelessness, mental and physical illness, as well as being a woman who uses drugs; (2) "Perceived stigma" examines the association between homelessness and substance use; (3) Women's experiences of multiple forms of "enacted stigma" related to substance use and homelessness, including violence, predation and victimization, discrimination, and police harassment; and (4) "Negotiating stigma" outlines techniques participants used to manage the stigma attached to substance use and homelessness, such as avoiding substance use themselves, avoiding other people who used drugs, and engaging with other social networks and activities. The paper argues that the framework of "intersectional stigma" can provide insight into the multiple stigmas negotiated by women experiencing homelessness.

Keywords Homelessness · Women · Drugs · Substance use · Stigma

Research has consistently demonstrated a strong association between homelessness and substance use, with evidence from Western nations suggesting that there is a significantly higher rate of substance use and substance use "disorders" among adults experiencing homelessness than the general population (Bevitt et al., 2015; Fazel et al., 2008; McVicar et al., 2015; Nielssen et al., 2018; Teesson et al., 2003). Much of the positivist and

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epidemiological literature on homelessness cites substance use as a "risk factor" for homelessness, suggesting a potential causal association between the two (McVicar et al., 2015; Somerville, 2013). Significantly, the public also link homelessness and substance use, with survey-based research indicating that a high percentage of the public believe that substance use is a leading cause of homelessness (Hanover Welfare Services, 2006; Johnson & Chamberlain, 2008; Toro et al., 2007). The direction of the relationship between substance use and homelessness is complex. While research has demonstrated that substance use features in the pathways to homelessness for a significant percentage of people experiencing homelessness, it should also be pointed out that not all people who are homeless use substances (Brown et al., 2016; McVicar et al., 2015), although substance use may feature heavily in their social networks and environment (Bower et al., 2021).

People who use drugs and people who are homeless are among the most heavily stigmatized and socially marginalized populations (McNaughton, 2013; Thomas et al., 2012; Yang et al., 2017). For people experiencing both homelessness and problems related to substance use, stigma and exclusion contributes to poorer health and wellbeing outcomes (Lloyd, 2013; Thomas et al., 2012; Yang et al., 2017). For women who are homeless and also use substances, poor outcomes can be further compounded because of gendered stigma and discrimination. Importantly, a recent systematic review of morbidity and mortality among four populations who experience social exclusion (homeless populations, individuals with substance use disorders, sex workers, and imprisoned individuals) showed that the relative effect of exclusion on health inequities was greater for females than for males (Aldridge et al., 2018).

Given this context, this paper explores the relationship between stigma and substance use in the lives of a sample of women experiencing homelessness based on the results of a secondary analysis of qualitative data collected during an ethnographic study conducted by the second author. The secondary analysis aimed to investigate the place and significance of the intersections of stigma and substance use in the lives of women experiencing homelessness who were the participants in this research. We begin here by reviewing the context of homelessness and substance use in Australia and situate our study in the literature on stigma, before describing the methods for the study presented here. The results highlight the multiple levels of stigma experienced by the participants, and are structured in four key themes: intersecting stigmas, perceived stigma, enacted stigma, and negotiating stigma. Finally, we discuss how a framework of "intersectional stigma" can inform policy and service responses for women experiencing homelessness and substance use.

Homelessness and Substance Use

In this study, homelessness was defined using Chamberlain and MacKenzie's (1992) typology of homelessness. They define three types of homelessness: primary (no conventional accommodation), secondary (moving from one shelter to another), and tertiary (medium to long-term occupancy of transitional housing). Homelessness in Australia is increasing. Although there are difficulties with providing the exact number of people who are homeless in Australia, the 2016 Census reported that 116,427 people were experiencing homelessness on the night of the 2016 census (Australian Bureau of Statistics, 2018a), an increase of 4.6% since the 2011 census. This is equivalent to a rate of 49.8 homeless persons per 10,000 of the population (Australian Bureau of Statistics, 2018a). Males make up the majority of the homeless population in Australia. The rate of female homelessness was 41.3 per 10,000 of the

population, which was lower than the rate of male people who are homeless at 58.4 per 10,000 of the population (Australian Bureau of Statistics, 2018b). In the state of Queensland (QLD), where the field work presented in this paper was conducted, the rate of people who are homeless per 10,000 of the population was slightly less than the national rate, at 46.1 people who are homeless per 10,000 (Australian Bureau of Statistics, 2018b); the rate of female homeless persons in QLD was 37.9 per 10,000 of the population compared with the male rate of 54.5 per 10,000 of the population (Australian Bureau of Statistics, 2018c).

Research suggests that the prevalence of substance use disorders in the Australian homeless population is high (Teesson et al., 2003). Topp et al. (2013) study of clients of needle and syringe programs (NSP) via the Australian NSP Survey found that there was a high rate of housing instability among people who inject drugs. The 2016–2017 annual report on specialist homelessness services found that of the 288,000 people assisted by specialist homelessness agencies across Australia in 2016–2017, close to 1 in 10 clients (9%) were identified with problematic drug and/or alcohol use (Australian Institute of Health and Welfare, 2018). Further, of these clients, male clients made up 54% percent while females made up 46% (Australian Institute of Health and Welfare, 2018). Only 6% of these clients were citing problematic substance use as the main reason for seeking homelessness assistance (AIHW, 2018). In fact, 79% of all clients experiencing substance use problems reported additional vulnerabilities (such as mental health problems and/or family/domestic violence) (AIHW, 2018). Existing research demonstrates that substance use tends to increase with homelessness (Johnson & Fendrich, 2007; O'Toole et al., 2004), and that many homeless individuals engage in substance use to cope with their homelessness (Johnson & Chamberlain, 2008).

Since the 1970s, the number of women who are homeless and also have a substance use disorder has been increasing (Geissler et al., 1995). More recent evidence suggests that there is a higher rate of substance use disorders among women experiencing homelessness than housed women (Torchalla et al., 2011; Tucker et al., 2011; Wenzel et al., 2004), and that women who are homeless have similar rates of substance use disorders to men who are homeless (Edens et al., 2011). Edens et al. (2011) found that there are few gender differences in rates of substance use problems among adults experiencing chronic homelessness, with women experiencing chronic homelessness reporting substance use problems at a similar rate to men (Edens et al., 2011).

There are significant gender differences in pathways into and out of homelessness, and women who are homeless face unique challenges during homelessness (Savage, 2016). Women who are homeless are more likely than homeless men to report a history of trauma (in childhood and/or adulthood), including physical, emotional, and sexual abuse, or neglect (Roos et al., 2013). Similarly, a very high percentage of women who are homeless and have substance use disorders also report a history of trauma (Christensen et al., 2005). Women who are homeless are also much more likely than men who are homeless to cite domestic and family violence as a reason for their homelessness (Chamberlain & Johnson, 2013; Johnson et al., 2008; Menih, 2020; Menih & Smith, 2017). Other gendered dimensions of pathways into homelessness include leaving violent or abusive intimate relationships, having a criminal history and/or history of imprisonment, and being a caregiver to dependent children (Savage, 2016). Women's homelessness is often described as an invisible problem because of definitions and measurements that obscure women's homelessness, as well as actions taken by women themselves to conceal their homelessness and avoid stigma (Menih, 2020; Reeve, 2018).

Along with stigma and discrimination, housing status also significantly affects the "risk environment" (Rhodes, 2002) for women's substance use and misuse, shaping the harms that women can experience from substance use (Collins, Boyd, Czechaczek, et al., 2020a; Collins, Boyd, Hayashi, et al., 2020b; Pauly et al., 2013; Wenzel et al., 2004; Wenzel et al., 2009). In their study of sheltered women experiencing homelessness and low-income housed women in Los Angeles, Wenzel et al. (2009) found that sheltered women experiencing homelessness reported greater rates of physical and sexual violence, substance use/disorder, HIV risk behavior, and co-occurrence of these problems than low-income housed women.

Stigma, Homelessness and Substance Use

Stigma was defined by Goffman in 1963 in his influential work *Stigma: Notes on the Management of Spoiled Identity* as "an attribute that is deeply discrediting" (1990, p. 13), where people who are stigmatized are made into a social "other" excluded from the "norm" of society (Goffman, 1990). More recent definitions of stigma draw on Goffman's initial observation of the links between stereotyping and stigma. Link and Phelan (2001) state in their definition that "stigma exists when elements of labeling, stereotyping, separation, status loss, and discrimination occur together in a power situation that allows them" (p. 33).

People who are homeless are often identified as a highly stigmatized group (Rayburn & Guittar, 2013). Parsell (2011) observes that place plays a key role in the processes of stigmatization and "othering" of people who are homeless, because behaviors like intoxication, violence, or mental illness are on display in public: "in contrast to those with homes who have opportunities to conceal these [undesired] behaviours, people without homes often have little opportunity but to display them. The public display of these behaviours both signifies and reifies their difference" (p. 458). It is the sheer visibility and public nature of the lives, activities, and behaviors of people who are homeless that means that they are more likely to be labeled as "different" (Gilman, 1988; Parsell, 2011). In fact, Falk (2001) argues that due to stigma—which leads to the treatment of homeless as "nonpersons"—these individuals then internalize stigma, and this manifests in a lack of sense of purpose, and a feeling of having no meaningful or valued place in the world. For women who are homeless, this can be compounded because they do not conform to gender stereotypes about women's traditional domestic roles as caregivers and as homemakers (Brown & Ziefert, 1990; Fotheringham et al., 2014).

People who use drugs are similarly a heavily stigmatized group that is associated with a negative, deviant identity (Lancaster et al., 2015; Lancaster et al., 2017; Lloyd, 2013). In a review of studies of stigma and substance use in non-clinical populations, Yang et al. (2017) indicate that people who use substances are often stereotyped in five main ways: (1) as dangerous or unpredictable because of their substance use; (2) as less capable of decision-making; (3) as blameworthy or responsible for their SUD; (4) stereotypes that people can recover from drug and alcohol problems without treatment more easily than from other psychiatric diagnoses, and that people can recover from drug and alcohol addictions; and (5) as immoral. Yang et al. (2017) also point out that several studies have shown negative emotional responses to people with substance use disorders, such as fear, anger, or pity. People who are homeless who inject drugs (PWID), in particular, are heavily disadvantaged, with research demonstrating they are more likely to be unemployed, inject in public, report schizophrenia, and have a prison history than PWID with stable housing (Whittaker et al., 2015).

Because of the gendered dimensions of homelessness and substance use, women experiencing homelessness who use substances face multiple, intersecting stigmas. In this paper, we argue that the concept of "intersectional stigma" is a useful framework for understanding and informing sensitive and culturally appropriate responses to the needs of women who are homeless. The framework of intersectional stigma is derived from the feminist and critical race literature on the idea of intersectionality—a concept which refers to the "interdependent and mutually constitutive relationship between social identities and structural inequalities" (Logie et al., 2011, p. 2). Crenshaw (1989, 1991) introduced the term intersectionality in her work to discuss the systems of oppression that impact on African American women along the lines of race, gender, and class. Intersectionality has since been applied fruitfully to a range of social problems to highlight how intersecting variables shape people's lived experiences, health, and social marginalization (Chambers & Erausquin, 2015; Gunn et al., 2016; Logie et al., 2011; Mizock & Russinova, 2015; Smye et al., 2011; Triandafilidis et al., 2017; Zufferey, 2017). Intersectional stigma draws on the concepts of both intersectionality and stigma "to understand the complexity of the manifestation (i.e., macro-level structures) and lived experiences (i.e., micro-level factors) of discrimination towards groups of people who have multiple oppressive social identities" (Chambers & Erausquin, 2015, p. 2).

The concept of "intersectional stigma" has been used to explore experiences in: how "drug use violates norms of womanhood" (Gunn & Canada, 2015, p. 281), overlapping stigma and discrimination faced by women with HIV (Logie et al., 2011), stigmatization of individuals receiving treatment (Luoma et al., 2007), experiences of smoking-related stigma (Triandafilidis et al., 2017), and of acceptance for women with mental illness (Mizock & Russinova, 2015). To date, however, there is little literature qualitatively exploring the intersection between the stigmas of homelessness and drug use for women who are homeless.

Our analytical framework also integrates different types and levels of stigma. Internalized stigma relates to the degree to which a person has integrated stigmatizing ideas and negative feelings about being part of a stigmatized group into their self-concept (Chambers & Erausquin, 2015; Earnshaw & Chaudoir, 2009). Perceived stigma relates to the awareness of negative attitudes and negative social identity (Logie & Gadalla, 2009; Luoma et al., 2007). Anticipated stigma refers to expectations that one will experience stereotyping or discrimination (Earnshaw & Chaudoir, 2009). Enacted stigma relates to the actual experience of discrimination (Chambers & Erausquin, 2015; Earnshaw & Chaudoir, 2009; Luoma et al., 2007). Other levels of stigma have also been identified, including symbolic stigma, which refers to "othering, blaming and shaming" (Logie & Gadalla, 2009, p. 742), and community norms "towards discrimination of groups of people based upon their social identities" (Chambers & Erausquin, 2015, p. 2) and structural stigma (i.e., establishment of discriminating laws and enforcement towards groups of people based upon their social identities)" (Chambers & Erausquin, 2015, p. 2). Finally, instrumental stigma refers to "measures taken to protect oneself and one's health" (Logie & Gadalla, 2009, p. 742).

While there is a significant literature on homelessness and substance use, there is less literature exploring the lived experience of stigmas resulting from homelessness and substance use among women, and few studies qualitatively exploring the multiple, intersecting forms of stigma faced by women who are homeless. To begin addressing this gap in the literature, this study analyzed the experience of multiple, intersecting forms of homelessness-related stigma and drug-related stigma for a sample of women experiencing homelessness in Brisbane, Australia. Brisbane is the capital of the state of

Queensland, and is the third most populous city in Australia with a population of 2.4 million. At the 2016 census, there were 5813 people who were homeless in Brisbane (Australian Bureau of Statistics, 2018a). We argue that intersectional stigma is a useful framework for understanding these women's experiences, and for guiding responses to the needs of women experiencing homelessness and substance use.

Methods

This paper is based on a secondary analysis of qualitative data collected through ethnographic research and life history interviews conducted by the second author with women experiencing homelessness in inner-city Brisbane, Australia. The ethnographic approach to fieldwork combined moderate participant observation (balanced between being an insider and an outsider) with life history interviews with 10 women experiencing homelessness in inner-city Brisbane. Participant observation was used to gain insight into women's lived experiences, to understand how they see the world and their place within it, and to investigate the meaning they ascribe to their lives. Such an approach is suitable for the study of less researched populations (Smith, 2009), where women experiencing homelessness may be considered a vulnerable and under-researched group (Menih, 2013). Life-history interviews were also used in order to further explore the social world of women experiencing homelessness (Davies, 2008). The interviews began with the question "How do you think your life led you here?", which enabled for the rest of the interview to cover any important events that each woman considered as a relevant contributor to their transition into homelessness. While most of the interview was unstructured, the aim was to cover the following key topics: reasons and pathways into homelessness, experiences of homelessness, and experiences of "risky" public space as women.

Ethical approval to collect the data for this research was granted by the Griffith University Human Research Ethics Committee. The participant consent process included use of the research data for future research purposes. Fieldwork was conducted by the second author; information provided to participants included that de-identified data may be used for future research purposes. Fieldwork occurred for a total period of about 10 months with approximately 8 h for 5 to 6 days a week spent in the field. The first phase occurred during the first 2 months of fieldwork, and involved entry into and becoming familiar with the research setting, and the public spaces where people who are homeless in Brisbane spent their time (for example public parks and homelessness service providers located in inner-city). During this phase, the researcher spent time at various service providers in the inner-city, becoming familiar with the main locations to visit during the second phase, and also conducting informal conversations with staff at these services. Following this, the researcher took a more active approach to participation in the field by spending more time in public (and at times institutional) locations commonly visited by women experiencing homelessness such as parks, shelters, areas close to various service providers, bus stations, and so on. These locations were recommended to the researcher by service providers or women experiencing homelessness. Time spent at these locations allowed the researcher to immerse in the field as someone familiar to many women. In addition, consistency of time spent in these locations enabled the researcher to become familiar to women who tended to occupy

these spaces regularly. This aided the researcher to recruit women for in-depth interviews.

Throughout the fieldwork, numerous informal conversations occurred with women experiencing homelessness (approximately 80), as well as service providers, and a fieldwork journal was produced. Fieldwork journals contain records of the experiences and conversations that occurred during the fieldwork, and as such provide an important source of information in ethnographic research (Brewer, 2000; Bryman, 2004; Emerson et al., 2001). The researcher noted down fieldwork observations, informal conversations, and any other information relevant to the research (for example experiences with recruitment, preliminary coding, etc.). All informal conversations occurred during the time the researcher spent with the women in various settings around the city. This also allowed the researcher to recruit women for the next phase of fieldwork involving qualitative interviews. Over the course of the final 8 months of fieldwork, life history interviews were conducted with 10 women experiencing homelessness, with the aim of better understanding the daily routines and experiences of women experiencing homelessness. As such, the fieldwork journal and the 10 interview transcripts form the data for this paper. All the data was de-identified and participants were given pseudonyms to protect their identity, before it was provided to the first author for secondary analysis.

The analysis presented in this paper focuses specifically on the role of substance use in the lives of the women experiencing homelessness who participated in this study. While this was not the focus of the original study, which was a grounded theory study of women's homelessness, during the course of the original study, the second author identified that substance use was a major feature of the lives of these women. The secondary analysis aimed to investigate the place and significance of substance use in the lives of women experiencing homelessness who were the participants in the research. The first author coded the interview data using a combination of thematic analysis and framework analysis, following the phases for thematic analysis outlined by Braun and Clarke (2006). The first step involves immersion in the data—this was achieved by reading and re-reading the interview data. Initial, inductive codes were then generated based on the themes in the data. After this, it became apparent that stigma was a major feature within the data, and the initial codes were categorized using a framework of intersecting stigma, perceived stigma, enacted stigma, and negotiating stigma. As Braun et al. (2014) note of thematic analysis, it is a flexible method that can be applied to a range of qualitative research questions, and can involve processes of both inductive and deductive coding. NVivo 12 was used to assist with the coding and analysis of the qualitative interviews. The second author reviewed the coding for accuracy, and reviewed and analyzed field notes. Excerpts from the field notes are also used to support the analysis presented here.

Results

Description of Participants

The transiency of the lives of the women who were participants in this research created challenges to recruitment, as well as challenges in properly determining the type of homelessness women were experiencing. The initial aim of the original research was to

explore the lives of women experiencing primary homelessness; however, it quickly became apparent that homelessness was not static, instead, women transitioned in-and-out of different types of homelessness (primary, secondary, and tertiary). Women occupying public spaces also tend to become "invisible" (Menih, 2020), which further impacted on recruitment and collection of demographic information.

While it was difficult to obtain specific demographic information for women who participated in the informal conversations, limited demographic characteristics were collected from participants who participated in the interviews (Table 1). The age of the participants ranged from 19 to mid-sixties. Two women were in their early-sixties, one in her mid-fifties, four in early-to-mid-forties, two in their mid-thirties and one young woman who just turned 19. Three women identified as Aboriginal, and two women indicated they arrived from New Zealand, with one of them clearly identifying as Maori. Out of 10 women, only one woman presented herself as married (experiencing homelessness with her husband), all the other women emphasized they were single.

Substance use featured heavily in the social contexts and lives of all women that were part of this study. The majority of participants described previous dependence on alcohol or other drugs at some point in their lives. There was variability in their drug use trajectories, and great variability in the role of substances in their narratives about life being homeless.

While some women still used substances such as alcohol, volatile substances, and cannabis, many of the women interviewed for this study expressed a desire to alter their substance use or had already ceased using substances. Nevertheless, their own substance use, or the substance use of other people, was an everyday reality of their lives on the street and shaped their experiences:

> And… and on the streets, like in the valley and that, it's like, you wake up, and there's just like syringes everywhere. No one cleans up after themself. Hundreds of syringes, and then… and then you've got the worry of the… the people that are drinking. You know, they just fall asleep wherever. Some people, yeah, me, I needed blankets and that. So there was such an awful lot of old people, um, on the streets, sleeping on the streets, uh, just to support, um, tobacco. (Niki)

As Niki's words show, the lives of women sleeping rough can be chaotic, harsh, and complex, and substance use features heavily in their social contexts. The next sections explore the intersections of homeless-related and drug-related stigmas in the lives of the participants using four key themes: intersecting stigmas, perceived stigma, enacted stigma, and negotiating stigma.

Intersecting Stigmas

Multiple intersecting stigmas were evident in the lives of participants, including the double stigma of being homeless and a woman who uses substances, as well as mental illness, physical illness, and prior criminal justice contact. Intersections between the stigmas of homelessness and drugs were evident in the stories of many of the women, even for those women who did not identify as using drugs. The women's stories highlighted the assumptions and stereotypes about the linkages between homelessness and addiction. Many of the women, however, explained that their drug use played a role in their pathway to homelessness. Two of the women described being involved in sex

Table 1 Description of interview participants

Pseudonym	Approximate age	Ethnicity (personal identification)	Substance use experience (declared by participants)
Niki	Early-forties	Caucasian Australian	Heroin, cocaine, cannabis, alcohol
Amy	Mid -thirties	Caucasian Australian	Some use of cannabis and alcohol; mainly witnessing on the street
Barb	19 years old	Caucasian Australian	Cannabis, alcohol, and other substances she framed as "drugs"
Deb	Early-forties	CaucasianNew Zealander	Alcohol and cannabis; mainly witnessing on the street
Hope	Mid-forties	Caucasian Scotland	Methamphetamine, prescription pills, cannabis, amphetamines
Mary	Early-sixties	Caucasian Australian	Mainly witnessing on the street
Erin	Mid-fifties	Aboriginal Australian	Cannabis, glue, alcohol
Lisa	Early-sixties	Maori (New Zealand)	Minor contact with cannabis and alcohol; mainly witnessing on the street
Val	Early-thirties	Caucasian and Aboriginal Australian	Cannabis, heroin, volatile substances (glue), alcohol
Pam	Early-forties	Caucasian Australian	Prescription use due to diagnosis of schizophrenia; witnessing on the street

work to support their substance use. One of the women, Niki, linked her sex work to both her housing status and her substance use:

> … at this stage I was living day to day you know, you know having first of all to work to pay for the hotel and then work to pay for drugs.

Val noted that she thought it was common for women experiencing homelessness who used drugs to also engage in sex-work:

> Yes, I was a drug addict on the street and to get by, most women to get by… survive homelessness, some of them have gotta to work in a brothel house. Some of them have gotta work in a strip joint to get money, to get by.

Two of the respondents linked their mental health issues with their substance use. For example, Barb linked some of her mental health issues with both her cannabis use and her alcohol use:

> Um, because I've got, um, acute anxiety and depression. I've got hearing problems. Um, I've got, um, memory damage. I've got, um, like, back problems. Um, I might have ADD and ADHD. I've also got schizophrenia from, um, smoking too much pot over the three years that I did smoke it. Um, bipolar, drug and alcohol-induced psychosis and about twelve other things.

Many women in this research experienced anxiety, which was revealed during informal conversations. For example, Sue explained: "…yeah, the only way I could fall asleep and not feel paranoid was to get high or drunk…" Jade shared a similar story: "You just don't know if you will ever wake up… so, if I wanted to sleep, I smoked [referring to cannabis]." The following fieldwork entry further highlights the links between mental health and substance issue:

> Around 2.30 p.m., a woman came into the Service. She was crying and shaking. The receptionist turned to me and said: "Nancy used to be a nurse and worked in oncology (pediatrics) and due to witnessing so many deaths she developed post-traumatic stress [disorder] and a drug addiction. She just started spiraling down and ended up on the streets.

The women also described experiencing health problems and diseases. Two of the women stated that they had Hepatitis C. Niki stated that she had been unable to provide a kidney donation for her mother because of her Hepatitis C status:

> Yeah... he was rude, and now mum was dying, she needs a kidney, but um…I spoke to them at the hospital and there is nothing I could do because I have got Hep C, they won't, you know even though I would be match they won't let me help. I thought you know a kidney with Hep C, would be better than a kidney that doesn't work but…

Social status and childhood experience was another source of stigma for some of the participants in this study. Some of the participants noted that a number of people who are homeless had been involved in the child protection system or foster care as a child, or the women discussed their own direct experience of being in the foster care or child protection system. Furthermore, women also identified that women experiencing homelessness that they knew had had their children removed from them. In the following quote, Barb draws on a number of multiple stigmas to describe this problem:

> Whereas, honestly, if all these people got given the opportunity they would be able to take their kids back, they would be able to get off drugs. They would be able to support themselves and hold a steady job and look after their family. But unfortunately there is a lot of us with, like, mental and health issues.

Barb's words were a harsh reality for Val, who was a ward of the state. Val indicated that by her past experiences led to her struggles with drug addiction, which in her words occurred due to coping: "Yeah, to cope the… to cope with the pain."

A number of women had some kind of contact with the criminal justice system. For Deb, she stated that this was the reason that she was homeless:

> If I could ground it down to three things that made me homeless, it would be police interference. This is going way back here in Australia, taking my driver's license and all that, putting me in jail, traumatising me with that, separating me from my mother at that time, who has now passed away.

For the majority of participants, trauma was a key feature of their stories about their pathways into homelessness, and trauma was also linked with their substance use.

This section demonstrates the complex nature of stigmatization for these women experiencing homelessness and who engage in substance use; participants described multiple stigmas due to the interconnected factors that have contributed to their homelessness, such as substance use, trauma, and mental health issues. In the next section, we describe how the women perceived the social stigma attached to their status.

Perceived Stigma

The majority of the women described substance use in the form of alcohol use, illicit drug use, and tobacco use as a significant part of life on the streets. Participants were aware that there was a general public assumption/view that people experiencing homelessness were often drug dependent. Mary described the stigma attached to substance use among people who are homeless in the following way:

> …in the time that I was on those streets, at least two out of three… uh, three out of, um, five people would drink, right, you know, or smoke. Um, or be on, sort of, some sort of drug, you know. If it's not, um, hard substance, it's… it would be cannabis most of the time, you know. And you would be surprised how many people would avoid those. You know, they walk around them as if, you know, they have got this great big sign on them, you know. Don't touch me, I'm diseased.

Barb noted that her friends "look down on her" because of her life circumstances, her homelessness, her experience of abuse, and her use of substances:

> They don't want to know me. They look down on me because I'm on the street. Because, um, I've been through ridiculous amounts of abuse because I've been, um, because I started smoking. Because I got caught up with drugs. Because I've been assaulted. Just anything like that. The sort of stuff that you need a friend to be there for you for. Not there, they don't want to know you.

Pam noted that people view homelessness and substance use as moral issues:

> Homelessness is a funny comparison. That people don't relate… have no… that cannot relate. It's a god thing to them. They're shocked by it. My family were. Bunch of paedophiles, you know? Bunch of druggies, alcoholics, we're all bedding prostitutes or something, you know?

Intra-Group Stigma

Intra-group stigma was another major theme that came through from the interviews. Some of the participants held stigmatizing ideas about people who use drugs, and identified particularly "types" or sub-groups of people who are homeless and of substance users as somehow different, "worse," or more "dangerous." Lancaster et al. (2015) also discussed this phenomenon in their research on the views of people who use drugs on stigma. Similarly, Gunn and Canada (2015) observed that even with supportive peers in a specific sub-group—such as women who are recovering from addiction—the very same cohort could also be enforcer of the stigma.

Some of the women drew on notions of "deservedness" of help when discussing people who use drugs. One of the women explicitly identified people who inject drugs as less worthy of help than other people who are homeless:

> Because there's… there's a few that might be needle prick, you know, drug users and all that. You got to be careful of them sort of people. And that's why they become homeless, because their money goes all up their arm, sorry to say that. But I reckon that the homeless people shouldn't sort of help them sort of people that are on that… (Amy).

Several of the women repeated the stereotype that people who used alcohol or other drugs would "prey" on people for money to buy substances. For example, Mary stated:

> And drug addicts. To get their next fix... they will rob a person blind, it doesn't matter who they are. Whether you're healthy or not. Whether you, um, are walking or not. They will bash a person to get what they want. Because to them, a next fix, the next fix is… that's what they're focusing on. Not the person, what they can get.

For many of the women, they had experienced predation by people that they identified as people who used drugs or were under the influence of substances—for many of the women this formed the basis of their opinions about people who used substances.

This theme indicated that women experiencing homelessness in this research were well aware of the public perceptions attached to their status. In fact, they acknowledged that the predicament of homelessness in society tends to be closely linked to substance use. In addition, the women also identified a "hierarchy" of drug use among homeless, with their words indicating intra-group stigma among people who are homeless and use substances.

Enacted Stigma

Public perceptions about the association of drug and alcohol use and homelessness bled into many of the stories that the women related about how they were treated by other people. The women in the study reported experiencing multiple forms of "enacted stigma" related to

substance use and homelessness (enacted stigma is overt discrimination), including violence, predation and victimization, as well as police harassment.

The majority of women were keenly aware of and cited the public perception that the majority of rough sleepers are homeless because of their substance use. Some of the women also discussed the perception that people who are homeless only "beg" to get money for drugs:

> Well, they're not probably that… basically public opinion is that, you know, you just want money for drugs and stuff like that basically. (Barb)

Barb was of the view that this public perception resulted in additional stress for women experiencing homelessness, as the public would be unwilling to provide money to assist them:

> …some homeless people, if they… um, well they don't always have doctors within like the city boundaries so they have to… some of them have to travel all the way, um, down near the Gold Coast to go to the doctors. So they'll need train fare to get all the way up to Beenleigh or something. And, um, people won't even spare like five cents or something. And, um… so yeah, it does get a little bit stressful and, you know, there's really not much we can do. But we still try.

The stereotype of people who are homeless being substance users affected the way that women experiencing homelessness were treated by law enforcement. The majority of the women described negative relationships and interactions with police. Some of the women also expressed a lack of confidence in police, or stated that they did not trust the police, or had experienced police harassment. Barb described police harassment on the basis that they were assumed to be in possession of drugs:

> Like, they're like, um, if they come up to us on the street or something, they'll search our bags, try and get us locked up for drugs or whatever. Even if we don't do drugs, they're like no, you're on the street, you've got to do drugs. With some of the females that can't fight, they'll slam them around a bit. Um, the boys, even in the watch house, get the shit flogged out of them.

The use of "move on" powers is another example of structural stigma. Several of the women reported being asked to move on from where they were rough sleeping or sitting on the street. Police in several jurisdictions in Australia have "move on powers" that allow them to request people to exit a particular area and not return for a period of time. These laws have been criticized for unfairly impacting on people who are homeless (Punter, 2011; Taylor & Walsh, 2006; Walsh & Taylor, 2007).

Many of the women stated that there was not enough help for women experiencing homelessness in a number of areas: temporary housing, mental health, and substance use treatment. As Barb explained:

> … they do want the chance. They're just either not able to work up to their expectations. Or they keep slipping. But at least they'd have a… a chance, and keep getting a chance to fix things up. And, you know, there needs to be more spaces in rehabs and stuff for people that want to get off drugs. Like, there is only like a certain amount of slots in rehabs.

As Barb notes, the expectations and rules of some services presented barriers for people experience substance use, homelessness, and other challenges. This is linked with structural

stigma, because service philosophies that emphasize punitive systems act to stigmatize their clients and present barriers to service access and utilization.

Violence and Victimization

The potential and actual experience of violence and victimization featured in all of the women's stories, and for many of them, these experiences were linked with substance use (either their own, or someone else's):

> And, you know, the sexual assault can happen mostly in the parks. The violent assaults happen everywhere. More so in the valley and in the city, especially on the weekends, long weekends and, you know, stuff like that, you know. The drunk and disorderlies, you know, they don't care. They will take anybody on [laughs]. (Mary)

Some of the women described the central role that substances played a role in their stories of victimization. For example, Barb, who was raped three times, described the role of substances in all of her stories of victimization (alcohol and other substances). In the final instance, she described being drugged:

> And then the third time, um, I finally got back in contact with one of my sisters and said, 'Come out for some drinks, we're all going to like a bar' sort of thing, and it was like a club of sort of thing. But I only stand in the bar area and just drank the whole night because of how shocking I was for alcohol. But, um, someone that night drugged my drink and 8:30 the next morning, I woke up. And her best friend had assaulted me while I was, like passed out.

When Barb was asked if she had reported these rapes, she noted that she had not been helped by police, and linked this with the stigma of homelessness:

> I don't talk to the police or anything. I don't trust them. I did put in a report once saying that I had been assaulted. And they lost the report somewhere and didn't help me out to find out what was going on or to try and help keep other women in the city safe at that time in the morning. So, you know, um, being on the streets and stuff, you get looked down on a lot at… you get looked down at a lot.

The women also described shelters as places of violence where they had experienced predation by other people in the shelter. Many women described being robbed, having medications stolen, experiencing violence, and in one case, being given an overdose of heroin purposefully. Many of the women described women's shelters as particularly violent places that were particularly affected by the drug-market:

> Um, I think that there's no… absolutely nowhere near enough help. Like, um, a lot of women's shelters, um, they are quite violent. A lot of the girls will… will always want a fight. And there's always, um, drugs around and stuff and you've got to either do them or sell them or you get robbed and stuff like that. So it's a really bad environment to be in. (Barb)

Val noted that women could feel more vulnerable because of their gender:

> I was depressed most… most women on the streets are more depressed than men, because we feel like, or, especially in our sexuality, we feel like more vulnerable. And,

> um, we feel like there is no way out, no way out, because the shelter, I've been there twenty-four times and I've had guitars stolen.

This is not to say that this is currently the situation in contemporary homeless shelters in Brisbane, but to say that this was the experience of several participants in this study at some point in their lives.

Negotiating Stigma

The women in this study used multiple techniques to resist or negotiate the stigmas attached to substance use and homelessness, such as avoiding substance use themselves, avoiding other people who are homeless who used drugs (often to keep themselves safe from predation and the risk of "temptation"), and negotiating what they perceived to be more positive identities for themselves (for example, through religion or motherhood) and a more positive social context (through attending AA or NA meetings).

A number of the women described actively avoiding people who use drugs. For some of these women, avoiding people who use drugs was for their own safety or to ensure their own health. Deb explained:

> I don't get into drugs or anything, so… and I get a bit wary of, like, getting involved in that cause, you know, it's associated with some bad things, so I guess I steer clear a little bit.

Val, who had been able to enter into public housing, explained how she would not assist other people who are homeless who used drugs and alcohol, for her own safety:

> … But if you're taking drugs and alcohol, I'm sorry I can't take you home. That's… it's just my belief and it's my safety. And I don't want to lose my place because I know how hard it is to be out there again.

Significantly, a number of interviewed women (5) described the desire to quit using drugs or alcohol, or had already ceased using particular substances. The women related different reasons for reducing or ceasing their substance use. One woman attributed her changed substance use to her new-found spirituality. She mentioned Christianity as providing her with tools to "resist temptation":

> The only way you going to get off alcohol and drugs and that, if you just turn your life to the cross. …My mind's in Christ. My soul's in Christ. You're under my feet everyday that I'm working with you'. But there is temptations, especially with men around, there's temptations. There are temptations in… in… in alcohol. There are temptations playing the pokies. (Val)

One of the women, Hope, had found NA meetings to be useful in her recovery, before she "relapsed":

> And going to a lot of NA meetings…It's a good meeting to go to. Yeah. But, um… it's amazing, I went for two years without touching anything.

Niki explained that she had been involved with the criminal justice system, and given a suspended sentence, which provided her with motivation to cease using heroin:

> I knew if I went back and used it once that I would use it again the next day and that and even when my suspended sentence finished I never went back on heroin because I didn't fancy going to jail.

For one woman, Barb, her relationship with her husband and desire to have family had provided her with motivation to stop using substances:

> ….we have quite a lot of really bad days. Um, probably when someone tried to overdose my husband. But now both of us are coming, like, he's come off the drugs and I'm coming off the drugs cause we're… might be expecting a little one.

Discussion

Using the idea of stigma as a conceptual grounding, four major themes were developed in this paper: *intersecting stigmas*, including being a woman experiencing homelessness, a woman who is using or has used substances, a woman experiencing mental illness or physical illness, and being a woman who has been involved with the criminal justice system; *perceived stigma* and the association between homelessness and substance use; *enacted stigma* and experiences of discrimination; and techniques to *negotiate stigma*. The women in this study described using multiple techniques to negotiate the stigma attached to substance use and homelessness, such as avoiding substance use themselves, avoiding other people who are homeless who used drugs (often to keep themselves safe from predation and the risk of "temptation"), and negotiating what they considered to be more positive identities for themselves (for example, through religion or motherhood) and a more positive social context (through attending AA meetings and other activities). The strategy described by many participants in this study of avoiding people who use drugs echoes the findings of Johnson et al. (2008), who observed that some of the people in their sample engaged in "associational" distancing, where they avoided their homeless friends and acquaintances (Johnson et al., 2008). Similarly, a recent paper by Bower et al. (2021) described how participants who were homeless negotiated the stigmatized social identity attached to being someone who uses substances. The findings of this study highlight how the stigma of the association between substance use and homelessness featured in participants' lives, whether or not they themselves were using substances.

We argue that intersectional stigma can be a useful framework to guide future service frameworks for women experiencing homelessness and concurrent substance use. "Intersectional stigma" steps away from an individualized view of homelessness and substance use, and accounts for a range of stigmas that women experiencing homelessness grapple with on a day to day basis. Proposing that substance use is somehow a reason for homelessness can encourage problematic interventions focused on the "individual deficits" of the homeless person, and a tendency to ignore gender differences in individual "pathways" into and out of homelessness, as well as the wider social, structural, and contextual factors that contribute to homelessness (Bullen, 2015; Somerville, 2013). Strategies should focus not just on the individual woman experiencing homelessness and her deficits, but should use "empowerment frameworks" and "focus on multiple levels (individual, interpersonal, community, institutional, policy)," as suggested by Chambers and Erausquin (2015) in the context of intersectional stigma to understand adolescent pregnancy and motherhood. In the context of responses for women who are homeless, intersectional stigma suggests that strategies could be aimed at: the

individual woman experiencing homelessness (Chambers & Erausquin, 2015) (e.g., through services such as substance use treatment, homelessness services, harm reduction and peer education around safe practices); women experiencing homelessness as a group (to reduce internalized stigma and intra-group stigma); housing and substance use treatment service providers to ensure staff are using best practice (Allan & Kemp, 2014); as well as communities (Chambers & Erausquin, 2015) and law enforcement to reduce stigma.

Stigma is one of the key factors that influence women's decisions to use a service or not; practices that lead women to avoid services include punitive measures, unreasonable expectations or micro-management, and disrespectful, moralistic, or judgmental attitudes among staff (Bullen, 2019). As highlighted in the findings presented here, the intersection of the stigmas of homelessness and drug use-related stigma can compound this kind of labelling and stigmatization of women seeking services. Given this important role of stigma in service utilization, service philosophy, leadership, and staff training should be designed to be gender-responsive, strengths-based and empowering, as well as trauma-informed, and staff attitudes should be supportive and not reinforce stigma (Bullen, 2019).

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Declarations

Conflict of Interest The authors declare that they have no conflict of interest.

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