An evaluative report on the Mental Health & Therapeutic Services

by Dr. Oana Burcu
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The image on the cover was drawn by Anawim’s clients in a work group. It depicts the 9 offending pathways which show that life, same as offending and recovery, is not a linear process, one takes steps forward and backward. The words on the top speak of the journey towards self-reliance in various areas, such as refuge, accommodation, counselling, friends, learning and volunteering. The words underneath reflect their feelings and the emotional journey undertaken, from anger, hatred and powerlessness to pride and happiness.

“Anawim: An evaluative report of the Mental Health Service” by Dr. Oana Burcu

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Executive Summary

Anawim women’s centre, based in Balsall Heath in Birmingham, is a voluntary sector organisation that aims to provide support and services to vulnerable women with multiple and complex needs, including those vulnerable to exploitation and prostitution, drug and alcohol problems and offending. Anawim initially started as a project of two not-for-profit organisations in 1986, Our Lady or Charity (OLC) and Father Hudson’s Society, and since April 2015 Anawim has been registered as a charity in its own right.

Anawim has a long history of successful partnership working with the Ministry of Justice and Probation, having built up extensive experience and knowledge of the criminal justice, health and social care systems. Being rooted in an outreach service to women exploited by street based prostitution has meant that assertive outreach to the most marginalised is at the core of practice; this is something that got lost in current contracts for services which rely upon referrals and hence miss certain hard to reach groups.

Along with the Birmingham & Solihull Mental Health Trust (BSMHFT) a multi-disciplinary team was established at Anawim in 2011 in response to needs expressed by its clients. It has built upon findings from 2 previous evaluations\(^1\) which identified the extent to which high rates of mental health issues, self-harm and alcohol/drug misuse issues were trauma-related. This report shows that it is particularly effective when therapeutic interventions are offered alongside emotional support, assistance with preventing homelessness, debt and benefit advice, children and substance misuse in one place with a lead caseworker.

This “one stop shop” women’s centre model has been widely tested and proved effective in the criminal justice sector over the last 10 years. When Anawim was running its alternatives to custody programmes they had a consistent re-offending rate of between 1% and 6%. This model could be rolled out to assist women with complex needs outside of the criminal justice system too. For women whose primary issue is domestic abuse, mental health or safeguarding there is no reason why it would not be as effective, even more so without the criminogenic needs.

The strength of the model lies in the mental health support offered, by BSMHFT particularly through the therapeutic group interventions which have been recently introduced. These include the Trauma Recovery Empowerment Model (TREM), Regulating Emotions and Dealing with Distress (REDD), Seeking Safety and Stop & Think. As it stands presently, such in-depth specialised interventions are only available in the personality disorder units within prisons and in secure mental health units; simply put, they are only offered to those who have already committed a serious violent or sexual offence. Therefore,

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this report stresses the need to prevent such offences by putting these therapeutic programmes in place as an early intervention and as an alternative to custody. **Try as one might to make prisons and secure units enabling environments, they will never be as enabling as allowing women to remain in their communities with or near any children they may have.** As Anawim has now tested and shown by providing therapeutic courses in the community, the results at the individual level are very positive, significant financial preventative cost savings can be achieved, as well as savings in professionals’ time and emotional distress for families and society. In comparison, prisons are the most expensive way to treat individuals and are unhelpful for those with a trauma history who are the majority of the prison population. Instead preventative measures readily available in the community could bring major contributions to the system. The cost of the psychological resource provided within a community setting is not as high as one might expect. Anawim has run this programme at a cost of around £1600 per head annually.

In addition to the therapeutic programs, mental health caseworkers play a key role in stabilising clients with multiple needs. The initial stabilisation phase is vital due to clients with chaotic lifestyles in ensuring they have access to focused workgroups delivered by psychologists and Anawim staff, and then to support them in navigating the intricacies of and often restricted access to public services. Throughout the entire programme clients receive continuous one-to-one mental health support from caseworkers and/or counsellors alongside the practical and educational support within the holistic women only setting. This type of service is limited both in public institutions, i.e. hospitals, prisons, judicial courts, residential care, and in the community. Anawim, to the best of our knowledge, is one of the very few organisations in the community that offers such a program, meaning it is a postcode lottery.

Based on the existing literature and on the data made available from Anawim, this model of service delivery has twofold positive outcomes. First, it demonstrates a transformational impact on women’s lives, particularly in psychological and physical health and reoffending. Second, it indicates considerable cost savings when compared with current mental health interventions.

**It is widely recognised that it is the trusting relationship which clients build with their dedicated worker within this environment that makes the difference. Group work is invaluable and the peer support women offer each other is key; nevertheless, without the additional one-to-one support, outcomes would be different.**

Community based women’s services may take interest in the “one stop” preventive model proposed, not only because of the positive outcomes for clients outlined above, but also on their own staff. Having psychologist led programmes has had the added benefit of uplifting the caseworkers understanding of Mental Health issues, Personality Disorder and the effects of trauma. It has given them increased confidence when advocating for women’s access to Community Mental Health Teams and really helped them to understand behaviours common to women suffering these issues, such as causing splitting within the staff teams.
By co-delivering groups such as Stop and Think in partnership with psychologists, Anawim staff have been able to bring the problem solving skills taught into their own practice. Anawim is now establishing a case formulation session where staff can share with each other and discuss clients for whom they feel stuck. Anawim has learnt that there is a cost to providing these interventions though as staff burnout rises. An important recommendation to put forward is the establishment of clinical supervision, counselling and group case formulation sessions from the initial phase of designing the programme.

Local authorities can draw several lessons from this report given the multitude of challenges they are facing in tackling mental health problems. The approach being adopted with the Combined Authorities is definitely the way forward; funding for holistic women’s centres cannot solely fall at the feet of criminal justice commissioners, it must be shared with Children’s Services, DWP, Health, CCGs, GPs, Local Authority, Housing Associations and other stakeholders, as the outcomes and cost savings are relevant across all budgets. With a coordinated approach women’s centres could be funded in a sustainable manner without costing any one commissioner dearly. Manchester is already demonstrating this as a start but they are yet to get buy-in from all stakeholders with much of the funding still secured by the women’s centres themselves. Additionally, Manchester recognised the need for a mental health team as well as the need for local services to integrate support around women who are placed at the centre of the service. These are valuable lessons that the West Midlands Combined authority can draw upon.

We are hopeful that the new Women Offenders strategy will utilise this “one stop” preventative approach as the solution for diverting women from the criminal justice system and support the rehabilitation of women with multiple needs. **Anawim, along with other women’s organisations including Women in Prison, Agenda and Women’s Resource Centre would also welcome the bold move of cancelling the proposed £50million investment in 5 new women’s prisons and diverting the funding to community options. This plan goes against evidence based research and practice that shows prison does not work to rehabilitate and actually causes harm not only to the women incarcerated but their children, families and wider society.**
1. Introduction: Anawim and the Mental Health Team

Anawim women’s centre, based in Balsall Heath in Birmingham, is a voluntary sector organisation that aims to provide support and services to vulnerable women with multiple and complex needs, including those vulnerable to exploitation and prostitution, drug and alcohol problems and offending. Anawim initially started as a project of two not-for-profit organisations in 1986, Our Lady or Charity (OLC) and Father Hudson’s Society, however since April 2015 Anawim has been registered as a charity in its own right.

A mental health team was established at Anawim in 2011 in response to needs expressed by its clients. A previous pilot evaluation\(^2\)\(^3\) of the mental health needs of women using Anawim services between 2009 and 2011 identified high rates of mental health issues, self-harm, and alcohol/drug misuse issues. In addition, this pilot found many of the mental health problems reported by the women sampled were trauma-related. The mental health team supports women through providing emotional support, advocacy at appointments with GPs and Community Mental Health Teams (CMHTs), delivering courses (e.g. mental health awareness), as well as generally supporting women in meeting their additional needs (e.g. accommodation and access to benefits).

In 2012, Anawim in partnership with Birmingham and Solihull Mental Health NHS Foundation trust (BSMHFT) and Staffordshire and West Midlands Probation started the “Mental Health Alternatives to Custody” project funded by the Department of Health (DoH). This two-year pilot project funded a probation officer, a registered mental health nurse, and two mental health support workers at Anawim. A preliminary evaluation of the impact\(^4\) of this project indicated women involved in the pilot made progress across a wide range of areas including their ability managing money, find stable accommodation, decrease substance misuse and reduce offending. These improvements over multiple domains reflected the holistic wrap-around nature of the service in supporting the women’s multiple and complex needs. Furthermore, the preliminary evaluation identified significant cost savings to public services as a result of these improvements, through reduced contacts with emergency, social, or criminal justice services. While DoH funding for the project did not continue, the findings from this preliminary evaluation not only highlighted the need for mental health support for women with complex needs, but the potential positive impacts of such services for both the women themselves and public services.

These findings are based on statistical data, case studies and interviews with clients who accessed the service and staff members, psychologists and mental health care workers, who ran the service. Generalisations at a wide scale may be premature at this stage because


the study draws on fairly small samples of respondents. Data collection was difficult due to personal, often chaotic, circumstances of each client, and due to the contractual changes between Anawim and the Probation service. Nevertheless, with new cohorts of clients being currently enrolled in the holistic program and provided that the results will continue to maintain their ascending trend, there are reasons to believe that the model could be potentially rolled out at the national level.

The report is divided into 7 sections. It starts with a detailed literature review of the existing services available in public and private institutions in the UK and the adjacent treatment options available in these centres. It then moves on to a short overview on Anawim’s structure, goals and vision, before delving into processes of referral and the support and intervention provided onsite. Findings are based on data collected from clients who took part in at least one of the four therapeutic courses which form the holistic program Anawim offers; the format, outcome and retention rates are all explained in detail and inform the discussion section.

As well as supporting the mental health case workers Lankelly Chase foundation and Barrow Cadbury Trust supported the early intervention project which led to the establishment of the current “New Chance” and with support from NHS England. Part of the funding went towards the costs of the Psychologist and assistant to develop the therapeutic programme co-delivered with Anawim.

1.1. Anawim and Lankelly Chase Foundation

The current funding of £177,882 provided by Lankelly Chase along with £75,000 from Barrow Cadbury Trust allowed the Anawim Mental Health Team to support women who are at risk of suicide, deteriorating mental health, drug abuse and offending. This enabled the Mental Health team to begin delivering a Trauma Recovery and Empowerment (“TREM”) group to support the estimated 85% of women at Anawim who have experienced childhood and/or adulthood abuse by funding a Psychologist from BSMHFT to deliver the 20-session intervention and provide supervision for Anawim’s co-facilitating staff.

Anawim shares Lankelly Chase Foundation’s vision as highlighted in “the theory of change” model. Marginalised individuals can be fully empowered only when systemic, structural and cultural changes come together (see Figure 1).
First, the change at the **systemic level** refers to the need for services to move from rigidly focusing on one issue at a time to being able to respond to the interrelated nature of multiple needs by offering a tailored, flexible and consistent approach. The aim is to prevent the escalation of the disadvantage, to support individuals in building relations and to empower them to become independent.

Anawim is in line with the proposed systemic change through its holistic women-only “one-stop-shop” service model. Within this service structure, women are able to access individual care from support workers which included financial and housing support, just to name a few. Women with mental health issues, who form the majority of Anawim clients, have access to a bespoke set of psychological courses (e.g. Stop and Think! and TREM), on which they can enrol depending on their own personal needs. This is part of a newly forged and ever-developing partnership between BSMHFT (mental health service) and Anawim – the approach is innovative through the nature of the courses offered compared with other women’s centres. For instance, pitted against Greater Manchester, where the devolution process is already in full swing in social care, they are still due to develop such a partnership with their local mental health service. This partnership is a “systemic shift” in working – rather than operating in a silo, Anawim is linked up with the expertise, knowledge and skill that BSMHFT can offer and is a key partner in the delivery of services to women coming out of secure care (either Ardenleigh Women’s Hospital or HMP Foston Hall, as examples) due to its unique and women centred approach.

In addition, with input and support from other organisations, such as Solihull & Bournville Colleges, Crisis and Women’s Aid (for a list of courses see Appendix A) women also had the option to attend a range of courses, including educational (e.g. numeracy and literacy) and vocational (nail art, beauty, Health & Social care). An additional partnership which has developed and is again key to future service delivery is that between Anawim and West Midlands Police and the Criminal Justice System (CJS), who are also in partnership with BSMHFT; this helps divert women offenders from the CJS by providing them with a more tailored and personalised women only approach. Again, this is a systemic shift which allows for a more joined up approach. Inevitably this translates into better communication and information sharing which in turn means better service for the women with complex needs.
So many women slip through the net due to the complexities and the difficulties they have engaging and trusting services. Once they engage with the service, given the holistic approach offered, they should be ready to move towards an independent lifestyle.

Second, according to Lankelly Chase, transformation will ultimately come from the individual’s own humanity, creativity and enterprise, defined as “cultural change”. The external support offered to an individual is not disregarded, but the decision to embrace change is in the hands of the client.

It is also the view of Anawim that clients can retrieve their own humanity if they are guided towards the services that fit their personality, interests and needs. At times, clients need support to rediscover their own humanity, motivations and strengths. The emotional support clients receive from Anawim staff or their peers can be the trigger needed to determine one to embrace change and find the power to continue their rehabilitation journey. Perhaps it is also about adapting the culture of the system so that service user can get the most out of it. After all, it’s about the humanity, creativity and entrepreneurship of all those involved at both ends of a service – providers and consumers. And for one to be transformed from a service consumer to an active service user and potentially contributor to the service, mutual engagement is needed.

Third, structural change is the deepest level of change that Lankelly target. It is the most challenging change due to its goal of reshaping the system so that power shifts towards those marginalised in the society. They must be encouraged to find their own voice and strength so that they can speak for themselves in order to achieve the changes they want.

Structural change ties in nicely with cultural change. For instance, the system can be reshaped internally through cultural change amendments mentioned earlier, or externally through lobbying and active citizenship. People who have undertaken the journey of change, who have become empowered and independent are the ones who should share their stories and contribute to activating or pushing for change. Anawim encourages women to find their own voice and to share their views publicly, and campaign wherever possible for their cause. These activities are wide ranging. Joy Doal, Anawim chief executive, regularly takes part in interviews for radio and news sites. Adellah, a former client and current employee, organises forums and has contributed to those of User Voice and Revolving Doors these give voice to the women’s concerns. Anawim’s work has also expanded to schools, in a new project, which aimed to tackle Child sexual exploitation, mental health and domestic abuse in teenagers. By working with various institutions and individuals, and campaigning for the cause, structural change will become less of a utopia.

Overall, the work carried out at Anawim - improved mental health, developed educational skills, practical skills and outcomes for women, e.g. housing and employment, high level of empowerment, lowering levels of offending/reoffending rates, are all underpinned ultimately by the theory of change explained above.
2. Literature review

The last population survey of mental health found that 17.6 per cent of the English population aged between 16 and 64 meet the criteria for one or more common mental health disorder. But only recently has mental health come to the forefront of the health policy agenda, after years of neglect in comparison to physical healthcare. This delay in recognising the importance and wide spread of mental health issues means that the national healthcare system is now confronted with a number of problems.

2.1. Problems – setting out the puzzle

Two main types of problems are discussed here: social/cultural problems and structural or systemic problems.

2.1.1. Social/cultural problems

First, mental health issues can be multiple and complex which makes them difficult to diagnose. Patients can be passed on from one department to another and from one professional to another which is disheartening. Second, stigma is still attached to people suffering from mental health problems, especially when associated with substance abuse and offending behaviour, which can be negatively judged as lifestyle choices. “Nearly nine out of ten people (87%) with mental health problems have been affected by stigma and discrimination”.\(^5\) Stigma is further embedded when services use such terms as “intentionally homeless” and “intentional self-harm”, thus blaming the person, incurring responsibility and culpability.

The difficulty to diagnose and the stigma cannot be justified, but can be explained through the prism of the multiple and complex needs involved and the prejudices that encroached British society for decades. In 2010 a team at Heriot-Watt University identified four broad sequence of events in the lives of people with multiple needs.

1. Substance misuse; leaving home or care
2. Transition to street lifestyles: Becoming anxious or depressed; survival shoplifting; engagement in survival sex work; being the victim of a violent crime; sofa-surfing; spending time in prison; being made redundant.
3. Confirmed street lifestyle: Sleeping rough; begging; and injecting drug use. Being admitted to hospital with a mental health issue; becoming bankrupt and getting divorced.

4. “Official” homelessness: Applying to the council as homeless, and staying in hostels or other temporary accommodation; being evicted or repossessed and the death of a partner.”

The reasons for entering the initial phase vary, but can include childhood abuse, bereavement, poverty, poor educational attainment, experiencing stigma and discrimination. This is a cycle sensitive to numerous trigger points which can keep one captive without enabling him/her to see a way out. It is insufficient to treat problems in isolation, a holistic parallel treatment is required for supporting people with multiple needs.

2.1.2. Systemic problems

In addition to the social and cultural problems mentioned above, there are systemic problems to be considered, presented here in five points.

1. Long waiting lists for accessing treatment - Despite “Improving Access to Psychological Therapies”, “a substantial proportion of people with severe mental health problems have had to wait for more than a year to access treatment and services are failing to provide sufficient access to the full breadth of evidence-based therapies recommended by NICE”. Only 15% of adults with mental health problems can access psychological treatment at the moment, which indicates a clear need “to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder”. Appropriate treatment has to be offered sooner rather than later for better clinical outcomes, as long waiting times can worsen patients’ conditions.

2. Access to treatment is too restrictive - A 2014 survey indicates that, “out of 2,000 people who tried to access talking therapies, only 15% of them were offered the full range of recommended therapies by NICE”.

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3. Access to mental health services is too selective - “Mental health services can often exclude people if their problem is perceived to be substance-related” and, conversely, substance use services exclude people if their substance use doesn’t fit their criteria.”

4. Delayed discharges - The Commission on Acute Adult Psychiatric Care (2015) found that 30 per cent of delayed discharges from hospital are associated with the absence of good-quality, well-resourced community teams. Research carried out by the Independent Mental Health Service Alliance (IMHSA) shows that between 2013/14 and 2014/15, the average number of days of delayed discharge per month for trusts providing mental health services increased by 22.2 per cent; this does not only translate in higher costs for the NHS, but it also means delayed access to care for new patients. Community mental health services could fill in this demand.

5. Funding and structural changes to mental health services – Despite more emphasis being placed on the importance of mental health, Kings’ Fund research indicates that “around 40 per cent of mental health trusts experienced reductions in income in 2013/14 and 2014/15” which led to “large-scale changes to services, workforce and corporate infrastructure”. These programmes have been based on reducing costs, shifting demand away from acute services, and delivering care focused on recovery and self-management. There is evidence of increased variation in care and reduced access to services as a result of the changes.

With the main issues of the mental health services at the national level being raised, the next section moves forward to look at the particular mental health services available in the West Midlands.

2.2. Mental health services in the West Midlands

Since most of the women who access Anawim services have mental health problems along with drugs and alcohol misuse and were involved to some degree in the criminal justice system, this section will particularly focus on the mental health services available in organisations that deal with these types of needs. The first sub-section discusses substance rehabilitation; the second sub-section looks at the services offered in prisons, chiefly to

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13 As discussed on pp.18-19 a number of organisations restrict access to treatment to those who are substance dependent which underlines again the need for “one stop shop” service


17 Ibid.

18 Ibid.
women; the last section discusses short-term and long-term residential care and other services available in the community.

2.2.1. Substance misuse

As many as 80% of the women that access Anawim mental health service have drugs or alcohol misuse issues in conjunction with mental health issues.

Consensus guidance in the UK (Specialist Clinical Addiction Network [SCAN], 2006) and in the USA (Center for Substance Abuse Treatment [CSAT], 2006) states that attempts to treat opioid dependence by means of pharmacological detoxification alone has high rates of relapse to dependent use. Detoxification alone is hence insufficient without “long-term follow-up therapy for at least 6-12 months”.19 In 2012 the NHS has pushed this forward by affirming that the timeline of the treatment should be defined by the “individual history, needs and circumstances, or the benefits of continued treatment”, meanwhile “long-term social support and personal psychological resources [should be offered] to sustain recovery”.20 “Recovery is a broader and more complex journey that incorporates overcoming dependence, reducing risk-taking behaviour and offending, improving health, functioning as a productive member of society and becoming personally fulfilled”.21 To address these issues, the same report recommended several solutions, among which: tailored and measured treatment intervention; engage with others in recovery, improve relationships, find meaningful work, build key life skills, and secure housing; enabling people to gain a sense of control over their own problems; treatment delivered within clear and accountable clinical governance structures.

Some of the above recommendations are already part of the recovery process in Northern Ireland and Scotland; for instance, housing and employment, community safety and local environment, and social reintegration are part of the NHS mental health service22; England NHS recognised since 2014 that there are lessons to be learnt. Overall, clearly, personalised therapy, on long term rather than short term, using a holistic approach is recommended. As suggested in the first part of this literature review, the NHS cannot meet the existent need at this point in time following these recommended guidelines; community services can offer the necessary support and can be a viable alternative. Nevertheless, this is not to say that community services can replace the NHS from one day to another, but can be


21 Ibid.

trained to further gain the expertise of the NHS in order to develop the skills and capabilities necessary to deliver interventions to such complex population, or they need to specialise in a particular segment of the population. Funding too needs to be obtained to support this type of partnership.

Anawim has successfully been working with BSMHFT, particularly the Secure Care and Offender Health Services, through the different contracts they hold for each of the services they provide. Just to name a few: a BSMHFT psychologist delivers the regular psychological interventions, part of the therapeutic programme at Anawim; a psychologist assistant works on the “Seeking Safety” project which links with the “New Chance” contract, “Through the Hospital Door” project – enrichment workers work in the hospital and a transitions group brings the women across to Anawim for regular sessions in order to help women at Ardenleigh Secure Women’s hospital to transition out of hospital.

To sum up, in time, however, similar partnerships expanded on a larger scale can lead to an overall improvement in service delivery which is likely to be more sustainable. More explorative research and debates on this topic should be encouraged.

2.2.2. Prisons and alternatives institutions that offer mental health services

Prisons in the UK face a major challenge from mental health inmates. The 2009 Bradley report found that over 90% of prisoners had one or more of the five psychiatric disorders studied (psychosis, neurosis, personality disorder, hazardous drinking and drug dependence). However, prisons are not equipped to deal appropriately with mental health problems; one reflection of this is the high rate of suicide - 70% of the prisoners who killed themselves had one or more identified mental health needs.

Theoretically prisons offer holistic services to those with mental health problems. For example, in 1999 the Prison Service set up CARAT (Counselling, Assessment, Referral, Advice and Throughcare) service aimed at offering help to every prisoner who is identified as having a drug problem. The service includes Counselling: 1-1 or self-help group; assessment- tailored treatment; referral to other services when necessary; advice- information about drug use and the treatments available; and through care- planning for support on release. In practice, however, the quality of support services, in general, remains questionable and the recent budget cuts are only worsening the situation.

Why do such services fail to offer appropriate treatment? Drug misuse and short term sentences are two particular problems which are explained next. Statistics are staggering when it comes to substance abuse among inmates: “As many as nine out of ten people in


prison have a mental health, drug or alcohol problem”\(^{25}\). This requires a wide and centralised collaboration among several service providers which proves difficult. The report issued by the Prison Ombudsman\(^{26}\) in 2016 found that mental health services need improvement, as well as information sharing and referrals between prison and healthcare staff, and between mental health and substance misuse services. In addition, while talking therapies might be in theory in place, in practice they are not always readily available, and long waiting lists can restrict access; more therapies adapted to meet the clients’ specific circumstances are also needed. From a sample of 218 people, only 7% received psychological therapy, while the others were on anti-depressants 41%, anti-psychotic drugs 24%, mood stabilisers 8%, benzodiazepem 2%, others 3% and a striking 38% received no treatment at all.\(^{27}\) It is clear that services in prison are unable to cope with the demand for mental health inmates; in summary, as the Prison and Probation Ombudsman indicates, overstretched service, poorly trained staff and uncoordinated care contribute to the problem. This is likely to translate into reoffending rates remaining high and overcrowded prisons.

Another problem is about marginalised short-term sentenced inmates. Considering that “over half the prison population are heroin and crack cocaine users who will remain in custody for three months or less – either serving short sentences, or on remand”\(^{28}\), a significant number of people will not be eligible for prison programmes and will not receive any support.\(^{28}\) These people are most likely to continue with their addictions and potentially to reoffend. Prison has a poor record for reducing reoffending with 60% those who serve sentences less than 12 months long being more likely to be reconvicted within one year after their release.\(^{29}\) In addition, the correlation between crime and drug misuse is well-known, “Reconviction rates more than double for prisoners who reported using drugs in the four weeks before custody compared with prisoners who had never used drugs (62% vs. 30%)\(^{30}\). The recommendation of the Prison and Probation Ombudsman is “At a minimum, all prisoners should have access to the same range of psychological and talking therapies that would be

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\(^{27}\) Ibid.


\(^{30}\) Ibid
available to them in the community” but this is not the case, particularly for those serving short sentences. Much more has to be done for these guidelines to be met.

This report supports Andy Bell’s statement, spokesman for the Centre for Mental Health, that even if most prisoners in England and Wales are diagnosed with at least one mental health difficulty and most have a complex range of needs, “few get the help and support they need despite the best efforts of prison mental health teams and prison officers. Many could be diverted away from custody with the right support in the community”. If more community centres and support was readily available to deal with mental health problems, then a burden would be taken off not only from the prison system, but criminal justice and social services too, by preventing (re)offending and keeping families together.

2.2.2.1. Women with mental health problems in the criminal justice system

Gender is an important factor in the way mental health issues manifest amongst the offender population. Women prisoners are at greater risk than men. “Rates of clinically significant mental health conditions are higher amongst women in prison than men - 30% of women and 10% of men, have had a psychiatric admission prior to entering prison. One in seven sentenced women, and one in fourteen sentenced men, in prison has a psychotic disorder”. Women prisoners are also twice more likely to commit suicide. Given that women are also 6 times more likely to be primary or sole carers of children the rippling effect on children and family life cannot be simply discounted. The problems they face ought to be addressed by other agencies at a much earlier stage.

In order to ensure effective responses to women, the Prison Reform Trust “Brighter futures” report makes recommendations to police and prisons mainly referring to an effective assessment and referral to other services. The first main recommendations takes a skilled female staff approach; staff “who can communicate and engage in a professional and practical but also supportive, empathetic and non-judgemental manner, identify the specific needs of women and respond through onward referrals where appropriate”. The second recommendation supports women-only spaces and time-slots. This is “in recognition of the

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35 Ibid.
proportion of women in contact with the criminal justice system who have been or are victims of physical or sexual violence and affected by abusive and coercive relationships”.

Despite the fact that the Department of Health also advocated for a women only approach, “there was little women-specific provision at the point of contact, and appropriate training was rarely offered to staff”. Anawim not only provides services tailored to women’s mental health needs, but also understands the importance of working in partnership with police, probation and health services in order to successfully deliver a mental health alternative to custody. The “Liaison & Diversion” and “New Chance” services are two such successful projects that Anawim ran in partnership with external public institutions in order to divert people with mental health conditions and substance misuse problems from custody to the right treatment service provider as quickly as possible.

2.2.3. Beyond NHS services in the West Midlands

Except NHS and Prison services, in West Midlands, and more specifically in Birmingham area, Change Grow Live (CGL) or residential rehab treatment, for short term and long term, are the other options identified.

Change Grow Live, a charity formally known as Crime Reduction Initiative, has been awarded in 2015 the contract for the delivery of a range of drug and alcohol treatment and recovery services across Birmingham, after incorporating 27 other local providers into its service. Their support is free of charge and is offered both at their centres in Birmingham and in the communities. Depending on clients’ needs there are 5 phases of support on offer: 1) initial assessment 2) users of drugs, but not dependent – this a group work programme that lasts 12 weeks, after which extra care is provided for another 12 weeks 3) lab prescribed opioid users – this constitutes the bulk of clients – they can stay in the programme for as long as they need to, generally between 12-18 months. Both at stage 2 and 3, a personal worker is allocated to each client, recovery coaches, peer mentors and volunteers can all be engaged in it. 4) Specialist residential – includes 2 weeks of detox at one of the inpatient treatment centres in Birmingham and 16 weeks at the second existent inpatient facility. Group work is available on site and post-detox services are available for those abstinent. 5) Recovery coach surgery – support ex-service users further down the line after the recovery process started.

Due to the fairly recent takeover of CGL for the Birmingham service, there are no public reports published yet on their outcomes, performance or quality of service. Despite being in contact with CGL for the purpose of this research, no data has been released. It is claimed that no external or internal reports exist in this sense “as we discussed don’t record

37 Ibid.
data down to the degree where we measure the impact of each group”. However, one impact report at the national level is being prepared which includes “some data around the change in people’s lives when they enter treatment relative to when they leave treatment, we capture information on mental health, physical wellbeing and so on”. A draft copy existed in April but, up to this point in time, it has not been finalised and access to it has not been provided. In general, steps to further enhance transparency on health and well-being services delivered to the public would be welcome.

Other organisations active in the area of substance misuse or mental health problems, can sometimes have selective eligibility criteria. For instance, rehab organisations tend to expect clients to be abstinent prior to starting their treatment, while others require service users to meet multiple criteria which can be an obstacle. Livingstone house, for instance, offers group therapy, 1-1 counselling, peer support is available. The program starts with a detox centre, followed by primary and secondary care and then by aftercare in 12 steps. Dependent on circumstances, clients can be privately funded, or may be eligible for funding by the local authority. However, this is a male only facility. Another example is The Bridge, an NGO who runs supported accommodation for men and women recovering from addictions. It is focused on Christian beliefs and offers a 12 steps program for 12-18 months, along with life skills, health and fitness and recreational activities. Applicants are expected though to test clear of substances before admission and no psychological support is offered. Perhaps the only more complex program identified was Recovery UK. It is open to anyone and it starts with detox, followed by “recovery academy” aimed at supporting people to achieve a state of mental, physical, emotional, social and spiritual wellbeing; this is delivered through group therapy, motivational interviewing, 12-step mutual self-help, Cognitive Behavioural Therapy, anger management and debt management support. Semi-supported accommodation for those preparing to live fully independent lives. Recovery UK makes available extensive support, but does not necessarily focus on mental health issues as it does not deliver therapy programs.

This report does not claim that the following represent an exhaustive list of the rehabilitation services in Birmingham, it is believed to be to the best of the researchers’ knowledge a representative sample of services.

2.3. Beyond the West Midlands – lessons from Greater Manchester

In February 2015, part of a devolution process in Greater Manchester, 37 NHS organisations and local authorities signed a landmark agreement with the Government to take charge of health and social care spending and decisions in the region. As a consequence, the Whole System Approach (WSA) to women offenders was put in place across Greater

38 Interview and email exchange with Russell Booth, CGL, 2017.
39 Ibid.
Manchester with the aim of providing support for women at three points of the criminal justice system - arrest, sentencing and upon release from prison. Nine women’s centres now operate as hubs across the city region for female referrals. The centres are “safe spaces” where key workers provide tailored, individualised support – addressing issues such as employment and housing needs, mental health, substance misuse, and domestic abuse. Women go through a triage system at arrest to better understand how the justice system can prevent reoffending as well as ensuring the public and victims are appropriately protected. At sentencing, options have been developed to allow more women to serve their sentences in the community and on release women’s provision are put in place. Except the whole system approach achieved through the well-rounded service support, the new delivery model aims to: end postcode lottery by rolling out triage and through the gate provisions; upscaling women provisions in communities by bringing all to a basic minimum standard; improving integration with wider services; improving pathways to and from troubled families; and looking to increase partner agencies involved.

Key funders of the WSA are the Community Rehabilitation Company, Justice and Rehabilitation Executive (local GM money) and the funding the Women’s Support Alliance brings (via BIG Lottery Fund and Tampon tax). Martin Nugent, from the Greater Manchester Public Service Reform Team, points out that “Benefits of the work delivered by the Alliance fall to central government departments especially MOJ but also DCLG, Home Office and DWP”, but none of these departments invest in the model. It is hence hoped that the MOJ will “allow some of the savings generated in GM to flow back to GM to keep the cycle going. We would also like health and local authorities to contribute as both are fiscal beneficiaries of our approach”.

An interim evaluation of the whole-system approach highlighted the positive improvements in wellbeing, confidence, health, and employability experienced by women who were referred to the centres, and noted that the whole-system approach had helped to share best practice, streamline reporting processes and facilitate closer partnership working between the centres. Positive progress has been recorded in the lives of 87% of the female offenders referred by probation services in Greater Manchester who accessed with their local women’s centre.

Some of the lessons to be learnt for other regions facing the devolution process, in the words of Martin Nugent are: “the need to take partners on a journey with you to build the environment where change can be welcomed and partners understand the value in doing

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40 Martin Nugent, correspondence via email, 2017.
something differently. Most of the change was predicated by strong data to demonstrate the value of doing something different”.

While WSA offers a holistic approach, at this point in time there is no mental health team on board. This is despite recognising that most of the women that they work have mental health issues. Nugent, explains that “We would like to align our outcomes more closely with health outcomes including mental health. This may mean work force development - all staff have been trained in improving well-being, co-location of services at centres, developing none medicalised solutions and moving away from a clinical approach in some cases (trauma informed / Psychological Informed Environment) as well as proposing that the alliance could be co-funded with some health money to help achieve this”. This is another lesson that the West Midlands can learn in time by putting the right mental health provision in place from the moment the new system is designed.
3. Service user profile

The current section presents a detailed profile of the women who accessed mental health services at Anawim, including age group, ethnicity on the one hand, and needs and source of referrals on the other hand. This builds a general picture of the clients who access Anawim and the routes through which they do so.

A breakdown of the ages of referred women (Figure 2), shows the largest age category to be that of 25-34 years with 46%. Meanwhile, the youngest group 16-24 and the eldest group 55-64 were the lowest represented with only 4%. The 16-24 age group is expected to grow in the next years and the gender gap is also likely to continue to follow the same trend; women are 40% more likely than men to develop mental health conditions, which means that more resources will have to be funneled towards women services.

![Figure 2. Breakdown of the ages (years) of women referred to Anawim's mental health team in 2015-2016](image)

In relation to ethnicity (see Figure 3), the majority of women referred were white British 70%. The remaining 30% was divided among various nationalities. This is not exactly reflective of Birmingham’s demographics, a city where 53% of its population is white British.

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and groups of Pakistani and Indians, for instance, represent approximately 20% of the population. Generally, more has to be done to encourage women from other ethnic groups to recognise mental health problems and to come forward.

**Figure 3 Ethnicity of women on the Anawim Mental Health Team caseload**

In 2015-16 the Anawim mental health team received 46 new referrals. Of these, significant proportions were referred by the probation services located at Anawim (36.9%), although other prominent referral sources included NHS mental health services (13%) and self-referral (20%).

**Figure 4. Source of women’s referrals to Anawim mental health team in the 2015-2016 financial year**

Of the total referrals, 16 (34.7%) women were completing a court order (SAR, RAR or on licence) at the time, although 26 (56.5%) women were involved with the criminal justice
system in some capacity. Data relating to number of children was known for 34 of the women referred. Of these, 73.5% had children with a mean of 1.59 children per woman. It is hence paramount to consider the generational impact when assessing women’s mental health needs, more so of those involved also in the criminal justice system.

Of the total 571 women referred to Anawim between 2014 and 2015, 290 (50.7%) had current mental health issues and 140 (24.5%) had demonstrated suicidal ideation or behaviour. The needs of women referred to Anawim’s mental health team varied as per Figure 5. Alongside their mental health needs, a high proportion of women referred also had needs relating to physical health (60.9%), domestic violence (67.4%), sexual violence (56.5%), or drug/alcohol misuse (78.3%).

![Figure 5. Proportion of women with needs (%) referred to the Anawim Mental Health Team](image)

Overall, all but one woman referred to the Anawim Mental Health Team presented with two or more needs in addition to their mental health needs, with 71.7% presenting with at least four additional needs. It is important to consider, however, that these needs only represent those disclosed at their first contact with Anawim. For many of the women disclosure only comes after they have built a trusting relationship with their support worker. The percentages presented in Figure 5 are therefore likely to underestimate the actual proportion of women with these needs.

For 9 years, from 2007-2016, Anawim collaborated well with the Probation Service and had a designated Criminal Justice team that worked closely together. Changes were brought in 2016, when Transforming Rehabilitation (TR) programme was introduced part of the government’s effort of managing offenders in England and Wales. Under this reform programme the previous 35 individual Probation Trusts were replaced with a single National Probation Service (NPS), responsible for the management of high-risk offenders; and 21 Community Rehabilitation Companies (CRCs) responsible for the management of low to medium risk offenders, referred to as Contract Package Areas (CPAs). Despite knowing that ending this collaboration with the Probation Service will have a substantial impact on the intake of clients (see Figure 4), Anawim refused to be part of the TR programme in what it
perceived to be an unfair compromise over the quality of its services. Joy Doal, explains the impact of these changes in Birmingham and clarifies Anawim’s position:

‘They’ve taken the same budget that they gave to two women’s centres, spread it out between five women’s centres, and asked those five centres to cover larger geographical areas as well (...) The only way you can make that work is to have a model that is just group work, with no individual support and no casework. The CRC wanted us to deliver a 10-week “Change Programme” course, which the centres have written. It would have meant that our caseworkers would have had to become tutors on that programme, which is a totally different set of skills for one thing. And we felt that without the casework, the women weren’t going to be stable enough to attend the groups as this takes months of pre-engagement work’.

The tutoring requirement implied running the “Change programme” six times a week which “would have filled our timetable pretty much with just that. We’ve got a really good, full range of different providers who come in and deliver courses for us and we would have lost them all. It’s just not viable”\(^45\).

Joy Doal further explained:

‘The CRC wanted to provide employment and money advice themselves so it would have meant the women going to another office for that support. And the problem is that they won’t do it. If they’ve got 10 appointments all over the place, that’s when they fail. Whereas, here, they’ve got it all in one place’.

Anawim has its own staff specialised in providing multiple services on site as one of its philosophies is to provide holistic services; this approach has proven to improve clients’ access rates to services and to contribute towards their overall development. Due to the different referral paths to Anawim, the changes imposed by TR would have made access to Anawim service unfair among clients:

‘if we’ve got women coming voluntarily who can access the holistic support we provide, and then you’ve got women who can only access the ‘Change Programme’, you’re going to have all sorts of problems, aren’t you, with the two lots of women mixing? One women walks in with a load of crises, and she’s seen and sorted. One of the women referred to us through the CRC would have come in for the “Change Programme”, with an equal amount of problems, and we wouldn’t have been able to help her in the same way’\(^46\)

\(^{45}\) Interview with Joy Doal, 2017.

\(^{46}\) Ibid
Other negative repercussions directly affect service users. For low to medium risk offenders, “Since TR, screening for the OPD [Offender Personality Disorder] pathway is no longer taking place for offenders who are managed by CRCs and instead only takes place for NPS offenders (...) therefore offender managers do not receive psychological formulation and consultation on their caseloads”. An additional problem with the TR was the lack of financial viability for an increase in the number of women, as Joy Doal, puts it: “they wanted us to work with about a third more women than we were working with, for less money”. Psychologists experienced in working with women with mental health problems also point out several other shortcomings:

The vast majority of these women will be managed under CRCs, which in many areas do not yet have a working model or formal contracts set up between them and community services. This could result in increased pressure on staff working in already pressurised and changing circumstances, not to mention the cost to services of this additional group of women. Hence, the likelihood is that there will be an overall detrimental impact on all women due to limited resources being more thinly spread.

Despite changes brought by the Probation contract, women are referred to Anawim by other pathways and continue to benefit from a holistic service that meets their multiple and complex needs.

4. Support and intervention provided by the Mental Health Team

The mental health team at Anawim sits at the core of the charity’s activities. This section discusses the support and intervention provided by the mental health team and is divided in three parts. The first part evaluates the impact of the mental health team on the clients’ progress. The second part introduces the therapeutic programmes ran by psychologists in conjunction with Anawim staff and highlights the outcomes. In the last part, cost saving analysis shows the potential public cost savings as a result of clients’ access to community services such as Anawim.

4.1 Mental healthcare caseload

The impact of the mental health caseload is measured across four sections: outcomes star, offending rate, course attendance. In addition, case studies provide insights from the client’s perspective.

47 Sarah Shanahan and Kay Garvey (2016) Women’s Pathway Analysis, Birmingham and Solihull Mental Health Foundation.

48 Ibid.
4.1.1 Outcomes Star

Anawim mental health support workers complete the Outcomes Star collaboratively with the service users at three-month intervals. The use of the Outcomes Star provides both an initial screening of the service users’ needs which informs the care and support provided, and a measure of the service-users’ progress during their involvement with Anawim.

The underpinning philosophy of the Outcomes Star is the “journey of change”, which acknowledges the significance of personal motivation and agency for a service user in achieving sustainable change in their journey towards independence and choice in critical areas of their lives. Each Star has a set of relevant domains. Clients initially identify “where they are at” in each domain, providing evidence to support their perceptions. This positioning is discussed with, and sometimes challenged by, their worker. The “journey of change” is measured across ten areas: motivation and taking responsibility, self-care and living skills, managing money and personal administration, social networks and relationships, drug and alcohol misuse, physical health, emotional and mental health, meaningful use of time, managing tenancy and accommodation, and offending. Each area is scored on a 10-point scale across five stages of change: stuck (1-2), accepting help (3-4), believing (5-6), learning (7-8), and self-reliance (9-10). A service user’s rating on the star is reflective of the service user’s reliance upon support, engagement and progress in that area.

At the time of this evaluation, 86 service users had completed baseline stars. Of these, 50 (58.13%) had completed a second star, with 28 (32.56%) completing three or more stars.

As shown in Figure 6, at baseline the areas with the lowest Outcomes Star ratings were “emotional and mental health” (M = 3.62, SD = 1.50), followed by “social networks and relationships” (M = 3.75, SD = 1.98) and “meaningful use of time” (M = 3.79, SD = 1.41).

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The largest shift from the baseline at the third star was observed for “offending” (+2.96), followed by “social networks and relationships” (+2.43) and “motivation and taking responsibility” (+2.28). On average, there was an increase of 1.45 from the baseline by the second star, and of .048 between the second and third star. Overall, by the third star there was mean increase of 1.93 from the baseline, representing a shift of almost one complete stage according to the Outcomes Star’s “journey of change” in approximately six months.

Table 1 presents the means and standard deviations for ratings across each of the ten areas of the Outcomes Star among women supported by the mental health team. Ratings on the Outcomes Star were significantly higher at the second star compared to baseline across all ten areas (p < .001). Further statistically significant improvements at the third star, when compared to the second star, were observed for “motivation and taking responsibility”, t(27) = -2.147, p = .041, “managing money”, t(27) = -3.022, p = .005, “physical health”, t(27) = -0.13, p = .013, “emotional and mental health”, t(27) = -3.195, p = .004, and “offending” t(27) = -3.662, p < .001.
To some extent the Outcomes Star is a subjective measure that is indicative of “distance travelled” by the service user during their engagement with Anawim. As a result, ratings on the Outcomes Star are dependent to some extent on the service users’ insight into their own needs. Support workers on the mental health team have reported that as service users make progress they gain greater insight into their needs and the improvement that needs to be made, which sometimes results in lower star ratings despite significant progress being made. Hence, the improvements in Outcomes Star ratings may sometimes underestimate the magnitude of the progress made.

### 4.1.2 Offending Outcomes

The re-offending rate among women engaged with Anawim is consistently shown to be below the national rate, which for 2013-14 was approximately 19.4%\(^{50}\). Currently, the overall re-offending rate across Anawim is 6%, however the rate among women demonstrating mental health issues (including those not supported by the mental health team) is slightly higher at approximately 8%.\(^{51}\) Even for those women who are demonstrating severe mental health issues, and hence are supported by the mental health team, the current re-offending rate is 17%, still lower than the national rate.

### 4.1.3 Services

As a holistic service, women can attend a variety of courses across Anawim. The focus of these courses ranges from practical skills (e.g. money advice), education (e.g. numeracy and literacy) to family (e.g. parenting) and psychological needs (e.g. TRE”).

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\(^{51}\) There is no precise point of comparison because there is no available national re-offending rate for women involved with the criminal justice system that demonstrate mental health issues.
In 2015, a total of 48 women supported by the mental health team successfully completed a number of courses (see Appendix). Where a woman successfully attends 80% of the course sessions, they are presented with a certificate to recognise their achievement at a biennial award ceremony.

Anawim’s clients with mental health needs can also require support from their case workers in a number of other areas. This support is holistic and includes: assisting women in accessing mental health services (e.g. attending meetings with community mental health teams and advocating at GP appointments), providing emotional support, as well as signposting to other organisations to help meet other needs (e.g. housing, benefits).

The following case studies illustrate how mental health support workers at Anawim supported women in meeting their mental health and practical needs.

**Case study 1: Vicky**

Vicky was fleeing domestic violence when she first moved to Birmingham, where her friends were living. She was unable to get housing assistance due to her age and lack of connections with the area, and as a result was sleeping on her friend’s sofa. In addition to housing problems, she had financial issues as she was not receiving benefits and was in significant debt. Vicky first attended Anawim voluntarily for support. The Police referred her to Anawim after they arrested and cautioned her for possession of an offensive weapon in a public place. At her initial assessment at Anawim, Vicky denied having any mental health issues. However, after further discussion she disclosed having overdosed five times in the previous twelve months, reporting that she often felt low and had suicidal ideation. She disclosed to support workers that she suffered abuse during childhood, and as a result struggles to cope with negative thoughts and flashbacks. She also reported alcohol dependence, a factor that made her GP reluctant to prescribe antidepressants for her mental health issues. Although Vicky was trying hard to maintain abstinence, she struggled to remain alcohol free after three months. In order to help Vicky deal with her alcohol use as well as mental health, at Anawim’s team advice Vicky enrolled in multiple courses. These included “Stop and Think”, “1:1 relapse prevention workshop?”, “Drug and Alcohol Awareness” and “therapeutic art”.

Support workers at Anawim helped Vicky access other services too, including accessing the correct benefits, referring her to Crime reduction initiative (CRI) for further alcohol work and to an agency offering dry accommodation (i.e. regular alcohol testing and support). Anawim support workers also helped Vicky access NHS mental health services through attending her GP appointments, leading to a referral to a Community Mental Health Team.
**Case study 2: Tanya**

“Tanya” is caught up in a viscous cycle. She is in her mid-fifties and has been diagnosed with schizophrenia since her early twenties. She experienced childhood trauma which she used crack cocaine and alcohol to try to numb the pain she felt on a daily basis. This compounded her mental health issues even further and she was caught up in the revolving door of becoming so unwell she needed to be hospitalised within a psychiatric unit for her own safety. Tanya would receive intense support in hospital, become well again but return to the community which she could not cope with. Everything in the community was a trigger for her, following her childhood trauma; this included simple things, from leaving her front door and catching a bus to walking down her local high street. The smell of a certain aftershave, a particular song playing from a car passing by or a raised voice could send her in to a state of sheer and utter terror. Therefore she would stop taking her medication, misuse substances and become emotionally and psychologically unwell again, ultimately resulting in her returning to hospital once again.

Now in her mid-fifties, Tanya had been in hospital more times than she can even remember, at times up to 29 times in a single year. The more and more time she spent in hospital meant the more and more institutionalised she had become. Tanya had been able to shop independently and cook a few basic meals, but she was beginning to lose the very few skills she had managed to retain in the community.

Anawim’s work with Tanya was very much about empowering her to regain and build on the skills she had lost through numerous hospital admissions, such as simple skills such as maintaining her own bank account and not falling victim to financial exploitation. Support workers ensured she had services to support her mental health and substance misuse issues. At Anawim, there is flexibility to do simple things like going out for a walk with Tanya, and showing her how to practice mindfulness on her walk; taking in the sound of birdsong and listening to the wind rustle the leaves on the trees; being with her in a coffee shop and attempting to manage her anxiety of being in a social setting; supporting her wish to join the local gym as she recognised the positive impact physical exercise has on her emotional wellbeing and mental health. Sometimes clients are unable to access psychological groups for a number of reasons and our work as Mental Health Support Workers was to make this therapeutic work accessible to our clients wherever this may be, even if that’s in their living room, with the aim of eventually encouraging clients to access the excellent work on offer at the centre. Tanya, to this date has not returned to a psychiatric unit and hopefully in time she will feel ready to work on the trauma she has experienced throughout her life.

**4.2. Therapeutic services**

The Therapeutic Programme available at Anawim is fairly unique among community services through the holistic approach that it takes; this includes four courses: TREM, Stop & Think, REDD and Seeking Safety. Courses can be divided into two phases based on the level of trauma that they address. RED” and Stop & Think are the first phase as they deal with “milder” issues, while TREM and Seeking Safety can be accessed only in the second phase as they deal with “deeper” issues. In this way clients are equipped with the skills to manage
emotional distress required on deep trauma courses such as TREM, psychologist Eleanor Haddock explains. Each of the four courses are evaluated in detail next.

4.2.1 Trauma Recovery and Empowerment Model (TREM) Group

The Trauma Recovery and Empowerment Model (TREM)\textsuperscript{52,53} is a manualised group intervention specifically designed for women that have experienced childhood (and often adulthood) abuse or neglect and have subsequently developed related mental health or substance use issues; TREM assumes that present dysfunctional behaviours and/or mental health symptoms are the result of coping responses to trauma and abuse. Cognitive-behavioural, psycho-education and skills building techniques are used throughout TREM in order to enable increased empowerment, trauma education and recovery.

Since September 2014, three TREM groups have been completed as a 20-week group through weekly 2-hour sessions. The first two TREM cohorts were co-facilitated by a mental health support worker and a mental health probation officer from Anawim, while the third TREM cohort has been co-facilitated by an Anawim caseworker and a psychology trainee from BSMHFT.

After each TREM group, women completing the group receive a personalised therapeutic letter which provides a summary of their engagement and journey through TREM, and makes recommendations for future therapeutic endeavours.

4.2.1.1. Attrition Rates

Thus far, three TREM groups have been completed. Twelve women were assessed for TREM 1 (September 2014 – March 2015), with seven of these starting the group. Of these seven, four (57.14%) completed TREM. For TREM 2 (April 2015 – September 2015), five women were assessed and started the group, with three (60%) completing TREM. Nine women were assessed for TREM 3 (October 2015 – March 2016), with five of these starting TREM alongside one woman who had earlier dropped out of TREM 2. Of these six women, three (50%) women successfully completed the group, including the women who had earlier dropped out of TREM 2. Across the three cohorts, there was an overall attrition rate of 44.44%.

Reasons for non-completion of TREM were not explicitly recorded, however anecdotal and observational data was collected. This data suggests attrition may be attributed to the dysfunctional lifestyle that women led due to their multiple and complex needs. For some women trauma-related alcohol and substance misuse was a significant barrier to engagement, while for others on-going trauma or other current personal or relationship


difficulties prevented them from fully engaging with TREM. Furthermore, for many of the women TREM was the first time they had addressed or discussed their previous trauma; this experience created challenges in terms of coping with the difficult emotions the group evoked.

4.2.1.2. Outcome Measures

Two psychometric outcome measures were used to evaluate the effectiveness of TREM at Anawim; one measured trauma-related symptomology and the other one psychological distress. These measures were completed both at the initial TREM assessment and at a subsequent post-TREM assessment. The Trauma Symptom Inventory-2 (TSI-2)\textsuperscript{54} measures psychological symptomology related to experiences of trauma, measuring four core symptoms: Self-disturbance (i.e. poor self-identity and problematic relationships with others), Posttraumatic Stress (i.e. flashbacks and hyper-alertness), Externalisation (i.e. aggressiveness and/or poor emotion regulation) and Somatisation (i.e. distress arising from perceptions of bodily dysfunction).

The Brief Symptom Inventory (BSI)\textsuperscript{55} measures an individual’s overall level of psychological distress, through nine primary symptoms including: somatization, obsessive-compulsive symptoms, depression, anxiety, interpersonal sensitivity (i.e. feelings of personal inadequacy), hostility, phobic anxiety (i.e. anxiety related to fear), paranoia and psychoticism. The BSI also produces a “general severity index” (GSI), which gives an indication of the overall level of psychological distress. According to the BSI, a client is considered to be a “clinical case” if they are clinically raised (Scores ≥ 63) on two or more subscales.

Using the procedures for determining reliable change described by Jacobson and Truax (1991)\textsuperscript{56}, the proportion of TREM completers demonstrating clinically significant improvement ($p < .05$) in trauma symptoms is shown in Table 2 (i.e. improvement rate). The table presents pre-and post-TREM means and standard deviations for trauma symptomology, also the recovery rate for the group (i.e. the proportion of TREM completers demonstrating significant reductions in symptoms from above clinical cut-offs to below).

<table>
<thead>
<tr>
<th>TSI-2 Subscale a</th>
<th>Pre-“TREM”</th>
<th>Post-“TREM”</th>
<th>Improvement Rate</th>
<th>Recovery Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Self-disturbance</td>
<td>69.10</td>
<td>4.07</td>
<td>58.38</td>
<td>6.29</td>
</tr>
<tr>
<td>Posttraumatic Stress</td>
<td>75.60</td>
<td>4.65</td>
<td>64.50</td>
<td>8.76</td>
</tr>
</tbody>
</table>

\textsuperscript{54} Briere, J. (2011). Trauma symptom inventory\textsuperscript{TM}-2 (TSI\textsuperscript{TM}-2). Lutz, FL.: PAR.


Although two women did not improve or recover on any of the four TSI-2 subscales included in Table 2, a further breakdown of trauma symptoms showed these women still made important improvements in their trauma-related symptoms. For example, both showed significant improvement and recovery in their symptoms of depression and anxiety, as well as suicidal ideation and behaviour.

In relation to psychological distress as measured by the BSI, of the eight who completed both pre- and post-TREM BSI measures, five met the criteria to be considered a “clinical case” prior to TREM. At follow up, two women no longer met the “clinical case” criteria. Furthermore, of those still considered to meet the “clinical case” criteria, many still demonstrated considerable improvements in symptoms of psychological distress. For example, one woman showed a reduction from nine clinically raised symptoms to just two symptoms.

Alongside improvements in mental health symptoms observed across the TSI-2 and BSI measures, there were also important observational changes among the women participating in TREM. These included reductions or complete desistance from offending or other destructive behaviours (e.g. substance misuse). In addition, women reported improvements in relationships, feelings of self-worth and empowerment.

4.2.1.3. Qualitative Findings

In addition to evaluating the effectiveness of TREM through outcome measures, TREM completers were invited to participate in face-to-face interviews with an assistant psychologist from BSMHFT. One completer was unable to be contacted due to subsequent disengagement from Anawim. Seven TREM completers agreed to participate, giving a response rate of 70% of the total sample, and 77.8% of the available sample.

Semi-structured interviews were conducted with TREM clients using an interview schedule consisting of open-ended questions and prompts. These questions related to the service users’ experience of TREM over the different stages of group, any strengths or challenges associated with the group, and practical questions relating to facilitators and location.

The interviews were subsequently transcribed verbatim and analysed using an inductive thematic analysis. The method of thematic analysis used followed the six stages...
described by Braun and Clarke (2006)\textsuperscript{57}. Using this method, 3 themes were identified, each with a number of related subthemes. Themes and supporting quotes are shown in Table 3.

Three themes emerged through the thematic analysis process, comprising of a total of eight subthemes. Themes, subthemes and the number of participants representing each theme are presented in Table 3, while supporting quotes are presented in the text.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Subtheme</th>
<th>Number of participants representing subtheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial self-disclosure</td>
<td>The challenges of finally “opening up”</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>“I felt free-er” – The relief of talking.</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>The influence of others on self-disclosure.</td>
<td>3</td>
</tr>
<tr>
<td>Group Cohesion</td>
<td>Belonging as a facilitator of engagement</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Universality within individuality</td>
<td>4</td>
</tr>
<tr>
<td>Unmet needs</td>
<td>Access to a psychological perspective</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Awareness of the impact of trauma</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>“Not enough”</td>
<td>3</td>
</tr>
</tbody>
</table>

*Note. N = 4*

**Initial self-disclosure**

**The challenges of finally “opening up”.** This theme captures the reference all the participants made to challenging emotions associated with opening up about their past. Two respondents stated that TREM was the first time they had acknowledged or gone over their past trauma, and how the anxiety associated with this was the greatest challenge of the group.

*Obviously bits of it were hard. When they went over certain things, which obviously I hadn’t brought up with anyone for a long time. That would have been the most challenging thing, I’d say, of it all. Just going over stuff that hasn’t properly been gone over for a very long time.* (Client 3)

*Very very nervous. Very very anxious, and very stressed, because I was like, worried about what it was going to bring up. Well I knew what it was going to bring up, that’s why I was worried. You know, like, can you deal with it? That was my biggest (inaudible) can you cope with that feeling that comes out? Because I’ve subdued my feelings for years, you know what I mean?* (Client 4)

Many respondents placed a great deal of importance in the trust required, both in themselves and others, for this process to occur. For example, “I thought I was going to find that hard, to even trust the facilitators” (Client 3) and “we all bonded, we told them our deepest darkest secrets, total strangers. That was one of the hardest things we have ever had to do” (Client 1). Opening up to strangers was not easy, as another client recounts:

I mean every time I’d have to openly share, erm, I’d have to trust myself to openly share. But like, I never knew what, how anyone was going to react to any part of my story. And the fact that I had never really spoke up about my story, to anyone never mind people that I’d, I don’t know. (Client 4)

Opening up came with “I felt free-er” – the relief of talking. Three of the respondents reflected on how while initially anxious about talking about their past, the outcomes of doing so were positive, referring to a gained feeling of freedom and relief. For example: “I felt free-er, I felt liberated that I’d finally like, I’ve opened up and I’ve found my voice and spoken” (Client 4), “you just start to feel better, like a weight has been lifted” (Client 2) and “every time you came here, you walked out of here with a spring in your step” (Client 1). Client 2 explained in detail:

I didn’t want to hold onto that stuff that I held anymore, I didn’t want to so I just went in there with “I’ll just say everything and let it out”. That’s the good thing about here, I learnt to talk, and once I got started I found that it was easy to just talk about my problems, things that nobody knew or that I had not talked about for years. (Client 2)

Influence of others on self-disclosure. Within the theme of “disclosure”, three respondents made reference to how other group members influenced this process. Two of the respondents discussed how they viewed their openness to talk as encouraging others to do so also.

At one point nobody wanted to speak so I just decided I was going to talk, I was losing patience so it was going on too long no one wanted to talk so I just (inaudible) sexual abuse, me mum and dad were horrible people (inaudible) the whole group and everybody started talking. (Client 1)

When I opened up so bluntly, and upfront about a couple of things, I think, I do think it encouraged a couple of the other girls to then. Because I do think they was a bit even more unsure than me. And then like, I don’t think maybe they would have said as much as they had maybe if then some others hadn’t. (Client 4)
Within this subtheme, as shown by Client 4 above, respondents mentioned that others’ openness to talk helped those who were more withdrawn or reluctant. This was associated with feelings of social support from other group members, which perhaps also had a normalising effect on this process through making the act of disclosing past trauma feel less intimidating. “I think because we was all there together, that give us all that support”, one of the clients stated. Another client mentioned:

Some people were quite withdrawn where it takes them a few weeks before we started talking and the thing that helped is that you have people that aren’t very withdrawn so they are just willing to talk about it straight away and that makes it okay for you to talk about yours, listen to other people first and you are like okay. (Client 2)

**Group cohesion**

**Belonging as a facilitator of engagement.** This subtheme represents the importance the respondents placed on feeling a sense of belonging and comfort both within the group therapy dynamic and the wider service context. In particular, respondents referred to this sense of comfort and belonging as important in facilitating their engagement with both the group and service. For example, Client 1 described how the sense of belonging in the group provided a feeling of security that enabled her to return, “…a bond in that group and I think that is why we went back to it, because we felt secure”. Other clients’ echoed similar feelings of belonging:

When I came here was the first time I felt like I belonged. I’d see other girls, and I’d be like, didn’t know their stories, didn’t know what they’ve gone through. But they’d be certain things they’d say or certain actions or attitude, and I’d be like, I just got it. I just saw something, and I could, I could associate with it. But I’d never ever had that feeling before coming here. I always felt like the odd one, the stranger or the weird one, or you know, the one that don’t fit in. You know. Then I come here, and I was like, all the other girls are in the same situations. This started to make me, not make me, help me accept myself, and I’d never accepted myself before that. (Client 4)

But with (women’s centre), from day one, […] I was made comfortable. […] I gelled well with (support worker) from day one, and then with the group and that. I that, because I felt more comfortable and stuff, in the centre I feel comfortable. (Client 3)

**Universality within individuality.** This subtheme relates to respondents’ feelings of similarity and individuality in their past experiences of trauma in relation to the other group members, and specifically how this impacted on their TREM experience. Some respondents

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58 Interview with Client 4, 2016.
related this feeling of shared experience as contributing towards the sense of comfort described in the previous subtheme.

Now you can have some groups, you’re all there for a few different issues. But that, we all knew we was all there for that one specific thing. We’d all gone through traumas in our childhood or later on, or whatever. We was there for that same reason. And I think because of that we all felt more at ease. Well, I did, I can’t speak for the others. But I, it helped me feel more at ease. We’ve all lived the same, we’ve all gone through the shit (inaudible). It’s like, yeah I find it a bit easier. (Client 4)

The respondents’ recognition of similarity in their experiences of trauma did not fade their recognition of individual people with their own experiences.

Like, everyone had been through a totally different walk obviously, but we all had experiences that gelled. When we was talking, it was easy to talk to them kind of people, which I didn’t think. I thought it would be the total opposite... (Client 3)

Client 2 also referred to this sense of individuality in their similar experiences; however she additionally discussed how this was sometimes challenging in terms of being able to relate to others. Despite this challenge she referred to a sense of ‘acceptance’ of other group members’ inability to relate.

There is a lot of things we understood but some things I just couldn’t understand and some things people didn’t understand about me and then you would speak about it. Someone would say I don’t get why you are like that and its okay for them to say it because they don’t understand. (Client 2)

Unmet needs
Access to a psychological perspective. This subtheme represents an appreciation for the psychological input to TREM provided by the facilitating clinical psychologist. Although only one respondent was specific in mentioning that support workers were unable to provide this insight, others alluded to a feeling of being “understood” provided by psychologists and support workers alike.

(Support worker)’s a fine key worker but she doesn’t know about psychology or psychiatry, if she does it will be just slightly you know, she is not as trained as you are. [...] I think they need a psychologist in here, I really do. (Client 1)

I thought (clinical psychologist) was a brilliant person to do that group. She was bang on, she got it, and I knew she got it. If I didn’t think, if for one moment I didn’t think
she got it I wouldn’t have stayed in the group. (Pause) Seriously, not with stuff like that. (Client 4)

Because you get different perspectives and opinions and they talk amongst themselves as well as us so you know like if (clinical psychologist) said something we didn’t understand (support worker) would be able to break it down into easy ways for us to understand. (Client 2)

**Awareness of the impact of trauma.** This subtheme captures the sense of increased insight gained by many respondents as a result of TREM into how their early traumatic experiences continue to affect them in the present, contributing to dysfunctional behaviours such as substance abuse and offending. For example, two respondents referred to how TREM had enabled them to understand their previous behaviours, with Client 3 commenting “It made me realise a lot of why behaviours that I had, and certain things that I used to do. It was a big understanding, a lot of things”. Client 1 describes TREM as a “light bulb moment, and the one group we all got the light”. She further detailed: “We are sorting ourselves out now, we are realising what happened to us, we are realising this is not our fault, we are realising that grooming is a thing that my dad done and some things I look back and (inaudible)”.

This increased insight and understanding of their behaviours was also associated with a wider recognition of the role of trauma for offending behaviour. This in turn was associated with a recognition of the need for TREM, and furthermore the need for TREM to be offered in services such as the women’s centre.

*I hope that the Judges get to know about it, that people in authority get to know about it especially cops. Try and send them here before you send them through the courts, go into the jail for 30 days and crave more drink and then you go out, try and recommend this place especially the young ones, get them in here before they get through (women’s prison). You don’t like going to (women’s prison).’* (Client 1)

‘So yeah, I think everyone in here needs to go through the trauma group at one point or another, so it would be nice if it does stay here now that they’ve got it here. It definitely works. (Client 4)

*“Not enough”*. When respondents were asked which aspects of TREM they would change, two respondents were explicit in mentioning that they would have liked “more” or a longer duration.
The only fault I can honestly say with the TREM Group was it was not long enough and we needed more time, you know what I mean? We needed, and we did say that, we needed another couple of weeks. (Client 1)

I definitely would recommend it, but I’d just think maybe doing a little bit longer? Not the session, but it’s erm [...] Yeah, more weeks. And say, when it comes to like the middle? When it get really heavy, more so, it’s like. Maybe so, like, do that one day on that really heavy area, maybe extend it to the next week, which sometimes might be needed. (Client 4)

Respondents were generally unable to articulate what this “more” might look like and tended to acknowledge that there may not be an ideal amount, recognising their needs may never be entirely met.

I think for the twenty-week course it is good enough to get you started, but you need it to be a hundred week course to be able to sort you out properly. But to get you started then yeah, or to at least understand certain things. (Client 2)

Yeah, the whole thing I think it was, and I didn’t feel like it was long enough. [...] This is it, I can say, like, it wasn’t long enough, but then how long? Because really, truly, you can go into that sort of thing in so many different angles and so many different ways. You could go on forever really. (Client 4)

Besides interviews conducted with clients, interviews with support workers offered further insights into TREM. Issha Barr helped facilitating these first two cohorts September-March 2015 and April-September 2015. “It was really well received, but it was really hard. We had a high dropout rate because we didn’t have REDD [...] which should have been the first step and was then developed”59. In terms of her role as a course facilitator, Issha says that:

I felt reassured by having a lead psychologist to provide supervision for us [Anawim staff]. It was all so new that we were looking at Sarah [lead psychologist, BSMHFT] like at a guru. She was fantastic. It was a partnership in a way. We divided work among us, but we looked at her for advice – she was breaking down psychological concepts for us because it was all about psychology (...) TREM suited women well because it was delivered at Anawim where they felt safe. They knew the place, they had a support worker to support them outside the course. They had a good motivation to be back.

59 Interview with Issha Barr, 2017.
Issha Barr describes two instances that left a deep impression on her. The first one is about the deep roots of trauma which often go back to childhood. It was session 10 of TREM, so exactly half way through the course, and it was entitled “What Is Emotional Abuse?” The session’s rationale was to discuss how emotional abuses and traumas contribute to a damaged and distorted sense of self in adulthood. One exercise, entitled “destroying emotionally abusive phrases” was particularly powerful. It asked participants to think of abusive comments directed towards them as children, anything that made them feel bad, inferior, or threatened; they would then write the phrase on a piece of paper and discuss it with the group. Group members will then shred the piece of paper to symbolically “eliminate” the phrase. Typical responses, Issha recalls, were: “You should never have been born”, “You are ugly and stupid”, “You’ll never amount to anything”.

Ripping off the pieces of paper was very powerful and cathartic for them. It is not surprising that when one of the participants recited the poem “Still I rise” by Maya Angelou, everyone was overwhelmed. Part of the poem reads:

“\begin{quote}
"You may shoot me with your words
You may cut me with your eyes
You may kill me with your hatefulness
But still, like air, I’ll rise"
\end{quote}

The poem resonated powerfully with the clients, some of whom wanted a tattoo with these lines and other chose to frame them. One can see why such TREM activities are so important for participants.

The second instance that Issha recalls is about the need to tailor the content to the needs of the participants and to remain continually aware of the sensitive nature of the clients. TREM facilitator tried a new activity; they drew the size of one participant and asked her to pinpoint the places where she felt pain, physically or emotionally. This activity was never repeated because it was too personalised and too painful; some participants pointed out that it resembled too much to a crime scene, while others struggled to come to terms

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60 Interview with Issha Barr, 2017.
with the shape of their own physical bodies. The lesson learnt was that being receptive to feedback from participants is essential in order to alter the course appropriately to their needs.

TREM has so far proven to be perhaps one of the key therapeutic programs that run at Anawim. Based on psychologists and Anawim’s staff knowledge, TREM does not run anywhere else in the community in Birmingham and West Midlands, but its usefulness for clients who suffer for trauma and require a deep level of introspection is reinforced by the positive outcomes revealed through both quantitative and qualitative analysis.

4.2.2. Stop and Think

In addition to facilitating or co-delivering trauma courses, support workers on the mental health team are also trained to deliver Stop and Think! as part of the Offender Personality Disorder Strategy\(^{61}\). Stop and Think!\(^{62}\) is a recognised social problem solving intervention specifically developed for offenders with personality disorder. Ineffective social problem solving have been closely associated with a range of issues demonstrated by women involved with Anawim, including mental health (e.g. self-harm and anxiety), impulsivity, offending and externalising behaviours (i.e. aggression). Hence, the course focuses on developing service-users’ ability to solve problems more effectively and on encouraging the thinking of more positive options and solutions to problems. The problem solving model used by Stop and Think! works through six key questions:

1. Bad Feelings?
2. What is My Problem?
3. What do I Want?
4. What are My Options?
5. What is My Plan?
6. How Did I Do?

At Anawim, Stop and Think! runs as a 16 weeks long course and is delivered as a rolling 4-week program, with a psycho-education session every fifth week where new women are allowed to join the group. The Anawim mental health team, composed of four members, are trained by a psychologist before taking charge of the course. Two of the four members team up and run the course together for 4 weeks. Then one team member leaves and one stays on the course for another week in order to offer some degree of familiarity and continuation to

\(^{61}\) “The Offender Personality Disorder (OPD) pathway programme is a jointly commissioned initiative that aims to provide a pathway of psychologically informed services for a highly complex and challenging offender group who are likely to have a severe personality disorder and who pose a high risk of harm to others, or a high risk of reoffending in a harmful way” https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/opd-strategy-nov-15.pdf

the participants. The “old” team member then withdraws and the fourth team member runs the course for the following four weeks. Due to the staff burnout the cycle continues until the course ends.

In order to get on this course clients are assessed for suitability; they have to score lower than 70 in the initial questionnaire assessment (SPSI-R-S). A minimum of 6 and maximum 8 clients are required in order for the course to run. During the sessions, women bring problems or issues they encounter in their daily lives, mainly having to do with decision making and impulsive reactions, hence the ‘Stop and Think’ name of the course. Sessions start with a simple question “what problem are you facing at the moment?” and “what do you want to achieve?” One participant will share a problem to the group who then suggest different solutions and together they evaluate the pros and cons of each option. It was often the women who had the 5-week experience on the course that would take the lead for the women who had just started. This was not always straightforward though, as facilitators found out. Sometimes when women were asked to volunteer to speak about their problem in the following session, they would say they have no problems. The way the team overcame this issue was by asking participants to fill in a form with three problems, part of the initial assessment, then they could just pick problems from the list. In this way a problem is raised every week by a designated or volunteer participant. The group develops an action plan and the person who raised the issue is then expected to feedback the group on her progress the following session. Every fourth week an “odd one out” session is organised which is not a problem-solving activity in order to give everyone a break; this could, for instance, be an arts and crafts activity related to the upcoming holidays.

What may seem a trivial issue for some is not a straightforward issue for clients with multiple needs. The founding principle of Stop & Think! was to tackle routine problems women encounter in their daily lives in order to solve problems more effectively. The problems raised varied, from sleep deprivation to children’s management. As support worker Claire Mulgrue, one of the course facilitators, explains:

Problems they often raised were related to substance abuse, shoplifting and sleeping problems. One thing that came up often was sleeping too late or too little which required the implementing self-management routines. This triggered a number of problems; for instance, if they were getting up late it was likely that the services that they wanted to access were already closed, in turn this created all sorts of problems affecting their accommodation, benefits, employments etc and triggering a surplus of stress and life misbalance. 63

63 Interview with Claire Mulgrue, 2017.
In another instance, Sharon Tulloch, Anawim facilitator for the course, recalls how a mother was seeking help with getting her child to go to school; suggestions on how to incentivise children’s school attendance were open to the group.

Claire downplays her role:

As a facilitator, I guided, structured and time the sessions and helped women to engage with each other (...) This was more effective than for a course facilitator telling women what to do. The shared experience of women helped them relate to each other (...) [and] transformed the topic proposed into a broader topic, which empowered women and made them feel less isolated. When we had a good group of 8-10 women it was really heartening to see the support and kindness, the lack of judgement they offered each other. This is after all the basics of Anawim – it’s about women working together’

Sharon Tulloch describes her experience as course facilitator in a similar manner to Claire: “as facilitators we aid them [service users], we are in the group just to help them communicate and solve their problems, to ensure the group is not disruptive, that they are not talking over each other, that mobile phones are turned off, etc.”

**Evaluation: sample, methods and outcomes**

Thus far, 53 women have started Stop & Think! at Anawim, with 32 successfully completing the course, resulting in an overall completion rate of 60.4%. Of the 21 women that did not complete the group, reasons for disengagement included completion of their court order (n = 6), breaching their court order/being recalled to prison (n = 4), personal reasons (n = 3), not liking the group format (n = 2), moving out of the area (n = 2), disengaging from service (n = 1) or other unknown reasons (n = 3).

The Social Problem Solving Inventory – Revised: Short (SPSI-R:S)\(^\text{65}\) is used to measure the women’s progress in social problem solving skills through “Stop and Think!” Service users complete the SPSI-R:S both before and after the course.

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\(^{64}\) Interview with Sharon Tulloch, 2017.

Of the 32 women that have so far completed the Stop & Think!, pre- and post- SPSI-R:S data was available for 30 women. Prior to the course, the mean social problem solving score was 67.13 ($SD = 13.17$), which increased to a mean score of 88.13 ($SD = 15.61$) post- “Stop and Think”. Statistical analysis shows the increase in social problem solving ability to be statistically significant, $t(29) = -8.267, p < .001$. Given that scores $\geq 85$ are considered “normal”, these results highlight not only the initial deficits in social problem skills among women engaged with Anawim, but more importantly demonstrate an increase to approximately normal levels of problem solving ability after completing the course.

Individual success stories are common. Sharon recounts one of a prolific shoplifter, who no longer does it. Even if she is no longer receiving any formal service at Anawim, she still rings Sharon “for a listening ear” as she puts it.\textsuperscript{66,67}

Despite these positive outcomes, the course is currently on-hold mainly because it has become optional for clients, whereas originally it was run in conjunction with the Probation Office and used to be compulsory. Ensuring consistent attendance has proven difficult since May 2016 when the partnership with the Probation office ended. In addition, women were excluded from the course if they missed 3 consecutive sessions because the course relies on group work and consistent participation is essential in order to keep disruptions at minimum and progression at maximum.

\textsuperscript{66} Interview with Sharon Tulloch, 2017.

\textsuperscript{67} Of course, challenges existed too, but they were surmountable. “Sometimes we had behavioural problems, some were disruptive and rude. On one occasion, one of the course facilitators had to leave the group and ask for the manager to speak to a particular disruptive person who had to be pulled out of the group. In another instance, there was a client who was very negative towards the person who raised problems of drugs and children; she was very obstructive so she was asked to restrain her subjective thoughts and eventually she was asked to leave the course” (Interview with Sharon, 2017).
Also, despite the fact that Stop & Think! was a lighter program than TREM and Seeking Safety, it sometimes happened that clients gathered the courage to disclose something deeper to the group. While “the feedback was positive and reassuring”, it was extremely helpful to have caseworkers that they were redirected to. It is about having the structure in place to cope with disclosures that require immediate support, ideally made available in the same environment of safety that prompted clients’ disclosure in the first instance.

4.2.3. Regulating Emotions and Dealing with Distress (REDD)

The need for the REDD course was highlighted by the attrition rate in TREM and by the TREM facilitators who noticed that the group struggled to cope with the emotions generated by the focus on their previous traumas. Emotions can be painfully vivid and difficult to manage; repercussions can be traced through one’s entire life if they are not dealt with appropriately. It may be intuitive to try to manage emotions in ways that seem helpful in the short term, but this approach often proves problematic in the long term. This can include symptoms of withdrawing, using eating as a solution (either eating more or eating less), escaping through alcohol or drugs, using self-harm or other risky behaviours. Research has suggested that without an initial stabilization stage, “working through” trauma can be re-traumatizing and that clients need to be taught skills such as coping strategies, calming the body and mind and staying in the present (Fisher, 1999). REDD was hence introduced as a pre-TREM course in order to equip clients with the necessary “tools” to identify, understand and cope with overwhelming emotions. It provides women with a greater repertoire of skills to manage their emotions better before embarking on the “deeper” level of self-analysis that TREM requires.

The REDD group focuses on new ways of coping with emotions by teaching women skills in three areas: emotion regulation skills, distress tolerance skills and mindfulness skills. Those referred to the REDD course either experience emotion dysregulation or report over-control of their emotions. Many often report a history of maladaptive coping strategies during periods of distress such as substance use and self-harm.

REDD is a 12 session course spilt into two sections. The “Dealing with Distress” module is taught over the first 6 sessions and the “Regulating Emotions” module is taught over the remaining 6 sessions.

68 These modules were adapted from the Distress Tolerance and Emotion Regulation modules of Dialectical Behaviour Therapy (DBT). “Originally designed to treat individuals with a diagnosis of Emotionally Unstable Personality Disorder (EUPD), or those who were acutely suicidal and self-harming, DBT has developed a wide evidence base within this population (Panos, Jackson, Hasan & Panos, 2013.) Further research has also highlighted its effectiveness for treatment of other disorders such as comorbid major mood disorder (Lynch et al., 2007), comorbid substance abuse disorders (Dimeff & Linehan, 2008), adolescent bipolar disorder (Goldstein et al., 2007) and Posttraumatic Stress Disorder (PTSD) triggered by childhood sexual abuse (Bohus et al., 2013). The expanding evidence base is important for justifying the relevance of
REDD is led by two facilitators which most often included a Qualified Clinical and Forensic Psychologist supported by an Assistant Psychologist or a member of staff from Anawim. Each session is two hour long divided into two parts - the first part focusing on Mindfulness teaching and homework feedback and the second part on psychoeducation and skills teaching. A 50% attendance rate is required for each module in order to qualify for the end of course certificates.

**Evaluation of REDD**

Clients were referred to the REDD group by their Caseworkers if they reported experiencing emotion dysregulation or over-control of their emotions with or without a previous diagnosis of a mental health disorder. Many often also report a history of using maladaptive coping strategies during periods of distress such as substance use and self-harm. There is no exclusion criteria for the REDD group which ensures that the group is open to women with a variety of difficulties at different stages of the recovery process. Twenty-one clients were referred to the first 3 cohorts of the REDD group however, due to difficulties completing the assessment measures, a total of 9 clients are included in the sample for this service evaluation. See Table 4 for a summary of client information.

<table>
<thead>
<tr>
<th>Number of Females</th>
<th>Mean age (years)</th>
<th>Age Range (years)</th>
<th>SD of Age</th>
</tr>
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<tbody>
<tr>
<td>Cohort 1</td>
<td>2</td>
<td>43</td>
<td>42-44</td>
</tr>
</tbody>
</table>

adapted DBT teaching to clients at Anawim. They often present with emotionally unstable personality traits, may have been diagnosed with various mood and anxiety disorders and some have previous experiences of abuse. In addition, DBT principles reflect Anawim’s approach by adopting an accepting and non-judgemental outlook on clients. Furthermore, as in DBT, the “REDD” group focuses on mindfulness teaching. Much research has highlighted the value of mindfulness based approaches for the treatment of mental health difficulties in various populations. Grossman, Niemann, Schmidt, and Walach (2004) conducted a meta-analysis which suggested that mindfulness based stress reduction could help individuals cope with both clinical and nonclinical problems. This is supported by Coffey and Hartman (2008) who found that an increased use of mindfulness reduced psychological distress. This relationship was mediated by emotion regulation, nonattachment and rumination. This suggests that in the “REDD” group the combination of teaching mindfulness to reduce rumination and teaching emotion regulation skills is will benefit clients and likely reduce levels of psychological distress. In accordance with this, Jain et al. (2007) suggested that mindfulness training is able to reduce distress through its unique ability to reduce distractive and ruminative thoughts. This may be particularly useful for the clients at Anawim, who often ruminate on their previous traumas.

69 Olivia Matheson, Researcher at Anawim from University of Birmingham, 2017.

70 Attendance rates fluctuate, often depending on clients’ personal circumstances. For example, the first cohort started in June 2016 with 11 clients. Out of these, 3 group members did not attend due to change in circumstances, 2 members attended 80% or more of the group sessions, 5 members attended 50% or more and 1 member attended less than 20%.
After referral to the group, a Triage Assessment is completed to ascertain the client’s specific difficulties and any presenting problem behaviour such as substance use or self-harm. In addition, three psychometric measures are completed: the Brief Symptom Inventory (BSI), the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) and the Five Facet Mindfulness Questionnaire (FFMQ).

The BSI was developed as a measure of psychological distress and psychiatric disorder. It is a self-report measure therefore straightforward to administer and the symptom specific scales are useful for the client group at Anawim who have a wide range of presenting difficulties and symptomology.

The CORE-OM is a 34 item self-report measure designed to provide a score of distress in four domains: functioning, problems, wellbeing and risk. It is quick to complete and clients respond considering how they have been feeling over the past week. Scores on each domain are rated from healthy (0) to severe (40). It is suitable for a service such as Anawim as the CORE-OM is pan-theoretical, pan-diagnosis and measures what practitioners have highlighted as the most important aspects of mental health.

The FFMQ is a 39 item measure consisting of subscales measuring five types of mindfulness: observe, describe, act with awareness, non-judgement of inner experience and non-reactivity to inner experience. In other words, it measures how often an individual engages in different types of mindfulness. Clients are required to respond on a 5 point Likert scale ranging from never or very rarely true (1) to very often or always true (5) according to their own opinion of what is generally true for them. The FFMQ is both a reliable and valid instrument for use with clients with clinically relevant symptoms of depression and anxiety (Bohlmeijer, ten Klooster, Fledderus, Veehof, & Baer, 2011).

Results

BSI

Nine clients completed the BSI pre- and post- treatment and the outcomes were compared. Overall, scores of distress on the BSI were reduced for every scale except the Positive Symptom Total (Figure 8). This indicates a general reduction in psychological distress as measured by the BSI.
To analyse the data in more detail, a Paired Samples t-test was used to compare scores on the BSI pre- and post- attendance at the REDD group, as the data was found to be parametric. Analysis identified a significant reduction in distress scores on the Obsessive Compulsive subscale after the REDD group (M=54.56, SD=11.47) compared with scores prior to attending the REDD group (M=62, SD=9.87); t(8)=2.55, p=0.034. The Paired Samples t-test also identified a significant reduction in scores on the Positive Symptom Distress Index after the REDD group (M=54.33, SD=17.1) compared with scores before the REDD group (M=62.89, SD=13.76); t(8)=5.96, p=0.000. There was not a significant difference in scores on any of the other scales pre- to post- treatment (Table 5).

Table 5: The results of a Paired Samples t-test used to compare pre- and post- “REDD” group scores on the BSI.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>t</th>
<th>Sig. (p&lt;0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somatization (SOM)</td>
<td>3.22</td>
<td>11.5</td>
<td>0.84</td>
<td>p=0.425</td>
</tr>
<tr>
<td>Obsessive Compulsive (O-C)</td>
<td>7.44</td>
<td>8.78</td>
<td>2.55</td>
<td>p=0.034</td>
</tr>
<tr>
<td>Interpersonal Sensitivity (I-S)</td>
<td>3.89</td>
<td>7.22</td>
<td>1.62</td>
<td>p=0.145</td>
</tr>
<tr>
<td>Depression (DEP)</td>
<td>6.11</td>
<td>11.55</td>
<td>1.59</td>
<td>p=0.151</td>
</tr>
<tr>
<td>Anxiety (ANX)</td>
<td>1.22</td>
<td>8.27</td>
<td>0.44</td>
<td>p=0.669</td>
</tr>
</tbody>
</table>

Figure 8. A graph comparing pre and post treatment scores on the BSI
<table>
<thead>
<tr>
<th></th>
<th>Pre</th>
<th>Post</th>
<th>Δ</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility (HOS)</td>
<td>2.44</td>
<td>10.17</td>
<td>0.72</td>
<td>0.492</td>
</tr>
<tr>
<td>Phobic Anxiety (PHOB)</td>
<td>2.56</td>
<td>15.45</td>
<td>0.5</td>
<td>0.633</td>
</tr>
<tr>
<td>Paranoid Ideation (PAR)</td>
<td>3.67</td>
<td>7.7</td>
<td>1.43</td>
<td>0.191</td>
</tr>
<tr>
<td>Psychoticism (PSY)</td>
<td>4.78</td>
<td>10.69</td>
<td>1.34</td>
<td>0.217</td>
</tr>
<tr>
<td>Global Severity Index (GSI)</td>
<td>4.89</td>
<td>8.78</td>
<td>1.67</td>
<td>0.133</td>
</tr>
<tr>
<td>Positive Symptom Distress Index (PSDI)</td>
<td>8.56</td>
<td>4.3</td>
<td>5.96</td>
<td>0.000</td>
</tr>
<tr>
<td>Positive Symptom Total (PST)</td>
<td>-0.78</td>
<td>10.46</td>
<td>-0.22</td>
<td>0.829</td>
</tr>
</tbody>
</table>

**CORE-OM**

Nine clients completed the CORE-OM pre- and post-treatment and the outcomes were compared. Overall, the average score on each subscale of the CORE-OM was reduced after treatment, indicating lower levels of distress (Figure 9).

![Figure 9: A graph comparing the average pre and post treatment scores on the CORE-OM](image)

The data was further analysed using a Wilcoxon signed rank test as it was found to be non-parametric. A comparison of the scores pre- and post- attendance at the REDD group indicated that distress scores on the Wellbeing scale were significantly reduced after attending the REDD group (Mdn=22.5) compared with Wellbeing scores before the REDD group (Mdn=25); Z=-2.214, p=0.027. There was no significant difference in scores on any of the other scales (Table 6).  

49
Table 6: The results of a Wilcoxon Signed Rank test used to compare pre- and post-REDD group scores on the CORE-OM.

<table>
<thead>
<tr>
<th></th>
<th>Median (pre)</th>
<th>Median (post)</th>
<th>Z</th>
<th>Sig. (p&lt;0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full</td>
<td>20</td>
<td>16.2</td>
<td>-1.481</td>
<td>p=0.139</td>
</tr>
<tr>
<td>Functioning</td>
<td>16.7</td>
<td>13.3</td>
<td>-1.248</td>
<td>p=0.212</td>
</tr>
<tr>
<td>Problems</td>
<td>25</td>
<td>18.3</td>
<td>-1.472</td>
<td>p=0.141</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>25</td>
<td>22.5</td>
<td>-2.214</td>
<td>p=0.027</td>
</tr>
<tr>
<td>Risk</td>
<td>10</td>
<td>5</td>
<td>-1.892</td>
<td>p=0.058</td>
</tr>
</tbody>
</table>

FFMQ

Five clients completed the FFMQ pre- and post- treatment and the outcomes were compared. Overall, average scores on each scale of the FFMQ increased after the “REDD” group, indicating increased levels of mindfulness in each of the five facets (Figure 10).

A Paired Samples t-test was used to compare scores on the FFMQ pre- and post- attendance at the REDD group, as the data was found to be parametric. Analysis identified a significant increase in scores on the Observe scale after the REDD group (M=3.59, SD=0.5) compared with scores before the REDD group (M=2.74, SD=0.92); t(4)=-2.94, p=0.042. There was also a significant increase in scores on the Non-judgement of Inner Experience scale after the REDD group (M=3.14, SD=0.61) compared with scores before the REDD group (M=2.22, SD=0.54); t(4)=-3.21, p=0.033. There was no significant different in scores pre- and post- treatment for any of the other scales (Table 7).
Table 7: The results of a Paired Samples t-test used to compare pre- and post- “REDD” group scores on the FFMQ.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>t</th>
<th>Sig. (p&lt;0.05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe</td>
<td>-0.84</td>
<td>0.64</td>
<td>-2.94</td>
<td>p=0.042</td>
</tr>
<tr>
<td>Describe</td>
<td>-0.46</td>
<td>0.88</td>
<td>-1.17</td>
<td>p=0.31</td>
</tr>
<tr>
<td>Act with Awareness</td>
<td>-0.78</td>
<td>0.93</td>
<td>-1.87</td>
<td>p=0.13</td>
</tr>
<tr>
<td>Non-judgement of Inner Experience</td>
<td>-0.92</td>
<td>0.64</td>
<td>-3.21</td>
<td>p=0.03</td>
</tr>
<tr>
<td>Non-reactivity to Inner Experience</td>
<td>-0.14</td>
<td>1.08</td>
<td>-0.29</td>
<td>p=0.79</td>
</tr>
</tbody>
</table>

Overall, based on the above evaluation of REDD, significant reductions in distress scores were registered on the obsessive compulsive scale, positive symptom distress, as well as wellbeing distress score. At the same time, women developed mindfulness skills in observe, non-judgement and inner experience facets. These positive quantitative findings are complemented by interviews with staff and clients which provide further insights into the outcomes of REDD, as well as lessons learnt.

Verbal feedback from the group was positive. Group member saying they felt the group had “been made for them” and that they would recommend it to others. One member recalled her account as being “it is the silly things that work” and another describing it being “what she had always needed”. One case study, perhaps atypical for Anawim’s clients, provides a good comparison of services and is told through the eyes of the young client K.

**Case study: K.’s experience**

K. experienced physical and emotional abuse since she was 5 and sexual abuse since she was 8. This carried on until she was 14-15 years old, when she shared her trauma with a friend who then informed the college and the relevant authorities got involved. As in many of this cases, her mu did not believe her and she went through 2 very tough years before finding any relief. Once her abusive experience came to light she was referred to Forward Thinking Birmingham, the city’s mental health partnership for 0-25 years old. As K recounts, weekly meeting were set with a psychiatrists and care coordinator, for the first 6 months, after which meetings were held every couple of months. In 2016 she was referred to Anawim because Forward Thinking did not provide trauma support courses, just mindfulness. After recently finishing REDD, K. just started TREM which “set me back a bit. I’m feeling horrible. I discussed some of my trauma today: the smart thing is that REDD came first, before getting on the heavy stuff [in TREM]. [In REDD] I learnt how to focus on my temperature, hunger and on this interview, I am trying to stay in the moment than live through flashbacks”. K is very
honest and blunt: “I didn’t like Anawim at all, at first. They [Anawim staff] care too much. They are too sensitive, I didn’t know how to react to it’. This obstacle is the result of K. transition from one service to another, as she puts it: “Forward Thinking was very clinical. They had clinical rooms, most of the doctors were very soft spoken, and always had a lot of solutions to problems. I couldn’t feel what they thought or felt. I liked that because I didn’t feel anything when I talked about my trauma. When I came to Anawim it was all ‘Oh, you poor girl!’, ‘we respect you and you are a strong woman’. I think of my mental health as of a cold that I can treat with medicine and it will go away. Anawim is a comfort now because it’s not strange anymore. Issha [K’s case worker] warmed me up to Anawim. She was so emotive. She wouldn’t expect anything of me, ‘tell me whatever you want’, she would say. I would tell her about my cat, school and then I’d feel more comfortable, like I’d be talking to a friend, not to a doctor -‘tell me your symptoms and I’ll tell you the solution’. Both organisations had a massive positive impact”. Indeed, K. recovery from trauma required both the “clinical service” to help her identify her trauma and open up about it, as well as the more “emotive” Anawim support in order to “warm her up”, to support her in finding “feelings” again.

As for REDD, K. is a very bookish person, she likes immersing herself into psychology books, and is very reflective of her readings and experiences. So K. is frank when she talks about the coping strategies taught on REDD “I knew everything already, it may sound arrogant, but I am a studious person. I learnt mindfulness in 2016, so I knew how to breathe and to keep myself grounded. I knew these”. Nevertheless, she was herself surprised to realise that “I wasn’t implementing them [coping strategies] regularly. The lead psychologist would talk about vulnerabilities and would go in more detail then when I had discovered mindfulness for the first time”. When asked about the group work on REDD, K. admits “at first, I didn’t like group work. It was difficult to share things in a group of people because I lost a lot of hope because of what happened to me. But you open up to people when you see sad people and you see how much effort the staff put into the course - she [the lead facilitator] was very sincere and genuine. She was genuinely listening to us and taking it on board. It was a powerful thing”. Despite her familiarity with mindfulness, one of her favourite activities learnt on REDD is “a breathing exercise with this beautiful bell. She [the facilitator] would hit it, making a beautiful sound. It would reverberate through my body and it would encompass the whole of me. I’d just be calm”. K. would have liked more such activities, interactive exercises catered to different audiences, where participants have greater involvement in.

Staff at Anawim, such as course facilitator Caron Runham, share K. views that “activities are often very simple but very helpful”71. Caron, one of the REDD facilitators, describer one of her favourite “distress” activity – “it is about changing body temperature in order to ‘bring you back’ because of its effectiveness”. Gel masks are put in cold water and

71 Interview with Caron Runham, 2017.
distributed to participants who use them to cover their faces for one minute. The reaction is that of “shock” at how effective the coldness of the masks is in dealing with anger, panic attacks and anxiety; a can of juice or a jar of gem from the fridge will do the trick. Indeed, “it’s so simple that you don’t think about it”.

Another example of an effective activity taught on REDD is about regulating emotions. The purpose of this exercise is to recognise the existence of “wise” and “irrational” “frames of mind” and learn how “to reframe bad thoughts”. Clients give an example of a “frame of mind” and then they are taught how to evaluate it by asking themselves if it is true or not. If it’s identified as being an irrational thought, then they have to go into the “wise mind”. In order to facilitate the evaluation of their thought, Tibetan singing bowls and leaves are provided. Women are asked to describe the leaf and hit the bowl after 2 minutes which means the description time has ended. They then have to describe their perception and experience so that they see the difference between “a leaf is green” and “a leaf is ugly”. In other words, they are guided through the process of differentiating between facts and associations, between factual and perceptive reality. Caron recalls the reluctance with which the exercise is first received: “When they first start, women think, it’s a bit fluffy, mindfulness is, but then they see the practical benefits of this toolbox. I can see the progress in women and that they are taking something away with them, it is all about learning coping skills”\(^{72}\).

Attendance has been quite low and clients who miss more than 3 sessions get discharged. Anawim has tried hard to maintain high attendance on the courses. Hayley, one of the psychologist assistants, calls clients every week the day before the sessions take place to encourage their attendance.

4.2.4. Seeking Safety

Seeking Safety is an evidence based group therapy focussed on helping high risk women attain safety from trauma/Post Traumatic Stress Disorder (PTSD) and substance abuse. Most clinical programmes treat PTSD or substance abuse, but rarely both. Seeking Safety accepts that trauma and substance abuse are associated with one another and focuses on the underlying precipitating factors for substance use, which are also likely to be associated with other offending behaviour, such as acquisitive crime.

This course started as a partnership with the police who commissioned it. It was part of the New chance project aimed at diverting people away from the prison system. Women entering police custody with needs associated to trauma, mental health, and substance misuse could be diverted from the CJS to attend Anawim for the proposed Seeking Safety programme, alongside the pre-existing Anawim holistic support.

Partnership working between mental health and the CJS has made progress in terms of early identification, assessment and consultation models to support women.

\(^{72}\) Ibid.
offenders. To date, most intervention models are only available in prisons for women on long sentences or within secure psychiatric hospital settings rather than in the community where the majority of this group reside. Women offenders with complex needs are also costly to public services, often presenting in crisis and unable to engage in mainstream services due to chaotic lifestyles and interpersonal problems. Equally, mainstream public services struggle to design interventions that can meet their multiple needs. The piloting of this intervention is aimed at show-casing how one such intervention could be offered as a diversion from the CJS route for these women.73

Seeking Safety is run by psychologists for 21 weeks, each session is 1h 30 minutes long, and there are 5 modules to go through. The course comprises two stages. The initial stage is 8 weeks long and is about stabilising the clients through low level of psycho-education. The second stage is 12 weeks long and is based on a CBT model focussed group around trauma, mental health, substance misuse, relationships, offending behaviour etc.

Usually 6-8 participants sit on the course and every 4 weeks a new member can join. Before clients can get on the course, referrals made by police are evaluated, initial appointments are set with clients, clinical interviews and pre-group assessments with psychologist are set, and finally initial formulation and crisis plans are developed.

Unlike TREM, the aim of the Seeking safety course is to enable participants to talk about the impact of their trauma on their current life, rather than about the trauma itself. Sometimes people want to talk a lot about the past, but then are unable to manage overwhelming feelings and memories that come up. The goal is to help clients establish safety first and to learn strategies to cope with intense negative feelings. Once they mastered these, they can and should move on to talking in depth about the past. The course seeks to help clients understand themselves, to develop a new identity as someone who can cope successfully with life, and to respect who they are. Each topic focuses on a specific strategy to help them cope with trauma and substance abuse. Examples of topics include: Introduction to Seeking Safety, Support, Self-care, Substance Issues, Recovery, Emotion Regulation, Achievements and Goals. The treatment is evenly divided among behavioural, cognitive and interpersonal topics.

At the start of each session, clients are asked how they are feeling and what good coping have they done since the last session. The rest of the session is aimed at finding ways in which to apply the concept to current problems they have. It is an opportunity to practice a new strategy, such as role plays, or an in-session practice exercise. At the end of the session, participants are asked to give feedback on the session and to name one action they can commit to before the next session.

The course is not running at the moment because there is a freeze on referrals. The attendance on the course is not compulsory because only the probation orders can have

73 Sarah Shanahan, bid for “Seeking Safety”, Anawim.
conditional caution, while the police can only make referrals on a voluntary basis. The police do not monitor people’s attendance as a probation officer would do and even the probation officer would be able to enforce only some degree of compulsory attendance. This is likely to have an impact on the level of engagement and motivation of these women with multiple and complex needs.

4.3. Cost savings

A cost benefit analysis has been carried out on several case studies to estimate the savings preventive and adequate community provisions, such as Anawim, can make to public services and more importantly to clients’ own lives and that of their families.

An effective way of understanding costs vs savings analysis, both on short and long-term, from a financial, as well as health and wellbeing point of view, is to look at the outcomes a “one stop” service such as Anawim offers.

<table>
<thead>
<tr>
<th>Reduced offending</th>
<th>Police, CRC, courts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced re-offending</td>
<td>National prevention service (NPS), children’ services, MoJ, DWP, Housing as well as Police, CRC, courts</td>
</tr>
<tr>
<td>Children prevented from going into local authority or family care</td>
<td>Children’s services, social care, health, family courts, Schools in extra-pastoral care</td>
</tr>
<tr>
<td>Stable accommodation</td>
<td>Housing associations, Council</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>Health, GPs, A&amp;E, Police, Drug services</td>
</tr>
<tr>
<td>Tackling the root cause - e.g. of shoplifting, sex work, anti-social behaviour</td>
<td>Police, health, local authority</td>
</tr>
<tr>
<td>Improved financial skills - avoiding debt and accessing benefits</td>
<td>DWP, Local authority, Housing, Police, Courts, Children services, Schools</td>
</tr>
</tbody>
</table>

Two case studies are presented next, followed by a cost analysis.
**Case study: L.’s story**

L. joined the service in June 2015 following serving a prison sentence for Arson with intent, which was an attempt to take her own life - she had not hurt or intended to hurt others. L. has a long history of childhood sexual abuse, DV relationships in adult life, drug and alcohol misuse and sex working. During her time at Anawim, L. has relapsed several times with alcohol as she struggles with her memories of childhood, she also struggles with safeguarding herself from abusive relationships with men.

She engaged well with Anawim and completed various courses during her time here including Drug and Alcohol awareness, DV course and various workshops by Crisis. L. also took part on TREM but was unable to complete the full course as numbers dropped and the course was put on hold after week 7/8.

Unfortunately, in December 2016 L.’s mental health deteriorated after she was the victim of a sexual assault. She was admitted to the Oleaster mental health unit as she was very unwell.

Over several weeks her health improved and she was visited by the caseworker and the floating support worker, both of which improved her confidence and gave her the strength to give a partial statement to the police regarding the assault. L was vulnerable and due to her complex vulnerabilities the Oleaster felt that it would not be safe for her to ever return to live in her property. Over the course of several weeks the caseworker approached many housing associations and providers asking for help, only for them to say no due to the arson conviction as their insurance often do not cover them. In desperation even options as far afield as Wales were considered.

The caseworker took L. to Newtown Neighbourhood office where she presented as homeless. That same day she was placed in temporary accommodation, where she immediately felt safer, more settled and her confidence built up each day. L attended Anawim frequently and engaged well on courses. The council provided her with a pin number and she would bid each week for a property. Within 4 weeks she was offered a viewing at position 1. The property was owned by Midland Heart and Anawim staff were concerned that despite viewing it at position 1 that they would then refuse her because of her arson offence as they had done weeks before when they were approached through the Direct Let avenue. Fortunately, the lettings officer that dealt with the case was extremely helpful & sympathetic, demonstrating a deeper understanding of her circumstances. Evidence was provided by Anawim staff to demonstrate L. no longer posed a risk and had worked hard on her personal development to get herself to a better place and how she had worked to improve her circumstances. The fact that robust support measures were available both in the week and at weekends should L. feel she required help, further reinforced her case. Midland Heart agreed that the client would be a suitable tenant as there was sufficient track progress and support measures in place. The client moved in recently and is continuing to thrive and make fantastic progress in building a new life for herself.
A) Cost benefit analysis for L.

The costs of L.’s support at Anawim are broken down into various elements as shown below.

Table 8: Cost benefit analysis for LB client

<table>
<thead>
<tr>
<th>Support</th>
<th>Unit Cost</th>
<th>Time Spent (hours)</th>
<th>Number of Sessions</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to One appointments</td>
<td>£14</td>
<td>1</td>
<td>29</td>
<td>£406</td>
</tr>
<tr>
<td>Other support (letters, telephone calls, liaising with external agencies etc.)</td>
<td>£14</td>
<td>70</td>
<td>N/A</td>
<td>£980</td>
</tr>
<tr>
<td>Star Appointment</td>
<td>£14</td>
<td>1.5</td>
<td>7</td>
<td>£147</td>
</tr>
<tr>
<td>Money Advice</td>
<td>£14</td>
<td>1.5</td>
<td>7</td>
<td>£147</td>
</tr>
<tr>
<td>Mental Health One to One</td>
<td>£14</td>
<td>1</td>
<td>51</td>
<td>£714</td>
</tr>
<tr>
<td>Floating Support one to one (including weekends)</td>
<td>£14</td>
<td>1.5</td>
<td>42</td>
<td>£882</td>
</tr>
<tr>
<td>Domestic Violence course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Positive Moves Course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Drugs and Alcohol Course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Heal Your Life Course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>TREM Course</td>
<td></td>
<td>10</td>
<td></td>
<td>£650</td>
</tr>
<tr>
<td>Flip the Script Course</td>
<td></td>
<td>7</td>
<td></td>
<td>£168</td>
</tr>
<tr>
<td>Health and Well-being course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Beauty course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>£4,094</strong></td>
</tr>
</tbody>
</table>

Overall, the cost of L.’s support from Anawim was of approximately £4,094.
**Cost benefit analysis on savings for public services.**

The following table indicates the costs that the public services incurred from L.B.’s case.

*Table 9: Cost benefit analysis on savings for public services for LB client*

<table>
<thead>
<tr>
<th>Support</th>
<th>Unit Cost</th>
<th>Sessions</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrest</td>
<td>£593</td>
<td>1</td>
<td>£593</td>
</tr>
<tr>
<td>Police time</td>
<td>£40</td>
<td>5</td>
<td>£200</td>
</tr>
<tr>
<td>Ambulance Call Out</td>
<td>£216</td>
<td>2</td>
<td>£432</td>
</tr>
<tr>
<td>A &amp; E</td>
<td>£134</td>
<td>2</td>
<td>£268</td>
</tr>
<tr>
<td>Hospital Day Case</td>
<td>£720</td>
<td>2</td>
<td>£1440</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>£1863</td>
<td>3</td>
<td>£5589</td>
</tr>
<tr>
<td>Mental Health Provision</td>
<td>£6540</td>
<td>2</td>
<td>£13080</td>
</tr>
<tr>
<td>Drug Misuse Treatment</td>
<td>£9234</td>
<td></td>
<td>£9234</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>£30,836</strong></td>
</tr>
</tbody>
</table>

The total cost incurred by the public service in LB’s case amounts to £30,836. This means that for every £1 spent at Anawim, £7.42 of social value was created.

**Case study 2**

a) **Cost benefit analysis for C**

*Table 10: Cost benefit analysis for C.*

<table>
<thead>
<tr>
<th>Support</th>
<th>Unit Cost</th>
<th>Time (hours)</th>
<th>Number of Sessions</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to One appointments</td>
<td>£14</td>
<td>1.5</td>
<td>10</td>
<td>£210</td>
</tr>
<tr>
<td>Other support (letters, telephone calls, liaising with external agencies etc.)</td>
<td>£14</td>
<td>7</td>
<td>N/A</td>
<td>£98</td>
</tr>
</tbody>
</table>
The cost of C’s support from Anawim was of approximately £2,800.

**b) Cost benefit analysis on savings for public services.**

The above table is based on assumptions that the client would continue to follow previous behaviour patterns in respect to arrests, drugs and self-harm.

*Table 11: Cost benefit analysis on savings for public services for C Client*

<table>
<thead>
<tr>
<th>Support</th>
<th>Unit Cost</th>
<th>Sessions</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrest</td>
<td>£593</td>
<td></td>
<td>£593</td>
</tr>
<tr>
<td>Police time</td>
<td>£40</td>
<td>3</td>
<td>£120</td>
</tr>
<tr>
<td>Ambulance Call Out</td>
<td>£216</td>
<td>3</td>
<td>£648</td>
</tr>
<tr>
<td>A &amp; E</td>
<td>£134</td>
<td>3</td>
<td>£402</td>
</tr>
<tr>
<td>Hospital Day Case</td>
<td>£720</td>
<td>3</td>
<td>£2160</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>£1863</td>
<td>3</td>
<td>£5589</td>
</tr>
<tr>
<td>Drug Misuse Treatment</td>
<td>£9234</td>
<td></td>
<td>£9234</td>
</tr>
<tr>
<td>Mental Health Provision</td>
<td>£6540</td>
<td></td>
<td>£6540</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>£25,286</strong></td>
</tr>
</tbody>
</table>

* The above figures were taken from Police/NHS reports in 2015.
The above analysis shows every £1 cost for Anawim benefits public services by £9.03.

**Case study 3**

VK had serious financial problems when she arrived at Anawim. This affected various parts of her life. Client’s mental health conditions have worsened dramatically, attempted to commit suicide and increased her medication.

**a) Cost benefit analysis for VK**

*Table 12: Cost benefit analysis for VK*

<table>
<thead>
<tr>
<th>Support</th>
<th>Unit Cost</th>
<th>Time Spent (hours)</th>
<th>Number of Sessions</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>One to One appointments</td>
<td>£14</td>
<td>1</td>
<td>80</td>
<td>£1120</td>
</tr>
<tr>
<td>Other support (letters, telephone calls, liaising with external agencies etc.)</td>
<td>£14</td>
<td>40</td>
<td>N/A</td>
<td>£560</td>
</tr>
<tr>
<td>Management Support</td>
<td>£18.07</td>
<td>1</td>
<td>3</td>
<td>£36.14</td>
</tr>
<tr>
<td>Star Appointment</td>
<td>£14</td>
<td>1.5</td>
<td>3</td>
<td>£63</td>
</tr>
<tr>
<td>Review</td>
<td>£14</td>
<td>1.5</td>
<td>2</td>
<td>£42</td>
</tr>
<tr>
<td>Money Advice</td>
<td>14</td>
<td>1</td>
<td>40</td>
<td>£560</td>
</tr>
<tr>
<td>Mental Health One to One</td>
<td>14</td>
<td>1</td>
<td>30</td>
<td>£420</td>
</tr>
<tr>
<td>Numeracy course</td>
<td></td>
<td></td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>Literacy Course</td>
<td></td>
<td></td>
<td>4</td>
<td>N/A</td>
</tr>
<tr>
<td>Seeking Safety</td>
<td>65</td>
<td>1</td>
<td></td>
<td>£65</td>
</tr>
<tr>
<td>Goals course</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>IT</td>
<td>30</td>
<td></td>
<td>10</td>
<td>£300</td>
</tr>
<tr>
<td>Hula Hooping</td>
<td>28</td>
<td></td>
<td>10</td>
<td>£280</td>
</tr>
<tr>
<td>Creative Writing</td>
<td>10</td>
<td></td>
<td>10</td>
<td>£100</td>
</tr>
<tr>
<td>Drugs and alcohol</td>
<td></td>
<td></td>
<td>1</td>
<td>N/A</td>
</tr>
</tbody>
</table>
b) Cost benefits analysis on savings for public services.

Table 13: Cost benefits analysis on savings for public services for VK client.

<table>
<thead>
<tr>
<th>Support</th>
<th>Unit Cost</th>
<th>Sessions</th>
<th>Total (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arrest</td>
<td>£593</td>
<td>2</td>
<td>£1186</td>
</tr>
<tr>
<td>Police time</td>
<td>£40</td>
<td>5</td>
<td>£200</td>
</tr>
<tr>
<td>Ambulance Call Out</td>
<td>£216</td>
<td>2</td>
<td>£432</td>
</tr>
<tr>
<td>A &amp; E</td>
<td>£134</td>
<td>3</td>
<td>£402</td>
</tr>
<tr>
<td>Hospital Day Case</td>
<td>£720</td>
<td>3</td>
<td>£2160</td>
</tr>
<tr>
<td>Hospital Inpatient</td>
<td>£1863</td>
<td>3</td>
<td>£5589</td>
</tr>
<tr>
<td>Mental Health Provision</td>
<td>£6540</td>
<td></td>
<td>£6540</td>
</tr>
<tr>
<td>Prison</td>
<td>£40000</td>
<td></td>
<td>£40000</td>
</tr>
<tr>
<td>Counselling</td>
<td>£35</td>
<td>24</td>
<td>£840</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£57,349</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

£1 spend at Anawim benefits the public services by £13.33.
Overall, these three case studies illustrate the substantial savings community services such as Anawim bring in comparison with the cost that public services would otherwise incur. More significantly, what should not be forgotten is the impact that this service can bring to the lives of the clients and their families when made available earlier rather than later. Given the budget cuts that public services are now facing, by not providing a timely and appropriate care that women with multiple needs require, means that services such as police and Social Services spend a vast amount of time dealing with problems that they are not adequately trained to deal with and which side-track them from their main priorities.

Against a backdrop of cuts in social care and health services, according to 2016 reports, as much of 40% of the UK police time is spent dealing with incidents which involve individuals who suffer from mental health issues; this figure is likely to be an underestimate due to the difficulty of identifying mental health issues by the police. Over a three year period, 2011-2014, these incidents grew by a third and the trend is likely to continue upwards. Concerns were raised by various police committees and institutions over the mishandling of mental health incidents. Police officers get a minimum of two days training in mental health, but as Joanne McCartney, chair of the London Assembly’s Police and Crime Committee, stated: “they are not best placed to do that. They are not mental health professionals.”

Alex Marshall, head of the College of Policing, also stressed that: “There is a real risk the high number of cases that frontline police deal with is because the police are stepping in where other agencies would have provided the support.”

Short-term detention orders for individuals experiencing a mental health crisis means that they have to be taken to a “place of safety” which is normally a hospital, according to sections 135 and 136. These sections allow a warrant to be granted by a magistrate to search for and remove a mentally disordered person to a place of safety. The police officer who attends must be accompanied by an approved mental health professional. “Data available from 22 forces showed that for 74% of section 136 orders where a health based place of safety was used, the police provided transport to the hospital.” This takes time particularly when safe units are full: “one in ten units told the CQC that they turned people away at least once a week because the place of safety was occupied” and “if there is no space, the patient waits outside in a police van” which takes up further police time. “A recent HMIC Inspection found that waits of 6 to 8 hours for police officers in these cases are not uncommon – which equates


75 Ibid.


to an additional 62,000 hours a year”78. West Midlands is an example of good practice which from 0% increased to 98% capacity of providing the appropriate “place of safety” provisions. This example should be followed in order to free police “waiting time” at hospitals where possible; yet this does not solve the problem of the time police spends in dealing with mental health issues prior to bringing individuals to “places of safety”.

Social Services, same as police, are under strain due to the high number of parents with mental health problems that they have to deal with. “Around 450,000 parents have mental health problems. Poor parental mental health is significantly associated with children’s own mental health and their social and emotional development”79. For example, the children of parents with mental ill-health are twice as likely to experience a childhood psychiatric disorder” as “maternal mental health has a significant impact on child development and the wellbeing of families”80. It hence comes as no surprise that the risk for children’s raises when mental health issues coexist with substance abuse and domestic violence.

An often overlooked cost, due to its partly “invisible” nature, when dealing with clients with multiple needs is the cost of social exclusion. “The failure to address social exclusion can levy high costs on children, parents, families, the community and wider society, in terms of poor life experiences and future prospects”81. The loss of productivity and of policing anti-social behaviour are key elements. “Families experiencing five disadvantages (depression, alcohol misuse, domestic violence, periods of homelessness and involvement in criminality) can cost the state between £55,000 and £115,000 a year”82. This figure does not take into account physical health and any other special needs costs that a child could require given his/her experience of a traumatising childhood. Adverse Childhood Experience (ACE)83 study found that those who were identified as having experienced in their childhood four or more out of the ten following factors were more likely to have a medical condition: recurrent and severe emotional abuse, physical abuse, sexual abuse, emotional and physical neglect, both biological parents not being present, a mother being treated violently, an alcoholic or drug-using family member, a mentally ill family member and a family member being imprisoned.

78 Ibid.
80 Ibid.
81 Ibid.
Additionally, in cases where the mother is incarcerated, the cost for every child who has to be looked after by the state is of £50,000 per year.\textsuperscript{84} Moreover, there is a strong need to prevent these children from becoming potentially (unpaid) carers and ensuring that they are offered a choice to a healthier lifestyle where they can also be more active contributors to society.

To sum up, preventive and “one-stop” services cut costs and time to public services which are already under pressure. They can prevent a “domino effect” that affects not only clients suffering from mental health issues but also their family, community and society.

\textsuperscript{84} Nicola Carroll (2016) Taking forward women centred solutions. Women Centred Working. 
5. Early intervention – New Chance

In addition to the therapeutic programmes, Anawim has been involved in a number of projects aimed at diverting women from the criminal justice system into community services where they can receive the support they need. The “New chance” project is aimed at people of 18-40 years old who have been arrested less than 5 times and have no convictions; they could be on conditional caution, community resolution or voluntary. The project is in partnership with and funded by the Police and Crime Commissioner. The main objectives are as follows:

- To offer a viable diversion from women who are at risk of getting a criminal conviction
- To provide structured one-to-one initial assessment/triage to develop a short term individual support plan to establish the clients priority needs.
- To initiate clients into internal and external courses and group activities that raise self-esteem, confidence, skills, awareness and social responsibility.
- To provide space at the Centre for women to drop in when needed to receive support, clothes, food, a wash, rest and use of the phone and Internet.
- To provide advocacy for the women and their children with social care and health, education, work providers and the criminal justice system and the wider community whilst the duration of early intervention.
- To provide assistance and support to women at court, pre arrest or on arrest and in the bail hostel in a flexible way, responding where and when it is needed.

Once the police refer clients to Anawim, a support worker makes contact within 3 days via text, phone call, visit or letter. If the client fails to engage, the issue is reported back to the referral officer. If the client engages, a face to face initial meeting takes place. Once immediate needs are met and clients are stabilised, they are encouraged to attend Anawim courses based on their development plan. New Chance clients have benefitted from attending, among others, Maths, English, Parenting, Domestic Violence, and the therapeutic programmes.

In Birmingham “New chance” started in June 2016 and up to April 2017, 124 women have been referred. The majority of these women suffer mental health issues, some of which are severe including PTSD and Bipolar disorders. Figure 11 indicates the multiple needs identified among a randomised sample of 24 clients. Out of 6 needs, 5 were very common in most clients; these needs in ascending order included “skills and employment”, “accommodation”, “health”, “finance” and “attitude”.
Figure 11. “New chance” women’s needs based on a random sample of 24 clients

**Outcome Star**

This Outcome star shows the distance travelled for the “New Chance” caseload for a sample of 74 women. During this quarter positive outcomes were recorded in several areas, with the most significant improvement being for offending, from scale 7 to scale 10. Except “meaningful use of time”, progress has been recorded in all other areas.

Observations and self-reflections presented in the following two case studies help paint the positive outcomes clients achieved.
Case study: X.T.’s early intervention

X.T., from the Chinese community, was presented with depression and anxiety. She was not feeling worthy for the huge amount of shame that she felt she had caused to her family because of the offence she committed. Once referred to Anawim, she was always on time and keen to engage. X.T was supported to engage with mental health services which really improved her anxiety and depression. X.T attended numeracy and literacy classes at Anawim in order to communicate more effectively and to help her children with school work. She socialised after classes and made friends. X.T looks to continue taking classes in her own area. She has been encouraged to volunteer at her children’s school, feeling more a sense of self-worth and pride. Since engaging so well PC was happy to close her file and X.T no longer feels like she has let her family down. Shame and humiliation are defining concepts for the Chinese culture, but as this offence will not go on her permanent record she feels less that she has blackened the family name and can start afresh.

The best reflection of the outcomes of the “New Chance” project is reflected in the words of one of the service users who wrote a thank you letter to Anawim staff:

Case study: Letter from Client J

I’m writing this letter regarding the support at Anawim.

I have been using the services since July 2016. At this time I was in a terrible place mentally and had no hope. After years of trauma and endless support workers from various place I can honestly say I have never experienced such warmth and support that I have here at Anawim. It helped me so much, having the support when I needed it the most is the reason I am where I am today. I had the support through the hardest part in my life. From support throughout my court case down to support with my health. Jas and Rowanne believed in me even when I couldn’t believe in myself. They understood my emotions and guided me on the right path. My whole outlook on life and who I was changed. I addressed my emotions and now I can handle situation a lot better. My confidence has grown and I now value and respect myself a lot more. I can manage my anxiety better that what I could, thanks to Anawim I now have faith that I can lead a life made of good choices and be where I want to be, I wouldn’t have got through court without the support. I’m forever grateful. I now want to help women who have survived domestic violence and tell my story to help people. Thanks to Anawim I now have the opportunity to get this path and I’m meeting with someone from BVSC to discuss and opportunity to do this. I’ve turned my life around and the life skills as well as all the support and positive feedback I have had from my support workers I will hold with me forever.
6. Liaison and Diversion

The Liaison and Diversion (L&D) Programme was the result of the Bradley Report (2009) which recommended ways to divert people with mental health problems and other vulnerabilities away from the criminal justice system. L&D was established in 2014 by the Department of Health in ten trial sites. Birmingham began with a small pilot in 2015, and was recognised as a Wave 3 scheme in 2016. L&D services aim to: improve overall health outcomes by preventing crisis point moments and ensuring the right support is available through the criminal justice system; reduce re-offending rates; inform sentencing decisions, limit the number of court hearings and avoid potentially high-cost adjournments; deliver awareness training to police and staff at the custody suite in order to improve their understanding of female offenders with complex needs.

The L&D services identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. Once someone is identified as having a potential vulnerability, the L&D practitioner can go through screening questions to identify the need, level of risk and urgency presented; this is then followed by an in-depth assessment which enables the support worker to refer people for treatment to the appropriate services. The information and assessment of the L&D services is used to support the Police, Probation and Judiciary to make informed decisions about case management, sentencing and disposal options.

The L&D at Anawim work closely with practitioners who refer clients who committed an offence to Anawim. At the moment of the arrest, practitioners triage those who have vulnerabilities and refer them to Anawim with a completed referral form. The L&D Anawim team comprises two experienced support workers, plus some management input funded by NHS England through BSMHFT. The support workers input the client’s details into the internal data system and with help from L&D, take responsibility for supporting the person referred. The first contact with the client is normally completed over the phone. Two paths can be followed from here. If clients choose not to engage, the L&D team pay them a home visit, continue to attempt contact by phone, and send one 14 days’ notice letter. If clients cannot be reached, the case is closed. Alternatively, if clients engage, the next step is to set an appointment and set a personal plan for them. As Caron Runham, one of the L&D team members explains, this plan most often includes support with housing, mental health and finances. In weekly meetings L & D caseworkers now negotiate on a case by case basis and refer on to other workers within Anawim when necessary to continue their care.

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85 Interview, 2017.
Analysis based on data collected from April to September 2015 show that 68 females, 5 of whom under the age of 18 years old, were referred by the L&D team. Eight of these refused to fully engage or cooperate with the screening assessment, but of the remaining 60, many complex needs have been identified as indicated in Figure 13. Mental health was the main problem identified among 37 women - depressive illness (18), anxiety/phobia/panic/Post-Traumatic Stress Disorder (8) and Personality Disorder (7). Substance misuse was a second major problem with a fairly equal division between alcohol and drug misuse. Sixteen reported problematic drinking and 5 identified alcohol dependence. Eight of the women reported problematic Class A drug use, with a further three reporting dependence to Class A substances, and 11 reported other drug use at a problematic level and 1 identified dependence to substances other than Class As. Accommodation issues were also very common and 15 women raised this issue, with one of them mentioning extremely difficult living circumstances. Furthermore, nine identified themselves as being at current risk of self-harm or suicide, with a further one being at risk of self-neglect. Six were identified as being the victims of abuse. Most of the clients were aware of their problems as 35 had been recorded as having had previous contact with mental health services and nine with substance misuse services.

As psychologists Sarah Shanahan and Kay Garvey assessed:

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86 Shanahan and Garvey, *Women’s Pathway Analysis*, Birmingham and Solihull Mental Health Foundation Trust, 2016
87 Ibid.
Further feedback indicates that many of the L&D referrals were not considered to be at “early intervention” stage due to having significant complex needs and extensive CJS histories, often presenting with entrenched and “chaotic” behaviours. This may well be a genuine reflection of the level of complex needs in offending populations and the stage which services are at, where “early intervention” services are currently being used more as “crisis” services to deal with more entrenched offenders.

Out of the 196 women that were referred to Anawim and were continually monitored between September 2014 and March 2017, 68 (35%) had successfully had they needs met. No initial contact was established with 95 women (48%) despite repeated attempts through home visits, phone calls and letters. Likewise, 25 women (13%) chose to disengage from the service, while the remaining others requested the file to be closed, declined support or referrals were identified as inappropriate. The high percentage of initial failure to engage or make contact may flag up potential mistrust in the health and police system based on previous experiences, as representatives of these services are the ones who make contact with the client in the custody suite. If more resources were available, L&D Anawim staff members could be present in the custody suite and make direct contact at the moment of the arrest, combating any preconceptions the client may hold while building trust.

Recently, the L&D team has to overcome several other obstacles. Until 2016 for some of the most common issues that clients raised with L&D, i.e. mental health and finance, Anawim was able to provide the necessary support on site. However, funding for the mental health team came to an end, which meant that Anawim was no longer able to allocate individual mental health caseworkers to clients. This posed a number of problems for vulnerable service users. First, safety and trust are two of the main features that clients valued at Anawim and that takes time to develop. Users tend to disengage when changes occur; phrases such as “clients don’t like changes” are commonly used among staff members. This is not surprising since “most clients had a trauma in childhood, suffered from domestic violence or have a personality disorder; the majority have anxiety and depression at some level and about 60% have complex and enduring mental health issues”.

Second, despite the fact that the L&D team have been trained to some extent in mental health and can deal with personality disorders and can offer dialectical behaviour therapy; for more serious issues Anawim now has to refer clients to their external services. As Caron Runham, the lead of L&D at Anawim, explains, one of the main issues is the lack of women only environment to refer them to. As discussed in the literature review, women benefit from women only spaces where they can be tended by female staff too. In addition, referral to other organisations can be

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88 Ibid
89 Interview with Caron Runham, 2017.
rather difficult as clients struggle to meet eligibility criteria. For example, at Shelter women have to meet three out of four criteria in order to be taken in: homelessness, substance misuse, mental health concerns and offending. Overall, considering that service users generally have abandonment issues, Anawim was able to provide a women staff only team who ensured the security and stability needed to balance against their traumas. Referring clients internally rather than externally is undoubtedly beneficial to their wellbeing.

Through the agreement that Anawim has with the NHS, all women should be referred to Anawim through “women’s pathway”. This is a phrase used in the Women’s Offender Personality Disorder (OPD) strategy to refer to the provision of “a pathway of psychologically informed services for a highly complex and challenging offender group who are likely to have a severe personality disorder and who pose a high risk of harm to others, or a high risk of reoffending in a harmful way”.90

So far, the NHS reports that:

The L&D service is a direct and vital link between the courts and support services ranging from mental health, housing, benefits and addiction support. Since the launch of the service, they have already seen a significant increase in the application and delivery of Mental Health Treatment Requirements, for example.91

According to Ravinder Rai, Senior Probation Officer working at Birmingham Magistrates’ Court, the L&D fills in the mental expertise gap that existed previously which now support a fairer application of wider sentencing options.92 The initial view was that if by 2017 the service proves successful, it will be extended at the National level; based on the outcomes presented, the L&D service has high growth potential. Nevertheless, L&D risks to become a crisis service rather than an early intervention service, unless appropriate measures are taken to ensure services are available in the community for prevention.

This is not considered a problem going forward as there is recognition centrally that L&D is not just seen as an early intervention but is capable of effectively supporting those with complex needs who are entrenched in the system by offering a diversion.

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92 Ibid.
7. Service user involvement:
Designing services, acting as mentors and volunteers

Anawim is encouraging the voice of its service users by the development of now two paid roles.

Adellah is a successfully rehabilitated young mother who has come at Anawim years ago with a complex past and multiple needs. Last year she has started working for Anawim in what she excitedly describes as being the professional life that used to be “beyond her wildest dreams”.

Case study: Adellah “We use our eyes, but do we actually see? And we use our ears, but do we actually listen?”

Adellah has come to Anawim in 2005 and then again in 2012 as a service user with a past dominated by domestic violence, crime and substance abuse. Her life has taken a new turn and after 3 years of recovery. Adellah’s story is too powerful to be narrated; her journey is presented next in her own words.

“My life consisted from the age of 17 of a domestic violence abusive relationship and that also involved substance abuse which spiralled out of control very quickly. I had two children at the age of 19. Loads of moving around, loads of chaos. I was developing a mental disability and not being aware of it at that time. It was only later on, when I was 33 that I was diagnosed with crack induced psychosis. From the age of 26 to 32 I used heroin as well as crack cocaine and all the other stuff that goes with it so alcohol, cannabis, pharmaceutical drugs, very chaotic lifestyle, crime, hit the roof with 10 times imprisonment, then the kids went into local authority care, homelessness for 3 years, loads of different probation orders, drug rehabilitation orders, loads of involvements with social services”.

She came to Anawim as a service user back in 2005, but “my head was nowhere near ready to listen to directions” and then she returned in 2012 through a court order, it was a Specified Activity Requirement. “When I came I still thought it was just another service that they don’t really care and that they just numbers in just to keep the funding coming and stuff. And then it felt completely different and I really got my foot stuck into it and I utilised the support and the tools that they had in place to progress and move forward. So I was here for 1 year and a half”.

Despite a tough start in life, Adellah has made great progress and regained her confidence “I’ve got over that now (...) It’s been 3 years since recovery, it feels like a dream (...) My life is completely different now, it is a life beyond my wildest dreams because I would only dream of having a life like this so for me to be living I have much to be grateful for but I know that there is so much more to come now”.

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While at Anawim, Adellah came across User Voice, a charity supporting ex-offenders, which was looking for forum members and which she joined. She then moved to London for 8 months to volunteer at an organisation where she worked with a mental health team on improving services for substance users and offenders. She returned to Birmingham to work with ex-offenders and to sit on the board of NHS England Liaison and Diversion. “I got a lot of work experience, I was out there on the street speaking to people and trying to get out the message that change is possible (…) My CV is quite impressive now, would kind of counterbalance my criminal record, I kind of have a lengthy criminal record”. In January 2016, Adellah received an email from her ex-support worker from Anawim regarding a job role that was advertised. “I looked at it and I thought oh my god, it’s a job! It took me 4 days to do the application form because it was lengthy – giving out dates and putting down your experience and then giving examples and I’ve not done that before and took a lot out of me to do. I came in to the interview and it felt surreal because these are the people I’ve got support from and now they interviewed me for a job. It did feel surreal. And then I got the job. I am grateful every day for I’ve been given these opportunities, I am grateful for the strength that I received to get through each situation”.

Adellah’s role was new for the service and new for herself so nobody quite knew what to expect, but at the same time “I was in limbo because I’ve never done this role before. I can be seen as quite confident, I can speak, I am not shy and things so maybe they assumed that I’ll be able to be creative in terms of forums and stuff and I wasn’t. I didn’t have much to do for the first couple of months. So I’d come in and I’d just be floating around. I need to keep busy, I am an active person and a kinaesthetic learner and sitting at the desk with stuff that it’s not very interesting is quite difficult for me to do. So I think the first couple of months were hard, but at the same time were exciting. Today, I’ve created two leaflets, I really pushed myself. If it’s something I am passionate about, it’s really easy”. Her current role became more defined in time as she found her place within the charity. Her role involves engaging women at an informal level, just conversing with them, having catch ups, assist them in any miscellaneous things that they need some supporting, inviting them to take part maybe in other activities outside Anawim, especially the ladies who are ready to move on and are more stable within themselves. Adellah has recently taken two women to attend a forum in Manchester revolving around the theme “do services promote abstinence in substance misuse?” “Because of the relationship that I built up with them I don’t allow them to feel that there’s me and them. I allow them to feel that we are friends but the boundaries are already set. So it felt like a group of friends going up to Manchester forum, but at the same time they know my role, they know my responsibilities and my boundaries.” The forum aims to get experiences from service users and ex-service users to feed into a bigger source to improve services around the country.

The interview happened to be timely as it marked a new chapter in Adellah’s life, as an employee at Anawim: “Yesterday was the first day when I identified myself as a professional only, even though I have been at Anawim as an employee for a year, it was only yesterday that I felt that I finally…because since the Christmas break holiday I’ve gone down a bit, it’s been a lot of pressure with life itself anyway (…) I interrupted my routine that I built up over the year due to these holidays and half term. It really took a lot out of me, so I missed a couple of
days of work due to my stress and when I came back I felt stressed because of how many things I was having to deal with. So yesterday when I had a chat with Joy [Director of Anawim] we have taken 2 tasks away from 3 so that I can focus my attention on the one main task that needs attention straight away. Since we did that and I had a chat with Joy about how I’m feeling, I still felt as a service user, a little bit as a token to the service, but I know that it’s all down to my perception. When I talked about it yesterday and I vocalised it, it made sense that that’s not what I am and I felt completely different. I transitioned into employment and away from my old life now. And last year was building me up to do it, it was a trial run. Remember I never had a job in this role ever. And I had loads of many other different jobs, cleaning jobs, catering jobs, security, bar, lots of different jobs, but never a professional job, so it’s a little bit bizarre for me”. Adellah recounts her journey with a smile on her face, focused on the present, on what the future has to bring, interrupted from time to time by reactions of disbelief of how she has tuned her life around.

Asked about the skills that she has improved since in work and the skills that are still to be improved, Adellah explained: “I doubt myself a lot. Now I am going to rephrase that – I am getting better at believing that I am capable of doing certain tasks. I put it down to the fact that I always needed approval, you know, it doesn’t just change like that overnight, so perhaps that’s why I have mentally kept myself back from excelling and that’s because of the old way of thinking and childhood stuff that don’t just go away. Now because I am aware of it, I know that I can improve it. But I learnt a lot, IT skills have really increased, my professional network with high calibre people (...) my academia is increasing, I started university, I am doing a youth and community degree at Newman College in Sept 2016. I have been out of education since year 8. So for me to go straight into my degree is pfaa [suggesting amazement]. The last 3 years have gone so fast and so many things have happened that I am only just catching up with myself. It was yesterday caught up with myself”.

Adellah is championing for more organisation to take on board ex-offenders because she knows the difference it can make to one’s life. “All service that support people in the community should have people who have successfully changed or turned their lives completely around to advice and guide by example (...) It’s the way forward. If you are trying to reintegrate people into community, you must then be prepared for those people to then be applying for jobs”.

This case study is one of many, and its positive effects are rippled not only at the individual level but at the community level. One of the lessons learnt is the confidence and stability that employment brings in the lives of substance users and offenders. “Access to employment is key but ex-offenders are 13 times more likely to be unemployed than anyone else. Getting a job is the single most important factor in reducing reoffending, cutting the rate by between a third and a half – a significant impact”.93

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Anawim was always built with the core heart of “Women Working Together” being central from the start. The Catholic Sisters who began the work utilised listening and befriending as their key technique and built the project around the services identified as required. Starting as a project, reaching out primarily to street workers ensured its roots were always with societies most vulnerable and marginalised. Their desire to reach the women took them into the places they were working and hence partnerships developed with Probation and Prisons. Anawim has been built on a non-hierarchical model, where being a woman is central and supersedes divisionary ideas of “professionals” vs “service users”, i.e. “us” vs “them”. This view sometimes sits in contrast with partners in the NHS and Probation and Prison where services are often more “done to” rather than “done with”. Nonetheless, both parties have learnt from each other.

Employing an ex-service user has been enlightening as well as challenging for both sides. Having someone with no experience in the employment world, but with a wealth of years of a chaotic lifestyle means things such as phoning in when off sick or having a crisis cannot be taken as a given. Being accountable for hours of work and distinguishing between home life and work, personal and professional profiles on social media networks are all a challenge. In employing the second women’s involvement worker the decision has been made to employ someone who is not an ex service user, this is working extremely well as she brings very different life experiences to play. Anawim’s plan is to train up women in weekly forums to take part in civic life; this can vary from increasing political activity such as initially registering to vote, sitting on interview panels, to learning how to effectively tell their story to highlight failings in the systems and demonstrate to commissioners and services how intervening at various points could have changed their trajectory. Joy Doal further explains Anawim’s future plans: “We have many differing ways that women can become involved in activities in the centre. In April 2017 we extended these and we are holding forums to develop their ideas along with our women’s involvement worker, Adellah. They will also be partnering with Women in Prison to contribute to their national Ready Steady Go magazine”.

More volunteers are being recruited who have relevant lived experience. For instance, volunteers are currently given the opportunity to staff the reception and to undertake a variety of small roles which will not only enable them to gain some work experience, but also to develop their skills and a growing sense of commitment and responsibility.
8. Conclusion

At a general level, there is a clear need for better recognition of mental health problems by professionals and timely referral into services. By continuing to raise awareness about mental health problems at both policy and societal level, “around a third of all people with a mental health problem [who] have sought no professional help at all”⁹⁴ may be encouraged to do so. However, if more people are likely to access the service, wider and faster access to treatment has to be facilitated. Likewise, interventions should not take place only in moments of crisis. Prevention is the key word which should be at the core of policymaking. Particularly for women who suffer from multiple and complex needs, holistic approaches and “one stop shop” type of services should be the path followed; it is more likely that clients engage with the service if they built up a relationship of trust with the staff and they can access everything they need in the same place. A structured and focused approach led by mental health caseworkers, in addition to group work and other therapies available, remains essential to the service.

The therapeutic programs offered by BSMHFT, part of their partnership with Anawim, has shown encouraging results across all four courses. First, TREM analysis indicated clinically significant improvement in trauma symptoms such as self-disturbance, post-traumatic stress, externalisation and somatisation. Women have expressed feeling “free-er” after disclosing their trauma to the group, as well as a feeling of belonging to the group and a better understanding of their life experience through the prism of the trauma endured. The sample for the qualitative analysis was small though, so Anawim should consider running the same analysis on a larger sample; the new TREM cohort could be used to substantiate the results above. This will also allow for a further assessment of whether TREM should be of a longer duration as some clients have so far suggested.

Second, the Stop and Think results point out not only the initial deficits in social problem skills among women engaged with Anawim, but more importantly demonstrate an increase to approximately normal levels of problem solving ability after completing the course. Third, REDD led to significant reductions in distress scores on the obsessive compulsive scale, positive symptom distress scale, as well as wellbeing distress scale. At the same time, women developed mindfulness skills in observe, non-judgement and inner experience facets. REDD has recently restarted and the previous positive outcomes are encouraging, but new ways to encourage and maintain attendance have to be developed in order to ensure the success of the course. Forth, Seeking Safety is an important course which allow women to focus on their present and deal with their immediate problems rather than digging up the past and invite to deep introspection as TREM does. However, the course has

not run long enough at Anawim and there was not sufficient data to extract for a significant analysis.

The social cost-benefit analysis shows the impact of the services offered by Anawim in relation to public services. On the one hand, on average £1 used at Anawim saves the public service between £7 and £13. Prevention is better than cure both for health and financial considerations. On the other hand, a consistent long-term support potentially prevents the snowball effect of multiple crisis, including violent behaviour and arrests, self-harm, substance addictions and hospitalisations, imprisonment and social care interventions. The focus should be on maximising the outcomes of preventive support rather than to use short interventions when already in crisis, however results for those already in crisis are equally encouraging.

Initiatives such as New Chance and Liaison & Diversion are extremely positive when combined with the women’s centre model. As for the prison reform changes, continuing to actively encourage the diversion of women from CJS to community services where their mental health needs and other problems can be addressed is key.

When looking more specifically at West Midlands, the Manchester model shows positive outcomes and should be followed, but the incorporation of a mental health team within the service is recommended from the early stages of designing it. Another lesson learnt from Manchester is the importance of getting all charities on board, part of the devolution process, of carrying out consultations and sharing best practice.

Based on the literature review, case studies, observations and data collected, a holistic approach aimed at women only and delivered in a women environment only is key to addressing mental health issues efficiently. Anawim’s successful work with psychiatric and psychological services in Birmingham, highlighted through the positive outcomes women registered, suggest that such partnerships should be paralleled up and down the country. The trauma courses particularly TREM and Stop and Think, and the general mental health support that Anawim provides brought an increasing number of referrals from Community Psychiatric Nurses (CPN’s) and Community Mental Health Teams (CMHTs). Anawim is becoming increasingly recognised within the NHS; the links forged with Ardenleigh and Callum Lodge have been exceptional.

This report not only advocates the availability of these partnerships and therapeutic courses in the community to women with multiple needs, but also preventative work which can reduce the need for more costly service provision, crisis intervention and hence longer term effects on both the individuals and their family.

More open and inclusive discussions held by decision-makers in the area of mental health services to which a variety of stakeholders from both public and private sectors are invited would also be welcome. Striving towards the same goal collaboratively would improve efficiency, overcome obstacles and create clearer pathways to navigate for both women in need and organisations which support them. This would ensure regular data collection and scrutiny of data on outcomes for women. Building an overall picture of the mental health
provisions in the community, whether private or public, is not an easy. Public signposting should be more readily available.

**Challenges**

There are challenges ahead not only of a systemic nature, but of more specific structural nature to Anawim. The sustainability of the mental health project discussed in this report is uncertain. Anawim relies on funding bids and once they run out, at times projects have to be interrupted and even stopped, losing all the hard work that was tirelessly put in and denying women in need the services that they require. Working on the long-term sustainability of its projects remains a challenge that Anawim is constantly looking to overcome.

In light of lessons learnt, stress and staff burnout can be common among difficulties encountered by staff members and appropriate support has to be in place from the very beginning. As within the majority of caring professions, workers have a tendency to give their all and more attention needs to be paid towards staff support and ensuring good work-life balances are maintained. Supporting women with multiple and complex needs can be emotionally and psychologically draining. The atrocities that these women have experienced and continue to battle with on a daily basis is extremely difficult; staff may need to apply their therapeutic skills to heal themselves emotionally and physically.\(^95\)

**Recommendations**

Women with multiple needs, often including those who suffer from drug and alcohol addiction, are sexually exploited or are involved in the criminal system, fall under the responsibility of many different local, regional and national authorities. A prime recommendation would be to commission the women’s centred approach which works in partnership with various agencies strategically with all stakeholders involved and investing.

Anawim would also recommend further involvement of the women with multiple needs into participating to discussions about how to best develop facilities and services for their needs. Their unique experiences and reflections can shed light on areas left otherwise uncovered.

Anawim’s model of holistic support could be utilised not only as a preventative intervention but also as a direct alternative to custody or secure mental health facility. This would reduce the prison population, make cost savings to the public services, and give a better chance in life to women with multiple needs and their families.

\(^95\) Interview with Issha Barr, 2017.
Appendix

Appendix A: timetable of courses

Anawim partners with organisations and professionals to deliver a variety of courses:

- Solihull College: Numeracy & Literacy
- Bournville College: Parenting, Domestic Violence Awareness, Health and Wellbeing, Beauty, Health and Social Care, Floristry and Drugs and Alcohol awareness
- Independent tutor: Therapeutic Art & craft sessions.
- ReCom: IT
- Crisis: “Need to Please” “Understanding anger and Stress”, “Healthy Lifestyles “and “Confidence & self Esteem Awareness” workshops
- Therapeutic programme which includes the following courses: “REDD”, “TREM” and Seeking Safety (these courses are run by a Psychologist)
- Psychologists: Anger Management
- Solicitors: one to one legal advice sessions.
- Independent tutor: Body Mapping
- British Red Cross: 1st Aid workshop
- Healthy Eating on a Budget
- Independent tutor: Coco butter (Business course)
- Stop and Think
- Body and Mind therapy (university placement)
- Self Esteem and Leadership
- Dance/Exercise workshops (university placement)
- Flip the Script - Adellah
- Positive Moves- a 12 week course delivered by Round Midnight which helps build confidence, self-esteem and increases employability skills
- Women’s Aid- DV awareness
- Spoken word project – by Jungo Arts
- Geese- Drama group who look at exploring communication, confidence, goal setting, self-esteem and new approaches to problems.
- Online safety workshops- by NSPCC
- Heal your life - IDVA
- Freedom programme-Domestic Violence awareness
- Hula Hooping
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