

Women with complex needs

Supporting their mental health needs



Early Analysis from a pilot project at Anawim in Birmingham

Partners:

Revolving Doors Agency

Anawim

Birmingham & Solihull Mental Health NHS Foundation Trust

NOMS West Midlands

Pan Birmingham Mental Health Commissioners

NHS West Midlands

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Contact details

This project has secured funding for a further 12 months, progress will continue to be monitored. For more information please contact Lynne Johnson in Birmingham and Solihull Mental Health Trust on Lynne.Johnson@bsmhft.nhs.uk or Joy Dol, Manager at Anawim on joydoal@aol.com

Information about this project and others is available at www.offenderhealth.org.uk

1. Introduction

This report outlines a partnership project that was initiated to acknowledge the difficulties for women who have a range of complex needs and look at their access to appropriate mental health services. The group of women identified were those in attendance at a Women's centre called 'Anawim'.

The report details the reasons for this particular piece of work, the 'partnership', our achievements, the actions taken and the outcomes identified. It will also identify some recommendations that could inform the future thinking, planning and design of services aimed at ensuring the equality of access and outcome for this marginalised group of women.

In 2007 Baroness Jean Corston published her review of women with particular vulnerabilities in the criminal justice system. She highlighted 3 main areas of vulnerability; domestic circumstances such as domestic violence and child care, personal circumstances including mental illness, low self esteem, eating disorders and substance misuse, and socio-economic factors such as poverty, isolation and unemployment.

Since the publication of the Corston review, Ministerial champion Maria Eagle and NOMS have supported the development of the "one stop" approach of centres such as ANAWIM, where services are co-ordinated to meet the profiled needs of local women. Centres have been encouraged to develop an integrated approach and draw together the various services in the community that provide interventions to address women's needs.

There was anecdotal evidence that suggested the women in attendance at Anawim were not accessing mental health services. A number of factors such as, dual diagnosis, drug dependency, their transient lifestyles and general chaos meant they were often unable to attend their local GP in order for access to take place, and if they did, consistent attendance at appointments appeared to be a difficulty.

They often did not meet the criteria to be seen by secondary mental health services, with primary care services unable to meet their needs. Often, the only contact with mental health services this group of women had, was in crisis or when in prison. Involvement in prostitution often made the women ashamed and they felt marginalised by the police, prison system and some health professionals. It also appeared that the centre was not being utilised by mental health workers as an ideal place to maintain contact and deliver intervention or treatment.

A high percentage of this group of women have had life experiences of violence and abuse, these are known significant risk factors for women to experience mental health problems. These experiences can leave some women with very complex needs, often presenting with a combination of offending behaviours, working in the sex industry, alcohol and/or drug issues, homelessness, and for many, continued experiences of violence, abuse and exploitation. Mental health consequences such as depression, anxiety, post traumatic stress disorder, self harm issues, and low self esteem are all too common compounded by the lack of sustained access to appropriate services. Suicidal attempts are much higher amongst women who have

been abused compared to those who have not.

Mental health services will often see the symptoms and the complex lifestyle but not the experiences that may have laid the pathway for these women or understand the behaviours that are often associated and exhibited. Services are not designed or developed to enable this group of vulnerable women to successfully access support or to sustain it. Mental health practitioners are not always equipped with the knowledge about the impact of these experiences.

The response from all healthcare professionals needs be one that acknowledges the underlying causes not just the consequences of the abuse and lifestyle. Understanding the dynamics of power inequality, persistent systematic violence and abuse on their physical and mental health, will enable appropriate responses and intervention and ensure collaborative and partnership working across all sectors.

Working together as real and genuine partners in the true spirit of collaboration is not the norm across statutory mental health services and the third sector, there is a process of referring across to third sector agencies or ensuring appropriate information is given to service users about other services but clear joint working is often absent.

This piece of work reflects a partnership approach to addressing the needs of a group of women with a range of complex difficulties. This approach recognises that no one agency/service can successfully 'go it alone'.



2. The partnership

Anawim



This is a charitable service for women that was founded 25 years ago by a group of local sisters from the 'English Province of Our Lady of Charity' who continue to be involved in the daily activities at the centre. It was set up originally for women involved in prostitution. This continues but now offers support to any women over the age of 18 yrs who are vulnerable due to their involvement in crime, prostitution, chaotic lifestyles, drug and alcohol or as a victim of domestic violence. It aims to offer the support to explore positive life choices that will help them achieve their goals and reach their full potential as part of the wider community.

Anawim seeks to work with partners and other agencies in a bid to achieve this by a 'one stop' approach. There are now 27 agencies offering their services from Anawim. The aim is to offer an holistic service to women with complex needs and their children. Mental health provision was one area that was missing and needed address.

For many of the women the centre is the only place they attend regularly and feel safe, so it is an ideal model for engaging an often hard to reach group and enabling access to a range of services in an integrated framework.

Women are also attending as part of 'community sentences' via Staffordshire & West Midlands Probation Trust. This has increased the amount of women attending the centre who are on community payback and the specified activity schemes. Between July 2009 and July 2010 there were 230 women in total who attended the Centre.

Revolving Doors Agency (RDA)



RDA is a charity focused on improving responses to people with common mental health problems and multiple needs who are repeatedly arrested or imprisoned. With a combination of service development, research and policy work the aim is to create opportunities for people to break out of the cycle of crisis and crime that can affect theirs and others lives.

RDA agreed funding to enable this project to get up and running and for it to be a part of a wider network of pilot projects under the national development programme. This would enable the work to be recognised nationally, evaluated and the learning disseminated. There was also an expectation that any learning would be built into mainstream local services.

Birmingham & Solihull Mental Health Trust (BSMHFT)



BSMHFT is commissioned to deliver many of the mental health services to those people living in Birmingham & Solihull who are experiencing mental health difficulties. The population is 1.2 million spread over 172 square miles and is very culturally and socially-diverse. The Trust has committed itself to ensuring equality is at the heart of all its functions and so recognise that gender equal services do not mean the 'same' services for both women and men. One size

does not fit all and the gender differences in life experience, socio-economic realities and pathways into care demonstrate the need to provide services that are specific to the needs of different groups.

National Offender Management service (NOMS) West Midlands



NOMS have a key role in ensuring that the public are protected from offenders, that those who do offend are punished and that fewer offenders re-offend. To do this NOMS are reforming the criminal justice system, which includes drawing on the knowledge and expertise from the public, private and third sectors to provide more innovative solutions to tackling offending behaviour.

NOMS West Midlands support the development of core interventions that seek to improve the lives of vulnerable women in the region.

NHS West Midlands



This is the NHS strategic health authority for the West Midlands. Through the offender health and social care programme there is a desire to support service improvements for individuals in or close to the criminal justice system. NHS West Midlands can cascade learning to mental health commissioners across the region.

Pan Birmingham Mental Health Commissioning Team

This team takes the lead for the commissioning of mental health services across Birmingham. They are responsible for the commissioning of both primary and secondary mental health care. The team has the desire to improve services for offenders and is working closely with partners to achieve this. The learning from this report will support appropriate commissioning in this area.

3. Terms of Reference

The overarching aim of this project was to ensure equality of access to timely, sensitive and appropriate levels of mental health support for this group of women. To ensure a collaborative cross agency approach where differing roles, expertise and responsibilities are recognised and respected, and the needs of these women remain the focus.

The gender equality duty specifies that mental health services must recognise gender difference and consider service design and delivery in light of these differences. To enable us to know what these differences may be and what services need to look like, it was vital in the first instance to identify a profile of this specific group and establish what it is that was needed. To ensure equality of access and outcome there is sometimes a need to do something different.

In the Corston report, Baroness Corston clearly lays out the need for ‘a radical new approach’ to support women with particular vulnerabilities in the criminal justice system. It was essential that women’s mental health needs were not excluded from this new approach. Having a range of services available in one place, including mental health care, aims to improve access to all the women.

The project was funded for 12 months and needed to be able to identify:

- The mental health needs of the women in attendance at Anawim
- The numbers of women needing mental health input and at what level
- The appropriate pathway for these women into mainstream and local services
- The interventions that would be appropriate
- Barriers to accessing Mental health services
- Better outcomes from more integrated, cross agency working
- Recommendations based on the findings that could inform commissioning

Methodology

To cement the partnership approach to this piece of work, a steering group was formed to oversee the project. This group was made up of key representatives from the identified partnership agencies.

The programme director of the community mental health services from BSMHFT agreed to chair the group and 4 meetings were agreed as a starting point. (January, March, May and September 2010.) An interim report was to be ready for the May meeting with the final report set for the September meeting.

A female qualified Mental Health Practitioner (MHP) was identified from the dual diagnosis field and she was seconded from the Mental Health Trust and based at Anawim’s centre for 1 day a week. She was identified due to her knowledge and understanding of the women’s mental health agenda and her experience of working with an often complex client group where engagement issues are key. She also had a wide experience of working with services and agencies outside of the statutory sector. The steering group felt that this role required a female practitioner, this was agreed following advice from the Trust’s Human Resources Team.

The MHP was tasked to offer a combination of appointment slots and some drop-in time for the women and the staff. This was to be a consultancy/ information service as well as offering specific mental health screening assessments and any follow up work necessary, paperwork, etc to include data collection. There was to be a key role in assisting women to access and engage with mainstream mental health services as appropriate. The secondment began in October 2009.

The project was to run for a 12 month period, to enable a settling in period and the chance to enable a clearer picture of what the mental health needs of these women were as well as to consider what Anawim staff needed to enhance their working with the women.

The first couple of weeks (2 working days) were about orientation to Anawim as an organisation, settling into the centre, finding space there, meeting the staff and informally spending some time amongst the women attending the centre.

The MHP introduced the Threshold Assessment Grid (TAG) to the staff; this is a tool as a means for them to refer women to her. This particular assessment tool was chosen for its design, ease of use and it is not just for 'professionals'. See the references for more information.

Once settled in and engaged with the staff, the MHP identified that there was a need to address the staff's knowledge, understanding and confidence about working with mental health issues, so she distributed a training needs analysis to Anawim staff as a way of establishing a baseline. This clearly showed the need for a training/development programme for the staff group. (See Appendix 1)

The MHP began taking referrals the last 2 weeks of October 09.

Alongside this she planned and delivered some 'bite size' training sessions for the staff at Anawim focused around the results of the training needs analysis she had carried out. Each of these sessions was evaluated to ensure that they were supportive to staffs awareness and confidence.

Anawim as a service was not that well known to local mental health teams, so to raise the profile of the centre and their services as well as knowledge of the local CMHTs, the MHP coordinated an open afternoon at the centre specifically for mental health practitioners. It was an afternoon when the centre was closed to women attending and staff were available to speak to mental health staff about the service and give out information.

As a way of establishing the views of Anawim staff on the issue of mental health need in their client group the MHP distributed a questionnaire to all staff that asked about their perceptions of their clients mental health needs. See appendix 1.

A data base was set up and a data collection form was designed as a way of recording information about the women that were referred. (See appendix 2)

This recorded the factual information:

- Number of women seen
- Equality monitoring
- Referral information
- Mental health history
- Medication
- Specific issues
- Children
- Physical health
- Outcome of the referral (what the MHP did/facilitated following the contact)

Narrative feedback was sought from the staff whose clients had been seen by the MHP and the women themselves about the intervention.

Between October and June there were in total 38 weeks however, taking account of 7 weeks where the centre was closed (due to issues of snow), the MHP was on annual leave and at a conference, there were in total 31 days that the MHP was in the centre. (This does not include the time that was used outside of the allocated 1 day a week)



Case study 1 Gill “a long and windy road”

Gill had been living homeless, she felt unable to cope in her flat, she attended the Anawim centre in crisis. Gill was reporting feeling suicidal and said that she had attempted to jump from the top of a tall building the previous night. Gill had a number of added social issues that had led to this crisis: about her child, her feelings of being unable to cope and a recent incident of sexual violence. Gill had also had a number of crisis admissions to psychiatric hospitals – but never any ongoing follow up. In previous crisis Gill disclosed she had an issue with being seen by male doctors.

With consent the MHP contacted mental health services and the GP for further information. Gill had been known on a number of occasions to crisis intervention and then discharged back to the GP. She had a ‘depression’ diagnosis. Gill reported that her previous experience of mental health services was that she felt no one listened to her.

The MHP was advised to contact the GP to request a home treatment referral.

The available GP was not familiar with Gill and suggested she be taken to A&E. Gill agreed to attend A&E with the MHP and a support worker from Anawim and they were all advised that psychiatric



liaison would be called to make an assessment. The first two A&E doctors that attempted to see Gill were male, there were difficulties in making their assessment. The MHP spoke to them privately in a separate room to explain the situation.

A psychiatrist arrived approximately 5 hours later to carry out a mental health assessment. Despite A&E department staff liaising with Psychiatric Liaison the doctor on call was a male, Gill became very distressed. A referral to the Home Treatment Team was made. Gill agreed to wait for the team, who arrived 2 hours later, they transferred Gill to an inpatient psychiatric ward.

Contact was made the next morning with the ward Gill had been admitted to. The ward manager said that the consultant was looking at discharging her. After explaining the situation that this was repeating an unhelpful pathway for Gill the ward manager did change their decision and Gill remained on the ward for a further 3 weeks as an informal patient. During this time MHP and project coordinator liaised with inpatient staff including the ward manager and consultant psychiatrist.

Following hospital discharge Gill was followed up by home treatment and was later transferred to a CMHT with a care co-ordinator allocated and outpatient appointment with her new psychiatrist.

Commentary

Although this pathway was **very long**, windy and arduous, if the MHP and the project coordinator **had not** been involved, this woman's past experience would have been again repeated. She would probably have not got to A&E or if she had it is unlikely she would have waited this length of time. Even if she had got as far as admission to the ward she would have been discharged the following day with no follow up as had happened on numerous occasions- only for her to again at some point re present in distress.

Taking account of the above case study, the January steering group suggested that the project coordinator along with the MHP attend the community mental health 'start of the week' meeting where the senior team get together.

The senior managers invited the project coordinator to the Community Mental Health Team managers meeting the following month to present the case study. Following this, there was agreement that access needed to be easier for these women. It was also discussed how this case highlighted the difficulties that extended further than the access point and that the pathway, once initial access was achieved, was of equal importance.

Following attendance at this meeting it was agreed that one senior service manager would support this project and a meeting was agreed with her to discuss the way forward.

It was agreed that if the MHP at Anawim had assessed a woman as needing to be seen by specialist mental health services then the local team would accept the referral.

There was also agreement made that there be an offer, open to all community psychiatric nurses to spend some time with the MHP at Anawim to gain further understanding of the issues for these women and about the centre as well as what services it provided. The senior service manager would take this forward in the meetings with the CMHT teams.

The MHP carried out 3, one hour training sessions for the staff at Anawim, that included:

- Understanding Personality Disorder
- The structure of mental health services & referral pathways
- Understanding mental health difficulties

With one more planned:

- Commonly used medications

Two of these sessions were carried out within the time allocated to this project however one was done outside of this time. These sessions evaluated well and staff found them useful but felt they needed more. This was not realistic from the time out of her one day a week at the centre and one session was carried out outside of the MHP allocated time to the project. This had not been anticipated as a key aim within the framework of the project; however it was clearly an identified need for the staff group that would enhance good practice for the women attending the Anawim centre.

4. Findings

Data base information

In the first 8 months of the project (Oct-June) there were 22 women referred to the MHP at Anawim. They were from a range of ages between the ages of 18 and 65 although 4 women did not specify. They were pre dominantly White British women with 9 women describing themselves as from a BME background and only 1 woman choosing not to say.

Referrals: There is an open referral process into Anawim and for the 22 women seen by the MHP:

- 3 self referred to the centre
- 6 came via probation (specified activity)
- 1 from the street out reach project
- 2 from the 'SAFE' project- an organisation specifically working with women in the sex industry
- 1 came from meeting the prison in-reach Anawim worker
- 8 were referred from 'other agencies' – drug & alcohol services, social services etc
- 1 referral was not specified.

The majority of referrals to the MHP were from Anawim staff themselves (20). These were more often women they were already working with but some were new to the centre and the Anawim staff felt that a joint initial needs assessment with the MHP would be useful. The other 2 women were 1 who requested herself to see the MHP and 1 who was approached by the MHP due to her visible distress whilst at the centre.

The MHP had introduced the 'TAG' referral to Anawim staff however only 3 of the 20 referrals from them had completed 'TAG' assessments. There was often very little information given to the MHP on referral from the staff.

The reasons given for the referrals to the MHP were:

- Informal chat (8)
- Mental health advice (3)
- Mental health assessment (9)
- Advice/support to staff (2)

Current mental health input:

- 6 women were found to be already currently involved with mental health services These 6 women were all being seen in out-patients by a psychiatrist with no care coordinator. This generally meant a 3 monthly appointment for 20 minutes.
- 15 women were not currently known to mental health services.
- 9 women said they were seeing their GP only, and 1 woman said she had contact with a primary care mental health practitioner at the GP surgery.
- 5 of the women said they had been known to mental health services for less than 1 year and only 1 had been known between 1 & 3 years. Only 1 woman said she had a care plan.

Previous involvement:

- 6 women said that they had previously been involved with mental health services 2 of these whilst they were in prison.
- 9 women declined to specify if they had been previously known.

Medications: Eight women said they were currently prescribed medication for their mental health:

- 6 of these 8 were prescribed anti-depressants
- 1 an anti-psychotic
- 1 a benzodiazepine
- 4 women had previously been prescribed medication for their mental health

Although 8 women said they were currently prescribed medication, there were some issues of prescriptions not being cashed in and also taking was irregular. There did not appear to be robust follow up or support about medication compliance or effectiveness.

Self harm: 12 of the women talked about self harming behaviours with only 3 saying that this was a current difficulty. However 10 women chose not to specify.

Alcohol & drug issues: 12 women talked about some difficulty with drugs and/or alcohol with 9 stating that this was a current issue for them. 4 women did not specify.

Offending behaviour: 10 women said that they had offending behaviour histories with 3 saying this was a current issue whilst 7 said they were on a community order via probation.

Pregnancy: 15 women disclosed they had been pregnant, 1 was currently pregnant and 2 had never been. 4 of the women chose not to say.

Children: 14 women said that they had dependant children, 4 said they did not and 4 declined to say. 7 women stated that their children were living with them. 3 stated that their children were 'looked after children' by social services 10 said they weren't, 1 had had her child adopted. None of the women stated that their children were living with a significant other although 9 women declined to answer or said it wasn't applicable. When asked about child protection issues 3 women said that there had been issues, 2 said there were current child protection issues and 8 did not specify or said it was not applicable. There is some discrepancy about these figures that could suggest women were not totally comfortable or trusting giving information about their children.

Relationship difficulties:

10 women described having relationship difficulties ever, 7 said these were current and only 1 said that they never had. 4 women did not specify. 16 women disclosed experiences of violence and abuse with 7 saying these were current issues only 1 woman said she had never had this issue and 5 not specifying. 14 women described these difficulties as domestic violence, with 3 saying that this was a current issue for them.

It is important to note that some women do not recognise or name their experience as domestic violence even when it would be defined as such.

The Home Office defines domestic violence as “Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.” However, the Birmingham strategy takes heed of the evidence that women and children are overwhelmingly the victims of domestic violence and men the perpetrators of domestic violence. Domestic violence is not gender neutral: recognising this ensures that we plan and provide services suited to specific gender needs, where these arise. Domestic violence also includes issues such as forced marriage and so-called 'honour' killings.

Physical health:

6 women stated that they had had physical health problems currently with 4 saying that they had never had any problems. 12 chose not to specify.

Outcomes from meeting with the MHP:

- The MHP arranged to specifically see 9 women again at the centre for further follow up
- 11 women were advised to go back to their GP
- Advice and/or a plan given to Anawim staff to work with the women
- 4 referred onto mental health services
- Referred 1 woman specifically to the Anawim counselling service
- No woman declined follow up plans agreed (as per the above points) however 9 women did not attend agreed appointments

Training & development The training needs analysis that was carried out with the staff group identified that staff felt they needed training/awareness on:

- Support from trained professional
- Support to help identify MH symptoms
- To be able to recognise MH issues early on, especially if clients do not self disclose
- Knowing where to refer to/signpost women to. Knowledge of support in community
- Knowing what to do to support women effectively
- Having someone to express views and concerns with
- Training/ more knowledge of mental health issues
- Additional support and training around women with severe mental illness

Although developing the capacity of the Anawim staff had been identified as an essential element to this piece of work, the MHP was finding it a challenge to address within the time constraints of her one day a week within the centre. The steering group acknowledged this and it was decided that the project coordinator approach psychological services in the Mental Health Trust via their business meeting, and request if they had capacity to assist in the training and development of the Anawim staff group. This was well received. The project outline and the training needs of the staff group were sent to them and they would look at how they could usefully support this work.

Engaging BSMHFT psychological therapies staff in delivering training was a way of addressing this need in a more sustainable way in the longer term as well as ensuring the allocated day a week that the MHP had for the project, was spent focused on the core aims of looking at the mental health needs of the women.

The MHP organised and ran a 'well being' group for the women using the centre. It was felt that not using terms like 'mental health', 'mental illness' would be more engaging for the women. This was an interactive session that was attended by 14 women who all participated and fed back that they had found it useful.

Care Pathways

Anawim organised an open day that was attended by 18 community practitioners from the mental health Trust. This was disappointing as there was clearly a lack of knowledge about Anawim and the services they offered to women with complex needs. It identified that raising the profile could have a two fold benefit – to the centre- having made links with the mental health community teams as a way of initiating joint working and also to the community teams as a resource that they could offer to their female clients as appropriate and access the range of support available there.

It was this that led the project coordinator to directly access the community services key meetings. The response was engaging and would set a protocol for direct access following assessment as appropriate, whilst the qualified mental health practitioner was based at Anawim. However, this would not hold out if the MHP was not based there.

The issue of care pathways required further development as case study 1 clearly demonstrated. The issue of crisis access as a repetitive intervention for some women, was notable and a very costly resource – not just in financial terms but in the negative experience for the women. There appeared to be a lack of appropriate follow up to engage these women; expectations that these women were able to follow the 'system' laid out for on- going support.

The fact that all the women who were identified as being seen by specialist mental health services already, were being seen as out-patients only This meant they saw a psychiatrist once every 3-4 months at the CMHT base. Considering the complexity of the needs these women were presenting with, this intervention was not sufficient on it own. These appointments were not joined up to other interventions e.g. probation, Anawim's package of support and therefore isolated from the women's real life experience.

There was also an issue of this group of women not attending appointments arranged which then led them to being discharged – often representing in crisis. There was an example of a woman known to MH services for over 10 yrs, not consistently with short spells of contact. This meant that each time she had to go down the same new referral route and the issues were always the same only more compounded. Her expectations of the services became very low and negative.

Primary care mental health services are currently being developed across the city, however, as the service stands, many of the women not meeting the threshold for specialist mental health care would not have their needs met at primary care level either. Their need is more complex; and so, they often receive medication only from the GP which is not monitored robustly and again is not going to address the needs of this group of women.

Case study 1 highlighted the need to follow the woman on her pathway and intervene at each stage to facilitate engagement, understanding and interventions that take account of the complexity of needs. The examples of when this was done, have changed the pathway for that individual woman, however, this is not a sustainable approach, however successful. There is something about attitudinal issues towards women with complex needs – particularly when presenting behaviours are difficult to manage.

Case Study 2 Liz

MHP asked to see Liz who had been newly referred to Anawim by the probation service.

Liz was on a community order as an alternative to custody and so attending Anawim was part of the specified activity. She had been in prison previously, had issues with drugs and had some mental health difficulties.

Liz reported having been previously diagnosed in prison as having 'schizophrenia', as well as having contact with child & adolescent mental health services previously but no current involvement. Liz described derogatory auditory command hallucinations and ideas of reference (TV and radio talking to her) and these experiences were distressing her.

With Liz's consent the MHP wrote to the GP requesting a referral to mental health services for further assessment/intervention.

To assist this process The MHP contacted the local CMHT and spoke to the manager to let them know about the project, the due referral and of her involvement with this woman. The manager then ensured that this referral was taken up and the information from the MHP taken into account.

Commentary

The MHP stayed in contact with Liz, the CMHT, the drug service and the offender manager. Liz was seen by the mental health team; diagnosed, prescribed appropriate medication and seen regularly in the out-patients clinic.

Because a package of care was developed around Liz that was multi-agency, took account of the complexity of this woman's issues and all professionals involved worked together, this appeared to be working well for Liz.

The CMHT manager then agreed direct referral for the MHP into their team.

Case study 2 also demonstrates the positive impact of the intervention from the MHP. If the MHP was not involved this pathway would not be sustainable.

The MHP kept daily activity sheets which detailed everything that she did on the days she was at Anawim. These captured much more than the data collection forms. They highlighted that she had more actual contact with women in an informal way in the centre than the actual referral numbers indicated. These contacts were about supporting women to attend other groups, giving information of other specific support agencies and supporting them to call these, general supportive counselling and advice about mental health and well being. This informal way of engaging with the women, appeared to feel 'safer' than an 'arranged appointment'.

This information also showed the times that the MHP followed up on the women she had seen formally and informally. It also showed telephone follow up and all the liaison time spent writing letters to GPs, psychiatrists and CMHT managers. The time spent with the Anawim staff discussing women, giving advice and support, also spending time with visiting CPNs who had come along to find out about the centre.

The activity sheets also highlighted the issue of women not attending set appointments. They were much happier to engage on an ad-hoc basis within the centre. The sheets also highlight that although women may not turn up at an agreed time so therefore gone down as a DNA, some have turned up later or on a different day when the MHP was not there.



5. Narratives

The staff and the women using the centre were asked to give some feedback as a way of measuring the input that the MHP gave to the women and the centre from their own perspective:

“I come into contact with several women suffering from mental health issues in varying degrees.”

The MHP has been placed at Anawim since October 2009 for one year.

“I personally believe that we need a mental health professional based at Anawim indefinitely as this eases the pressure off staff and creates the opportunity for the MHP to build relationships with clients that may “slip through the net” so to speak. It gives our clients the opportunity to approach a professional about their MH issues when ordinarily they may never have done so, or not had the option to.

The fact that the MHP attends once a week gives us the reassurance that there is help at hand when we really have not got the expertise in certain areas. An example was when I received a referral stating that the potential client had an extreme personality disorder, I invited the MHP to the assessment, whom advised me what steps she thought would be necessary after the assessment. Several months later the client concerned has been referred to the appropriate mental health team, attends Anawim for counselling and is engaging well”.
(Support worker at Anawim centre)

“I am really pleased that the MHP is with us one day a week, she has been invaluable in supporting us with so many women at the centre. I find it reassuring when anxious about a client to talk with her in confidence, as I find she has a great understanding of mental health issues and human nature. The MHP knows the right agencies to contact and where to refer the women to for the treatment that suits them.

*I have enjoyed the training given by the MHP and have found them informative and helpful. The MHPs presence at Anawim has highlighted the need there is for a mental health nurse at the centre”.***(Outreach worker & counsellor at Anawim centre)**

*“The MHP has been a real asset to Anawim. The knowledge, help, expertise, and the support that she offers us and our clients is incredible. She has helped many of my clients and has helped overcome my own concerns with regards to clients. Furthermore she acts professionally and gets things done. She is productive and likes to achieve good outcomes. She has helped 2 of my clients in a major way where the mental health service so far in the past has let them down. Her services really are required and I think it’s not always about referring people but introducing her where there are clients whom we are concerned about to let her make a judgment about our concerns prior to making referrals”***(Specified Activity Key Worker- Anawim centre)**

“Prior to the MHP secondment, a huge gap was noted within our holistic service, for mental health provision. I feel the MHP current involvement at Anawim is hugely beneficial, it is

imperative for the work we do to be aware of provisions available in the community for women with mental health needs. It is also extremely useful to know how to commence structured work with the women of Anawim who present with mental health needs.

For myself personally having her on hand once a week means if I am concerned about a women's mental health or receive a referral from probation, I am immediately able to discuss this and seek to take appropriate action.” (**Criminal Justice Key-worker at the Anawim centre**)

One of the key features when considering a pilot is the actual staff member who will be seconded to the project. In the case of Anawim it was particularly important for the worker to integrate within the staff team and to build trust and confidence to enable women to engage.

“We have been extremely pleased with the MHP here, who has settled in very quickly. Her friendly, gentle manner and pleasant disposition has enabled her to be seen as one of the regular staff and as such has been beneficial to her being accepted by women using the service. Her weekly presence both in the main room and around the centre has offered chance for informal chats which in turn have broken the ice for women. It is often difficult for the women to trust professionals. This may be because they have felt judged or not been able to comply with keeping appointments, and therefore been removed from waiting lists or their case closed.”

“Several women report to us about not understanding services they may have been offered. On occasions they feel pressurised into accessing services which professionals deem appropriate but they do not feel ready to deal with presenting issues. Several of the women are transient and therefore experience difficulty in maintaining contact with services. The staff team as a whole have benefited by increasing their knowledge and understanding of mental health issues. The training sessions have enabled us to discuss topics such as personality disorders which has increased our understanding and ways of dealing with specific issues which arise. It has increased staff confidence and the ability to offer appropriate support.”

“We are more conversant with care pathways and who and how to refer to. It is often problematic for non-statutory services to navigate and advocate through the range of services. We can identify with the difficulties faced by service users when trying to get appropriate support.”

Staff consult on a weekly basis with the MHP on specific issues, use her as a springboard for ideas and seek clarity in what course of action will help any particular woman they may be working with.

Another feature of the success of this work has been the fact that we have not heavily promoted mental health. Many of our services users already feel marginalised and labelled by professionals and this MHP promotes emotional well being for us all.

The MHP recently facilitated a workshop around emotional well being and women. This was really well attended and feedback from women really positive. All the women remained for the whole of the session and actively engaged in the discussion. This does not always happen at the centre and is directly attributed to the skill of the worker.

Overall her input has been really well received, many women seeking to disclose issues for which they have never accessed support. We are delighted it is to continue to build on the existing good work". (A Manager at the Anawim Centre)

6. Challenges

A number of challenges were identified as the project progressed that needed a much more flexible approach, however there was also a need some how to build in some governance on the way these women were engaged, worked with and their needs identified. They are a very vulnerable group of women.

Some women did not return to the centre to see the MHP again, or if they did attend it was on different days.

The pathways are rigid and often inflexible into the MH services (see case examples). If a senior clinician who works for the MH services had this difficulty negotiating the pathway to MH care it is easy to see how hard it must be for the women and the voluntary sector staff groups. There did also appear to be a lack of understanding generally about the complexity of these women's needs often and some attitudinal issues about whether they needed MH care.

Only having 1 day a week proved to be a challenge and the MHP did use some time outside of the agreed day to follow things through on a regular basis. Supervision time was also sometimes outside the allocated time.

Not having access to the mental health trust's patient data base from the Anawim centre. This was essential to establish if women referred to the MHP were already known to mental health services currently or in the past and who was or had been working with them. It also gave a picture of the past pathways which assisted in 'changing outcomes' for women. This increased the use of time outside the allocated project time.

Accessing women's files, storage of MH information and access to computer and desk space at Anawim proved problematic for the MHP. Initially it was felt that the MH information would be stored with the woman's Anawim file, however it proved difficult to always track these files. There was limited space for all the staff in the office and the MHP was an extra person to be accommodated with access to a computer which was problematic.

The TAG referral was not being used systematically by the staff, sometimes little or no information was given to the MHP when she was being requested to see women (this may be due to women being new to the Anawim staff also) more work with the staff was needed to

support them using this tool as a way of identifying need and priority.

Lack of specific systems for communicating to all staff at Anawim, to inform all staff about training sessions, open days, requests to complete questionnaires etc. Some staff didn't seem to have received information even when hard copies were left on desks.

The data collection system was not capturing the follow up work and how many times women were seen. The information was entered from the referral and this was a flaw that needs addressing. However, it would be hard to capture the 'soft' positive interventions and outcomes for these women and it is these that they appear to feel safe with.

No centre manager at the time of the project and new staff starting did add to the difficulties as above.



7. Conclusion

This project so far has identified that many women accessing the Anawim centre have a level of mental health need. It is also showing us that the access pathway is often not simple, straight forward, positive or welcoming.

There is also the issue that the complexity of their needs are not totally acknowledged and when they do get access it is more often as an out-patient client only; this suggests a predominately medicalised approach that will not on its own lead to real engagement, change and ultimately positive outcomes.

The case study examples also indicate that it is not just the access to MH services where there are barriers but at every stage for these women and it is demonstrated how the 'crisis only' approach is sustained.

The data does show the interplay of a range of social issues for these women and a level of vulnerability to mental health difficulties and other health factors. Alongside this is the lack of knowledge and understanding of the consequences of this interplay from practitioners and not seeing these as serious mental health issues and therefore not in need of the specialist services.

There is the gap that is identified where many women are falling through, not reaching the threshold for specialist mental health services but too complex for the current provision within primary care. It does appear that having the MHP at the centre has helped to address some of that for this group of women and also is assisting the staff at the centre to feel more confident to speak up for these women and support their need.

What has been demonstrated is the real positive reception from the staff and the women at Anawim, and how useful the MHP has been. She has role modelled a way of challenging the pathway, other professionals and services; as well as the pro-active approach that comes with feeling more confident in your role and skills.

The issues of 'engagement' are key and necessary for services to understand. These women appeared to feel safer with a more informal approach. This does then need to be developed to enable and support clear and appropriate intervention of care that is put together around the woman and takes account of the range of difficulties including their 'fear/mis-trust' of the statutory service providers. It very much evidenced the real need for joint/cross agency working.

The lack of attendance/knowledge/communication with the Anawim centre from MH services is an area that needs further address. Not only could the staff there benefit from links in the local CMHT, but the CMHT staff would benefit from such a comprehensive resource for the women that they are also seeing. The centre could be an ideal contact point for women who are struggling to engage with the CMHT but feel comfortable at Anawim. It could enable more creative thinking about ways of engaging women that so often are deemed to be 'hard to reach' and only accessible in crisis.

8. Recommendations

At this stage of the project the recommendations are:

- To review the data collection and to amalgamate the daily contact sheet information- this gave a fuller picture of the MHP input.
- To follow up with the service manager in MH services to look at the links to the CMHT (there have been good individual links forged with specific teams via the manager, but not across the whole system)
- To follow up on the mental health psychological services with regard to their input into the Anawim staff development with an aim to get a programme ready for the 2nd year of this work.
- There has been an agreement to continue with the MHP input for a further year until October 11. The sustainability issues would need to be a priority for this 2nd year so possibly different aims could be agreed by the steering group.
- To continue in the final 4 months of this year to get feedback from the women that the MHP has contact with to ensure that we are focused on their needs and clear about what does and doesn't help.
- To try and address the practical arrangements at the centre with the MHP and the manager (now returned) to ensure some allocated time on a computer/desk space etc. Discuss access to referred women's files and the use of the Tag referral tool with the staff and put in a more agreed process to ensure some consistency and effective use of time.
- To revisit the staff questionnaire about their clients mental health issues.
- To ensure support & supervision is in place for the MHP and embedded into ongoing work.
- To acknowledge the need for a full orientation and understanding of the differences in culture between statutory and voluntary sector agencies and support for this adjustment.

9. References & Bibliography

Corston report

<http://www.newsocialartschool.org/pdf/Corston-pt-1.pdf>

Gender equality duty 2007

<http://www.equalityhumanrights.com/search-results/index.html?q=gender+equality>

TAG (Threshold Assessment Grid) this has been developed by Kings College London and is available at <http://hsr.iop.kcl.ac.uk/prism/tag/download/tag.pdf>

Across the West Midlands, the TAG has been refined to be used as a referral tool for those working in the criminal justice sector to refer to health professionals, additional information about this is available at www.offenderhealth.org.uk

Additional data information is available from Lynne Johnson, please contact Lynne at Lynne.Johnson@bsmhft.nhs.uk



10. Appendices

Appendix 1 – Copy of the Training and Support Needs Questionnaire

Appendix 2 – Contact data form



Appendix 1

Training and support needs questionnaire

Following the discussion at the meeting today, I would be grateful if you could complete this questionnaire designed to look at the training and support you feel you might need in working with your client's who have a mental health problem.

Name _____ Job Title/Role _____

Date _____

Current and Past Experience

1. How long have you been working at Anawim? _____

2. As Part of your current work do you work with clients who you feel have mental health problems? **YES/NO** (Delete as appropriate)

3. In the past, how have you personally dealt with clients who have a mental health problems?(Please tick appropriate response)
 - REFERRED TO SPECIALIST MENTAL HEALTH SERVICE
 - TRIED TO WORK JOINTLY WITH OTHER PROFESSIONALS
 - REFERRED TO GP

 - OTHER Please state what _____

Personal and Service Needs

4. What do you see as the specific needs of Anawim in working with clients who have mental health problems?

5. What would help you personally to deal with clients who have mental health problems?

6. How do you rate your knowledge of mental health problems?
0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
No Knowledge Expert knowledge

7. How do you rate your competence in dealing with clients with mental health problems?
0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
No Knowledge Expert knowledge

8. How do you rate the importance of mental health issues to your practice?
0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____
No Knowledge Expert knowledge

9. Please state how strongly you agree or disagree with the following statements by ticking the appropriate box.

	Strongly Agree	Quite Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Quite Strongly Disagree	Strongly Disagree
a) I am interested in the nature of mental health problems and the responses that can be made to them.							
b) In general, one can get satisfaction from working with clients who have a mental health problem.							
c) I feel I have a working knowledge of mental health difficulties.							
d) I feel I have a clear idea of my responsibilities in helping clients who have mental health problems.							
e) I feel that I can work just as well with clients who have a mental health problem compared to working with clients that don't.							
f) If felt the need when working with clients who have mental health problems. I could easily find someone who would help me clarify my professional boundaries/responsibilities.							
g) I feel it is part of my role to work with clients who have mental health problems.							
h) If feel that I have concerns about a clients mental health I am aware of where to refer for specialist help.							

15. Do you feel you need additional support to enable you to work with clients who have mental health problems/symptoms? **YES/NO** (Delete as appropriate). If yes, please define what this support would entail:

Any queries/comments please speak to Jo Leci on [mobile number] or 0121 301 1750 at BSMHFT, COMPASS Programme, 55 Terrace Road, Handsworth, Birmingham, B19 1BP

Appendix 2

Contact Data

ANAWIM MENTAL HEALTH PROJECT

Number _____

Name: _____

Ethnicity _____

Age _____

Referral From _____ Self Staff

Tag Yes No

Reason for Referral (please circle)

Informal Chat /Advice/Mental Health Assessment /no face to face required, advice/support to staff

Other (please specify) _____

Reason for non face to face

How did woman hear about Anawim?

PREVIOUS MENTAL HEALTH HISTORY

Involved with a current mental health team Yes No

OP only or CC? (Please state) Yes No

GP/ MHPCW Yes No

Which Team _____

Name of CC/Consultant _____

How long being seen _____

Have they got a Care Plan _____

Known to a team in the past Yes No

Which team _____

Name of CC/Consultant _____

How long ago _____

Exit reason? _____

Current medication Yes No

If yes, what medication?

What medication has been taken in the past _____

Was it helpful?

Yes

No

Specific Issues

Self Harm

Pregnancy

Alcohol/Drug Use *(please specify)*

Offending Behaviour *(please specify)*

Been In Prison *(please specify)*

Community Order *(please specify)*

Violence and abuse experience *(please specify)*

Relationship difficulties *(specify who with)*

Ever	Current

Number of children

Do children live with woman

Yes

No

If no, whom do children live with

Child protection issues(outline)

Yes

No

Physical health issues(specify)

ever

current

Self Assessment of Presenting Issues (brief outline)

Referrer Perception (if different) _____

What Does the Woman want?

Length of session/time spent _____

Outcome *Please tick*)

See again at the centre

Advise to see GP

Refer back to worker with recommendations and plan

Refer onto mental health services

Refer to Anawim counselling service

