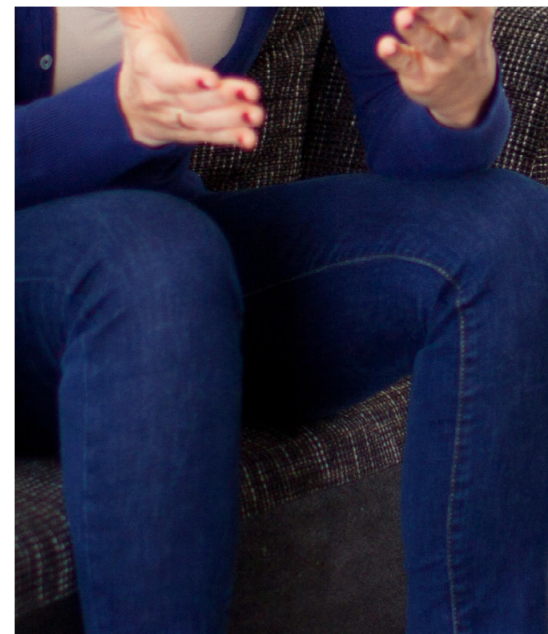
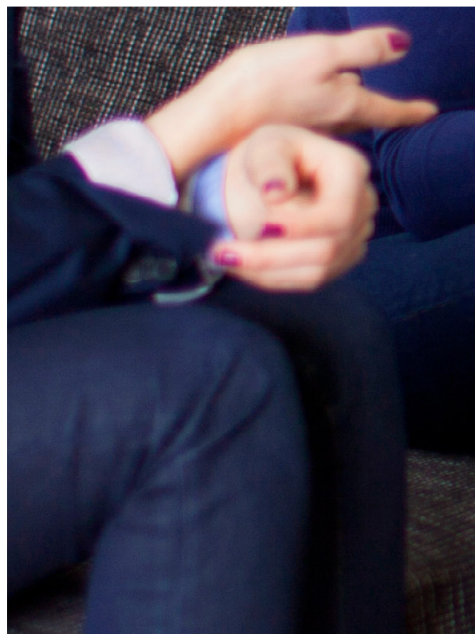


Mental Health Provision in Women's Community Services:

Findings from a survey conducted in England and Wales

bacp

British Association for
Counselling & Psychotherapy



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Contents

1. Introduction	4
2. Methodology	5
3. Findings	6
4. Discussion	11
5. Conclusions and recommendations	13
References	14
Appendix 1: Survey questions	16
Appendix 2: Invitation to complete the survey	23
List of tables and figures	
Table 1: Regional breakdown of services who responded to the survey (N=34)	6
Table 2: Frequency table of the organisational role identified by survey respondents (N=34)	6
Table 3: Details of in-house mental health interventions: types of staff, employing organisations, funding providers, and referral methods	8
Table 4: Details of off-site mental health interventions: service providers and referral methods	10
Table 5: Client demographic information across all services	11
Figure 1: Bar chart of the numbers of services providing in-house mental health interventions (n=26)	7
Figure 2: Bar chart of the number of services providing each type of psychological therapy (n=23)	7
Figure 3: Bar chart of the types of off-site mental health provision (n=33)	9
Figure 4: Bar chart of client presenting issues and location of treatment	12
Figure 5: Services' use of information gathered through evaluations of mental health interventions (n=13)	12

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BACP is a membership organisation and a registered charity that sets standards for therapeutic practice and provides information for therapists, clients of therapy, and the general public.

Centre for Mental Health



Centre for Mental Health is an independent national mental health charity which aims to inspire hope, opportunity and a fair chance in life for people of all ages living with or at risk of mental ill health.



Women's Breakout is a third sector umbrella organisation that represents voluntary and community sector organisations working with women offenders and women at risk of involvement in the criminal justice system in gender sensitive environments.

1. Introduction

Despite there being a number of commonalities amongst offenders irrespective of gender, such as disadvantaged social backgrounds, limited or no employment skills, and financial difficulties (Hollin & Palmer, 2006; Loucks & Zamble, 1999), there is evidence to suggest that female offenders have additional, and usually multiple, needs (Social Exclusion Task Force, 2009). Women offenders have been found to have more severe substance use histories and psychological impairment, and are more likely to report a history of sexual and physical abuse than women in the general population (Light, Grant & Hopkins, 2013; Messina, Burdon & Prendergast, 2003). The Prison Reform Trust has reported that female offenders are more likely to have experienced childhood abuse, witnessed domestic violence and been taken into care as a child (Prison Reform Trust, 2013).

One particular need which has been identified amongst women offenders is mental health (Hedderman, Palmer & Hollin, 2008). Research from the UK has found higher rates of learning difficulties, personality disorder, substance misuse and self-harm amongst female compared with male inmates (Maden, Swinton & Gunn, 1994). There is also greater prevalence of mental health problems such as depression, anxiety and psychosis amongst female, in comparison to male, offenders (Home Office, 2007). Many female offenders experience comorbidities, which can put them at increased risk of self-harm and suicide (Marzano, Fazel, Rivlin & Hawton, 2010). In addition, mental health problems can be a contributory factor in offending behaviours, with female prisoners suffering from combined anxiety and depression being significantly more likely than those without such symptoms to be reconvicted in the year following release from custody (Light, Grant & Hopkins, 2013).

There are a number of research studies providing evidence for the effectiveness of psychological therapies in the treatment and management of mental health problems, such as depression and anxiety, which are frequently experienced by female offenders (e.g. Brazier et al., 2006; Cape et al., 2010; Mulder & Chanen, 2013). Some research has specifically explored the effectiveness of such interventions with women offenders, often finding significant improvements in symptomology and associated difficulties (Gee & Reed, 2013; Nee & Farman, 2005; Spiropoulos, Spruance, Van Voorhis & Schmitt, 2006). Psychological therapies have also been found to be effective in managing substance misuse (Brettell, 2010; Chiesa & Serretti, 2013; McMurrin, 2007). Furthermore, when asked about their experiences of the criminal justice system, women have highlighted the importance of counselling and appropriate mental health provision in supporting their recovery (Fischer, Geiger & Hughes, 2007; House of Commons Justice Committee, 2013).

The prevalence of female offenders with mental health problems is a recurring theme within the Corston Report, which was published following a review of vulnerable women in the criminal justice system. The Corston Report highlighted the lack of consistency regarding the provision of psychological support across criminal justice establishments (Home Office, 2007). Baroness Corston recommended that women-specific, community-based

2. Methodology

centres be used as referral centres for women who offend or are at risk of offending, to enable the delivery of probation and other programmes as an alternative to custody for non-violent, low-risk women (Home Office, 2007). This recommendation was subsequently accepted by the Government, and financial support was provided for the development and expansion of the existing network of women's centres (House of Commons Justice Committee, 2013).

Women's centres (or community services) deliver individually tailored services to women offenders or those at risk of offending, with a holistic approach to addressing their needs and vulnerabilities. They enable women to access a range of services, including counselling, support for drug and alcohol problems, financial and welfare advice, accommodation, education, and advocacy (BACP, 2013). Previous findings from research on women's centres have been inconclusive regarding their impact on proven re-offending (Jolliffe, Hedderman, Palmer & Hollin 2011), although it is recognised that, when used effectively, they provide a place where offence-focused work can be undertaken (Criminal Justice Joint Inspection, 2011). Research evidence suggests that women's centres produce improvements in client wellbeing (Nicholles & Whitehead, 2012) and that female offenders respond positively to women-only provision (McCord, 2012), which in turn may support desistance from offending. In addition, findings indicate return on investment in women's services, in terms of social value and savings from reduced demand in areas of health, reoffending and housing (Nicholles & Whitehead, 2012).

Despite the supporting evidence for psychological interventions for female offenders and the potential positive impact of women's centres, there is little understanding of the current provision of such interventions within women's community services across the UK. As such, this study aimed to provide a comprehensive overview of the current provision of mental health interventions within women's community services in order to identify any areas for development in services, and to increase awareness of the needs of women who access these services. An additional aim of the study was to explore the extent to which existing mental health provision within services is evaluated, as previous research has highlighted limited investment in outcome measurement systems within women's community services (Radcliffe & Hunter, 2013).

2.1 Design

A 32-item survey was developed which comprised four sections: in-house mental health provision; off-site mental health provision; client profile; and evaluation of interventions. The aim was to ascertain: the availability, type(s), delivery mode and funding of in-house mental health interventions; the use of external providers to deliver interventions; demographic details on clients using the service; and the extent and types of service evaluations undertaken (see Appendix 1 for a full copy of the survey questions). The survey was produced in an online format to facilitate completion through ease of access.

2.2 Participants

The survey was targeted at the women's voluntary and community organisations represented by Women's Breakout that provide gender-specific, community-based services to female offenders and females at risk of offending across England and Wales.

The organisations share core characteristics, such as a women-only environment, holistic approach and multi-agency partnership working, but vary in their design and delivery of services to meet the needs of their local community.

The survey was distributed to all 48 services in the Women's Breakout service directory in November 2013, with a two week window for completion.

2.3 Procedure

Women's Breakout selected one of the services in their directory (which covers services across England and Wales) to act as a pilot site. An invitation to complete the survey (see Appendix 2) and a link to access the survey were sent via email to the pilot site in October 2013. The survey for the pilot site included feedback questions on: time taken to complete the survey; the experience of completing the survey in terms of question navigation, question clarity, and overall layout; and a free text space for any further comments or suggestions for improvement.

Minor adjustments were made to the survey following the completion of the pilot. These were: the addition of a question on how services store client demographic information; and the separation of the response option of 'do not record/do not wish to provide this information' into two options for questions in the client profile section. The invitation letter to complete the survey was also amended to advise participants that they may find it useful to have client data to hand due to the questions on client profile.

2.4 Data analysis

The data were exported from the survey host website into a Microsoft Excel file and a PASW SPSS (version 18) file for analysis. Data were analysed descriptively, as appropriate for the type of data collected.

3. Findings

3.1 Survey respondents

Thirty four services took part in the survey, representing a response rate of 71%. The response rate across regions varied from 0% to 100% (see Table 1).

Table 1. Regional breakdown of services who responded to the survey (N=34).

Location	Number of participating services	Actual number of services	Response rate (%*)
North East	0	3	0
North West	2	5	40
Yorkshire & Humberside	5	5	100
Midlands	8	8	100
East Anglia	2	2	100
South West	3	4	75
London & South East	12	17	71
Wales	2	4	50
Total	34	48	71

* Percentages are rounded to the nearest whole number.

Participant descriptions of their organisational role were grouped into categories based on the job titles and any further information they provided. The majority of respondents (85%) were in senior managerial (n=11) or managerial (n=18) roles within their organisation (Table 2).

3.2 In-house mental health provision

Twenty six services (76%) indicated that they provide in-house mental health interventions. Psychological interventions were the most frequently provided intervention (n=24), followed by psycho-education (n=18) (Figure 1). 'Other' mental health interventions included: 'holistic therapies', 'art therapy', 'soft skill sessions' (such as self-esteem/confidence building), 'mentoring', 'mood mapping', and 'one to one support with a keyworker'.

Services offering any form of therapeutic intervention typically offered more than one intervention (n=21), and all services offering more than one intervention provided psychological therapy.

Twenty four services (71%) indicated that they provide psychological therapies; twenty three of these services provided information regarding the types of psychological intervention provided. Counselling was the most frequently provided type of psychological therapy (n=20), followed by person-centred therapy (n=17) and mindfulness (n=12) (Figure 2). Qualitative responses made by those who selected 'other' included 'neuro-linguistic programming' (NLP), 'co-production approach to emotional resilience', and 'wellbeing' groups.

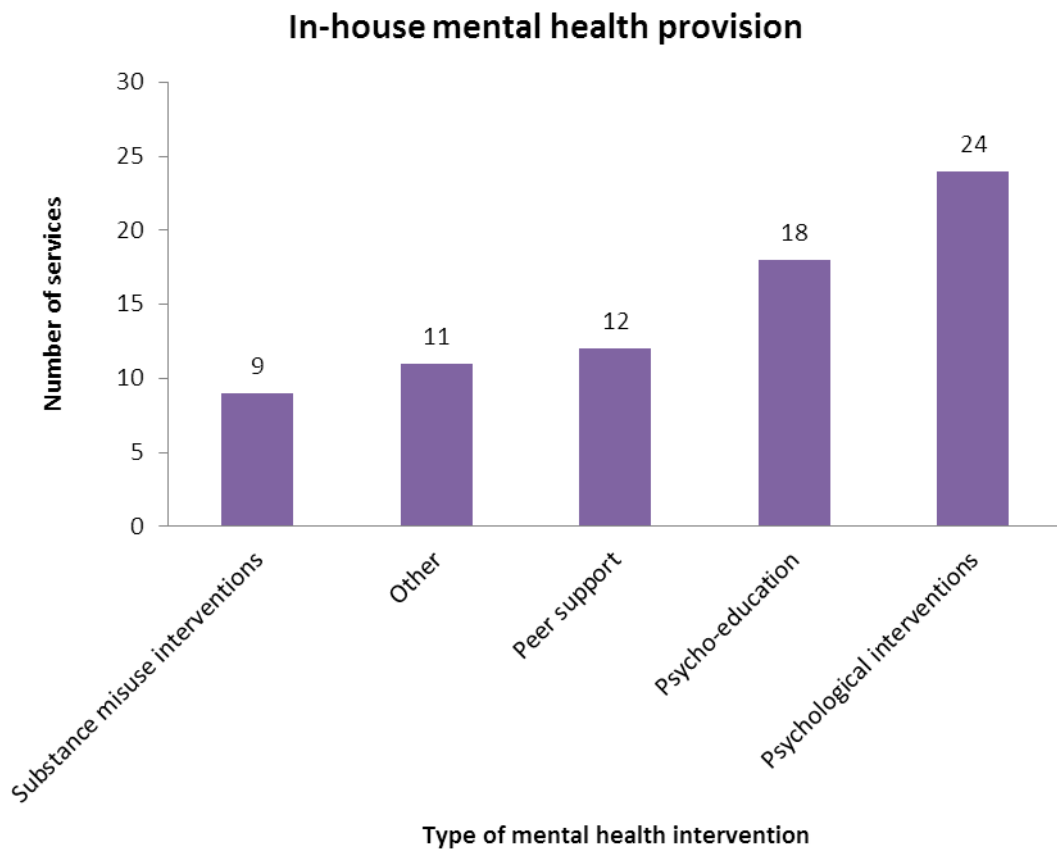
The majority (87%) of services providing any form of psychological therapy offered more than one type, on average offering 3–4 types of psychological therapy.

Twenty five services delivered mental health interventions (peer support, psycho-education, substance misuse interventions and psychological therapies) on a one-to-one basis. The majority of these services (68%) also offered group-based interventions.

Table 2. Frequency table of the organisational role identified by survey respondents (N=34).

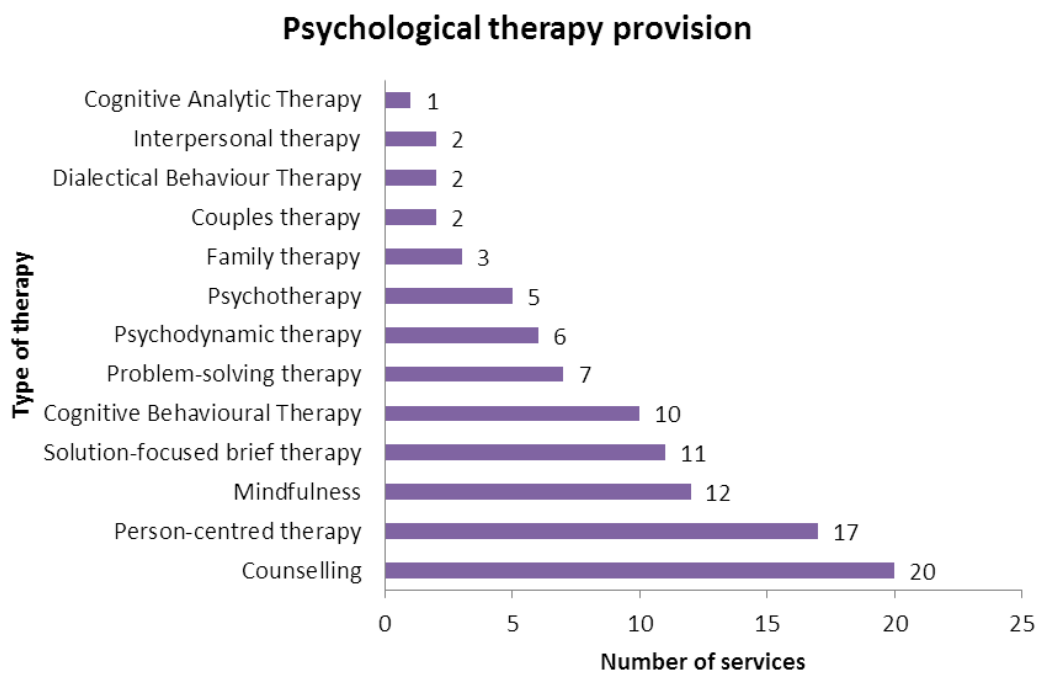
Organisational role category		Number of respondents
Senior Managerial	Chief Executive (CEO) / Managing Director	7
	Director / Senior Manager	4
	Total	11
Managerial	Service / Project / Operations Manager	13
	Data Manager	1
	Project Co-ordinator	3
	Assistant Head of Education	1
	Total	18
Non-managerial	Administration and Information Officer	1
	Project / support worker	3
	Counsellor	1
	Total	5

Figure 1. Bar chart of the numbers of services providing in-house mental health interventions (n=26).



Note: the sum of all categories is greater than 26 due to some services selecting more than one option.

Figure 2. Bar chart of the number of services providing each type of psychological therapy (n=23).



Note: the sum of all categories is greater than 23 due to some services selecting more than one option.

Staffing

All services had a qualified counsellor or other qualified practitioner, e.g. nurse, social worker or psychologist, delivering the in-house mental health interventions (Table 3). Closer inspection of the data revealed that 13 services (52%) employed both professionally qualified counsellors and other qualified practitioners.

Qualitative responses for the 'other' category indicated that services made use of a wide range of personnel alongside qualified staff to deliver in-house mental health interventions, including: student/trainee/volunteer counsellors; drug and alcohol workers; project workers; drama therapists; and a probation officer. The use of appropriate and adequate training/supervision was commented on particularly by services utilising trainee/student counsellors and volunteers.

The majority of services (80%) directly employed the staff delivering mental health interventions (Table 3). In one service, staff were employed by 'probation service', in another by the 'NHS'. One service also had a 'seconded mental health practitioner'.

In seven services (including the three services who selected 'other'), more than one organisation was responsible for employing the interventions staff, and all of these services also employed staff directly.

Funding

The majority (56%) of mental health interventions were funded by the women's centre/service, with 15 services identifying more than one source of funding (Table 3). Four services sought funding solely from external sources, including 'NHS', 'Clinical Commissioning Groups' (CCGs), 'Probation Traded Income', 'Big Lottery' funding, and charitable trust funds.

Referrals

The method of referring clients to in-house interventions used by most services was referral by staff member (80%), followed by referral by another agency (e.g. probation service) (76%) and self-referral (64%) (Table 3).

Respondents provided qualitative information about any variations in the referral method dependent on the type of intervention. Some indicated that the referral process

Table 3. Details of in-house mental health interventions: types of staff, employing organisations, funding providers, and referral methods.

		Number of services (n=25)	% of services*
Type of staff delivering interventions			
	Professionally qualified counsellor	21	84
	Other qualified practitioner (e.g. nurse, social worker, psychologist)	17	68
	Other	13	52
Organisation responsible for the employment of staff delivering interventions			
	Women's centre/service	20	80
	Local authority	1	4
	Other government body	3	12
	Third/voluntary sector organisation	6	24
	Other	3	12
Funding provider for interventions			
	Women's centre/service	14	56
	Local authority	6	24
	Other government body	8	32
	Third/voluntary sector organisation	7	28
	Other	9	36
Method of referring clients to interventions			
	Self-referral	16	64
	Referral by staff member	20	80
	Drop-in service	8	32
	Referral by other agency (e.g. probation service)	19	76
	Other	7	28

Note: the sum of values in each section is greater than 25 due to some services selecting more than one option.

*Percentages are rounded to the nearest whole number.

is the same for all clients, with one identifying the use of a triage approach to referrals regardless of the referral source. Other services indicated the use of staff (from the service or other agencies) referrals for specific therapeutic interventions such as anger management. One service also identified the use of joint working between themselves and the probation service in the assessment of referrals.

Waiting times

The most common average waiting time for an in-house appointment with a mental health practitioner was two weeks or less (36%). Twenty four percent of services indicated that the average waiting time was 'other', describing waiting times as being: dependent on the service or counsellor's caseload; 'immediate'; 'drop-in' appointments; or 'up to six months'.

3.3 Off-site mental health provision

Thirty three services (97%) indicated that they refer clients to off-site mental health providers, with the majority of services (58%) identifying more than one reason for referral. The most frequent reasons for referral were a lack of or limited internal resources and service availability (48%), followed by specialist client needs (e.g. substance misuse, self-harm, bereavement) (45%), and specialist mental health/psychiatric client needs (39%).

Substance misuse interventions (70%) and psychological interventions (64%) were the most commonly cited types of off-site mental health intervention (Figure 3). 'Other' provision included 'psychiatric assessment', 'referral to secondary services', 'recovery through arts', 'complex or diagnosable mental health conditions'.

Provision

The most frequent providers of off-site interventions were the local NHS or Primary Care (PCT) Trusts (82%), followed by charitable and third sector organisations (70%) (Table 4). 'Other' providers were 'Probation' and the 'Women's Centre workers...via outreach appointments'. The majority of services (67%) indicated more than one organisation as providing off-site interventions.

Referrals

Referral by staff member was the most common referral method used by services to refer clients to off-site interventions (94%), followed by referral by another agency (52%) (Table 4). 'Other' methods of referral included 'GP' and 'most of our referrals are to specialised areas'. Nineteen services (58%) reported the use of multiple referral methods.

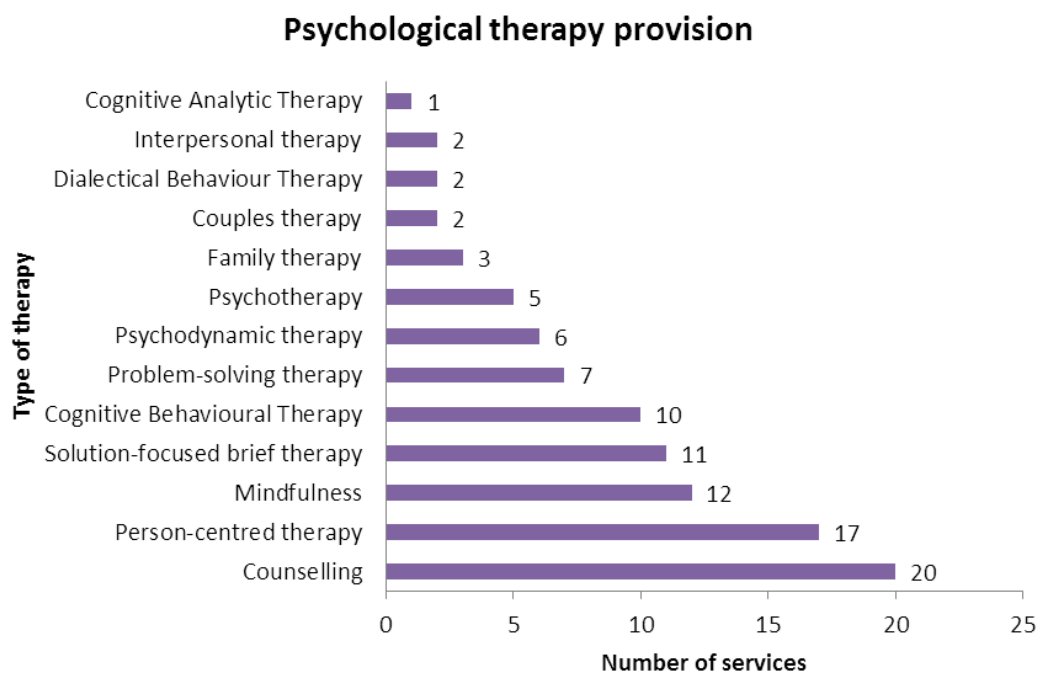
Waiting times

When asked about the waiting times for an appointment with an off-site mental health practitioner, the majority of respondents (45%) were unable to give a clear answer and selected 'other'. Qualitative descriptions provided by these respondents included: 'don't know'; 'depends on service'; 'between two and 24 weeks'; 'up to twelve months'. The most frequently identified average waiting time from categories with a specified value range was six weeks or more (21%).

3.4 Client profile

Twenty two services (65%) provided information on the total number of clients who had used their services in the past month (Table 5). Fifteen services (44%) provided information

Figure 3. Bar chart of the types of off-site mental health provision (n=33).



Note: the sum of all categories is greater than 33 due to some services selecting more than one option.

Table 4. Details of off-site mental health interventions: service providers and referral methods.

		Number of services (n=33)	% of services*
Organisation providing off site mental health interventions			
	NHS/PCT	27	82
	Local authority	11	33
	Charitable/Third sector organisation	23	70
	Private sector organisation	4	12
	Don't know	1	3
	Other	2	6
Referral method			
	Self-referral	13	39
	Referral by staff member	31	94
	Drop-in service	3	9
	Referral by other agency (e.g. probation service)	17	52
	Other	3	9

Note: the sum of values in each section is greater than 33 due to some services selecting more than one option.

*Percentages are rounded to the nearest whole number.

about client age, with the majority of clients being aged 25–64 years (Table 5).

Thirteen services (38%) provided data on client ethnicity, although data from four of these services were incomplete (the sum of category values did not equal the total number of clients for that service). All categories of ethnic background were represented amongst clients, with the majority of clients being of white ethnicity, followed by clients of black/black British origin (Table 5).

Information on the number of clients with dependents under the age of 18 was provided by ten services (29%); over a quarter of all clients (28%) were in this category (Table 5).

Four services (12%) indicated the living arrangements of their clients, with one of these services providing incomplete data. Most clients lived with family members, closely followed by those living with friends (Table 5).

Responses from services that provided limited or no details on client demographics indicated that some data collection took place, but that this was not necessarily consistent, e.g. 'not for all service users', 'this would involve further data collation than currently available', 'only record quarterly'.

Twenty four services (71%) indicated the presenting issue(s) experienced by clients who had used their services in the past month, and where the treatment took place (Figure 4).

The most common presenting issues treated in-house were anxiety (n=20) and relationship issues (n=20), followed by domestic abuse (n=19), depression (n=18) and anger management (n=18). The most common presenting issue treated off-site was personality disorder (n=17), followed by substance/alcohol misuse (n=14). Personality disorder

was the only presenting issue which was treated more frequently off-site than in-house.

Responses to the 'other' category for presenting issues (n=8) included: loss and bereavement; self-esteem/confidence; identity; abuse and trauma; isolation and agoraphobia; parenting issues; offending behaviour; and safeguarding of children.

3.5 Evaluations of in-house mental health interventions

Of the 26 services who provide in-house mental health interventions, 13 (50%) indicated that they undertake evaluations and gave details of these. Some services identified specific, externally validated measures and tools, whilst others gave more general descriptions such as 'reviews', 'evaluation forms' and 'in house monitoring'.

All 13 services indicated that they use information gathered through evaluations to secure funding or bid for commissions (Figure 5). The majority also use evaluation data to improve interventions (92%) and justify service provision (85%). Almost two-thirds of these services (62%) use the information to develop new interventions and maintain client records. Responses for 'other' uses of information were: 'for contract outcomes monitoring' and 'to track recovery rates'.

Nineteen services (56%) indicated they would be interested in helping to evaluate mental health provision in women's community centres, whilst twenty one services (62%) indicated that they would be willing to take part in a more in-depth interview about mental health provision within their service.

Table 5. Client demographic information across all services.

		Total	% of all clients*
Number of service users within the past month		2296	–
Client age	16–24 years	398	17
	25–64 years	1222	53
	65 years and over	147	6
	Unknown	529	23
Client ethnicity	Asian/Asian British	72	3
	Black/Black British	323	14
	White	538	23
	Mixed ethnicity	28	1
	Chinese/other Asian ethnicity	5	<1
	Other ethnicity	23	1
	Unknown	1307	57
Number of clients with dependents under the age of 18		636	28
	Unknown	1660	72
Client living arrangements	Living with a partner as a couple	151	7
	Living with family members	313	14
	Living with friends	53	2
	Living alone	111	5
	Unknown	1668	73

*Percentages are rounded to the nearest whole number and therefore do not necessarily total 100 for each category.

4. Discussion

The findings from this survey indicate that a high proportion of women's community services provide a variety of in-house mental health interventions to meet client needs, including various psychological therapies which are known to be effective in treating a range of mental health needs. It was encouraging to note that within the majority of these services, interventions were delivered by qualified and trained professionals, and that access to interventions was facilitated by a multitude of referral methods.

All participating services except one indicated that they refer clients to off-site mental health providers, suggesting that they had established effective working relationships with other service providers. In addition, the reasons outlined for using off-site provision, such as to meet specialist client needs, indicate an awareness of professional competencies and limitations, and an understanding of the needs of their clients.

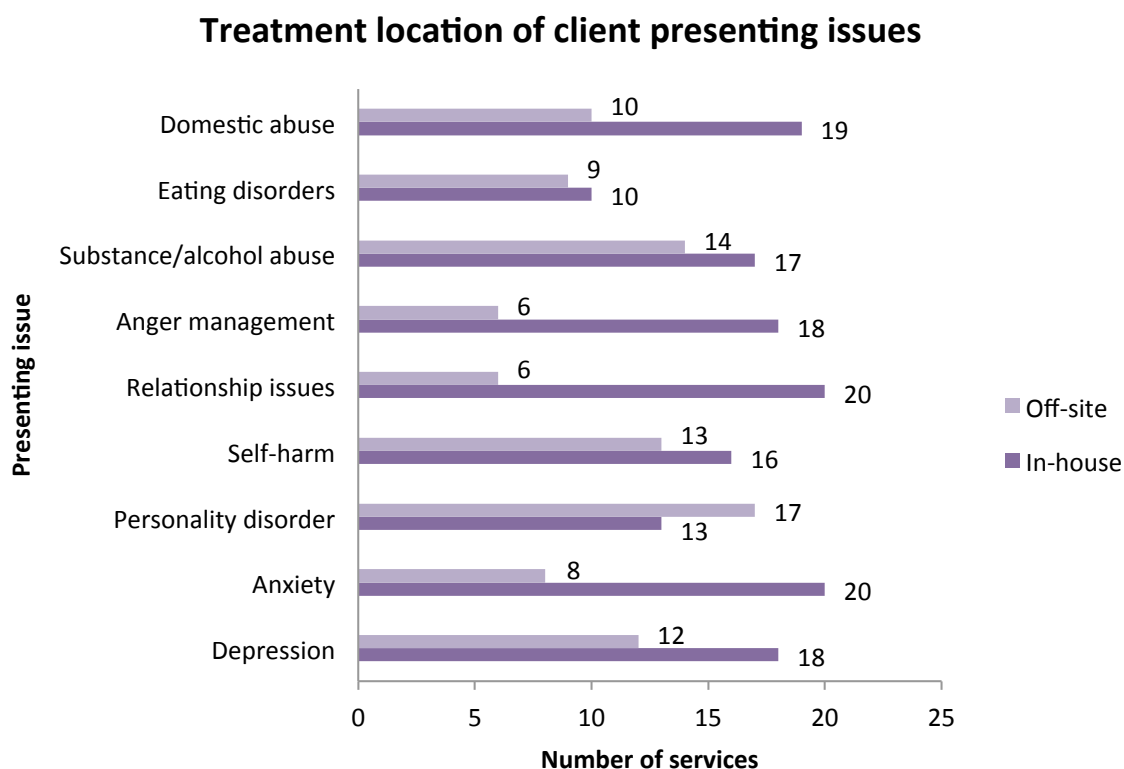
A comparison of in-house and off-site provision indicated that clients typically wait longer for an appointment with an off-site practitioner, and the qualitative responses provided for the 'other' category indicated more uncertainty regarding waiting times for off-site appointments than in-house appointments. In addition, the longest waiting time reported in the 'other' category for in-house appointments was six months, compared to 12 months for off-site

appointments. This could have detrimental effects for clients when one considers that referrals to off-site provision were typically to meet specialist needs or due to limited internal resources, and mental health has been identified as a risk factor for offending and recidivism (e.g. Light, Grant & Hopkins, 2013).

It is difficult to draw meaningful conclusions from the client demographic data, as for some questions less than a third of participants provided information. It should also be noted that there was considerable variation in the number of clients seen by individual services, which ranged from one client to 600 clients. Overall, findings indicated that the majority of clients were white and aged between 25 and 64, and that many women had dependents under the age of 18. Whilst the majority of clients were white, black and black British women were over-represented within this population when compared with the population in England and Wales as a whole. Data from the 2011 Census of England and Wales indicated that just 3.4% of the population were of black or black British origin, compared with 14% of female clients in this study (Office for National Statistics, 2011). However, the figure found in this study is comparable with that of the female prisoner population, with 13% of female prisoners being of black/black British origin in 2011 (Ministry of Justice, 2012).

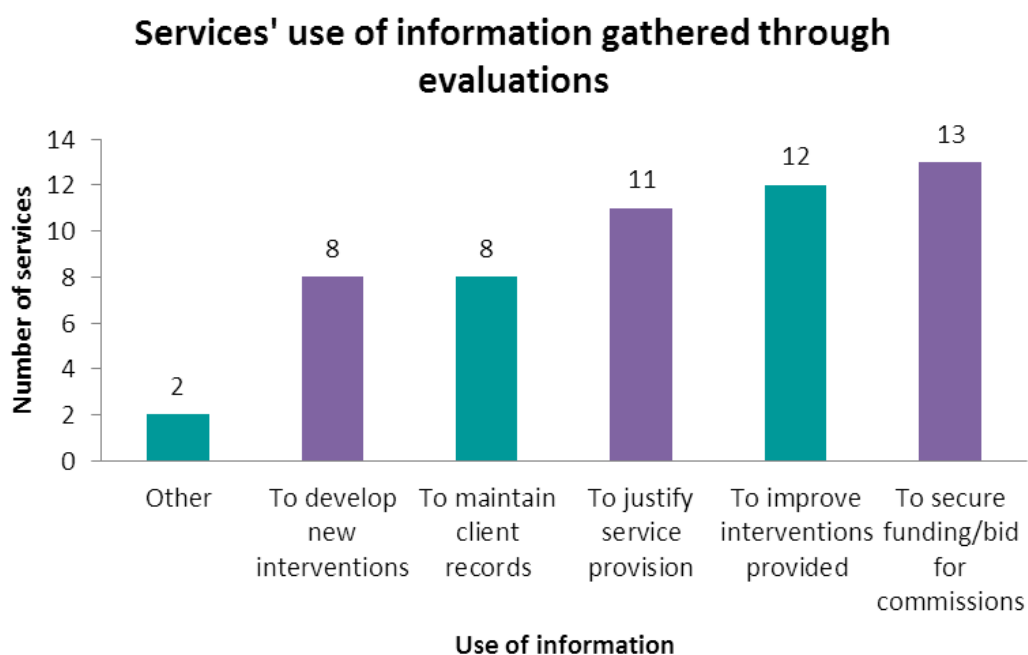
The information gathered on client demographics is suggestive of limited recording practices within services.

Figure 4. Bar chart of client presenting issues and location of treatment (n=24).



Note: the sum of all categories is greater than 24 due to some services selecting more than one option.

Figure 5. Services' use of information gathered through evaluations of mental health interventions (n=13).



Note: the sum of all categories is greater than 13 due to some services selecting more than one option.

5. Conclusions and recommendations

Data were not provided on the ethnic background of more than half of the clients seen in the past month, and there was no information on client dependent and living status for almost three quarters of service users. This is unfortunate given that such details can be useful for targeting service provision and identifying trends amongst service users. In particular, data regarding the number of clients with dependents is particularly important given that parental imprisonment is a predictor of undesirable child outcomes (Murray, Farrington, Sekol & Olsen, 2009), and family separation is an event likely to cause distress to all parties. Thus diverting women from custody may also have beneficial effects for their offspring as well as for their own wellbeing.

The data gathered on client presenting issues reflect the findings of previous research (e.g. Light, Grant & Hopkins, 2013; Maden, Swinton & Gunn, 1994) regarding the range and complexity of the needs and vulnerabilities of female offenders. Within this study, service users presented with various mental health issues, such as depression and anxiety, as well as substance misuse and eating disorders and experiences of abuse and self-harm. It was interesting to note that personality disorder was the only presenting issue more likely to be treated off-site as opposed to in-house – most likely a reflection of the complex and challenging nature of this disorder, highlighting the need for specialist intervention.

On the basis of overall responses, services appear to have an awareness of the purpose of evaluations in terms of measuring client progress and gathering client feedback on interventions. An understanding of the applications of the information gathered from evaluations, for example to secure service funding or improve interventions, was also evident. However, only half of the services providing in-house interventions undertook evaluations of their provision, despite such evidence being vital in the current climate where services need to demonstrate tangible impacts and benefits in order to secure future funding. There was also variation in the types of evaluations undertaken, with some services using validated measures and others utilising generic questionnaires and evaluation forms, which suggests there is not a uniform approach to gathering this information. Again, this could be of detriment to services in ensuring their continuation if there is a lack of consistency in their measures of impact and effectiveness.

The majority of services indicated they would be interested in evaluating mental health provision in women's centres, and be willing to take part in a more in-depth interview about provision within their service, which bodes well for future research in this area.

The findings from this survey indicate that women's community services provide a variety of mental health and other psychosocial interventions in order to meet the needs and vulnerabilities of a diverse client group.

Services appear to have established good working partnerships with other organisations, such as local authorities, NHS trusts and probation services in order to meet the mental health needs of their clients.

The use of evaluations in some services is promising, although this is an area in which substantial developments could be made. In the current climate of probation service privatisation (Ministry of Justice, 2013a) and the Ministry of Justice's drive towards a payment by results (PBR) system (Ministry of Justice, 2013b), the ability to demonstrate the effectiveness and value of services will become paramount to ensure continued funding. In addition, the National Offender Management Service (NOMS) has acknowledged variations in how services have interpreted guidance on data collection, leading to disparities in recording practices (National Audit Office, 2013).

This research has provided a base upon which to build future studies. This would ideally include:

- conducting follow-up interviews with respondents who indicated a willingness to participate in further discussions regarding mental health provision, to obtain a clearer picture of this aspect of work within services;
- exploring in further detail the types of evaluations and outcome measures used by services to assess their mental health provision;
- developing a standardised approach to client data collection and management, to allow for meaningful comparisons across services;
- developing a robust package of valid and reliable outcome measures for use across services;
- investigating women's experiences of receiving psychological therapies in this context
- conducting a pilot introducing in-house mental health provision within services which currently have no such resources, and evaluating the impact and benefits of this in meeting the needs of female clients, promoting their wellbeing, and reducing re-offending.

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Appendix 1:

Survey questions distributed to members of Women's Breakout. Coloured text provides information only and was not included in the actual survey.

This survey aims to explore the current provision of mental health services (e.g. counselling) across women's community services in England and Wales. The term 'women's community services' is used here to encompass organisations which provide gender-specific, community-based services for women in contact, or at risk of coming into contact with the criminal justice system.

The information gathered will be used to provide a better understanding of the services offered and the women who use them, with an overall aim of identifying and promoting best practice, and increasing awareness of the needs of women.

All survey responses will be kept anonymous.

The survey should take approximately 20 minutes to complete.

Q1. Please tell us your role within the service (job title/brief description)

[Free text box]

Q2. Please indicate the location of your service

[Drop-down list of options; respondents able to select one option only.]

Options:

- North East
- North West
- Yorkshire & Humberside
- East Midlands
- West Midlands
- East Anglia
- South West
- London
- Other South East
- North Wales
- South Wales
- Prefer not to say

Section 1 – In-house mental health provision

Q3. Does your centre provide in-house mental health interventions?

[Tick-box list of options; respondents able to select one option only. Those who selected 'No' or 'Don't know' were routed to Section 2 of the survey; those answering 'Yes' continued with Section 1.]

Options:

- Yes
- No
- Don't know

Q4. What type(s) of mental health intervention do you offer? (Please choose all that apply)

[Tick-box list of options and free text box; respondents able to select multiple options and enter information into free text box. Those who did not select 'psychological interventions' were routed to question 6; those who did continued to question 5.]

Options:

- Peer-support
- Psycho-education (e.g. anger management)
- Substance misuse interventions
- Psychological interventions (e.g. counselling/psychotherapy)
- Other (please specify) [free text box provided]

Q5. What type(s) of psychological therapy do you offer? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box.]

Options:

- Counselling
- Cognitive behavioural therapy (CBT)
- Cognitive analytical therapy (CAT)
- Couples therapy
- Dialectical behavioural therapy (DBT)
- Family therapy
- Interpersonal therapy
- Mindfulness
- Person-centred therapy
- Problem-solving therapy
- Psychodynamic therapy
- Psychotherapy
- Solution-focused brief therapy
- Other (please specify) [free text box provided]

Q6. How are mental health interventions delivered within your service? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into free text box.]

Options:

- One-to-one
- Group session
- Other (please specify) [free text box provided]

Q7. What type(s) of staff deliver the interventions? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into free text box]

Options:

- Professionally qualified counsellor
- Other qualified practitioner (e.g. nurse, social worker, psychologist)
- Other (please specify) [free text box provided]

Q8. Who employs the staff delivering the interventions? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into free text box]

Options:

- Directly employed by the women's centre/service
- Local authority
- Other government body
- Third/voluntary sector organisation
- Other (please specify) [free text box provided]

Q9. Who provides the funding for mental health interventions within your service? (If funding is from a number of providers, please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into free text box]

Options:

- Women's centre/service
- Local authority
- Other government body
- Third/voluntary sector organisation
- Other (please specify) [free text box provided]

Q10. How are clients referred to in-house mental health services? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into free text box]

Options:

- Self-referral
- Referral by staff member
- Drop-in service
- Referral by other agency (e.g. probation service)
- Other (please specify) [free text box provided]

Q11. If there are different referral processes for different interventions (e.g. self-referral for some, but referral by staff for others) please give details below.

[Free text box]

Q12. What is the typical waiting time for an in-house appointment with a mental health practitioner?

[Tick-box list of options; respondents able to select one option only]

Options:

- Two weeks or less
- Two to four weeks
- Four to six weeks
- Six weeks or more
- Other (please specify) [free text box provided]

Section 2 – Off-site mental health provision

Q13. Do you refer clients from your service to off-site mental health providers?

[Tick-box list of options; respondents able to select one option only. Those who selected 'No' or 'Don't know' were routed to Section 3 of the survey; those answering 'Yes' continued with Section 2.]

Options:

- Yes
- No
- Don't know

Q14. What are your reasons for using off-site mental health provision?

[Free text box]

Q15. What type(s) of mental health interventions are provided off-site? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box]

Options:

- Peer-support
- Psycho-education (e.g. anger management)
- Substance misuse interventions
- Psychological interventions (e.g. counselling/psychotherapy)
- Don't know
- Other (please specify) [free text box provided]

Q16. Who provides off-site mental health interventions? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box]

Options:

- NHS/PCT
- Local authority
- Charitable/third sector organisation
- Private sector organisation
- Don't know
- Other (please specify) [free text box provided]

Q17. How are clients referred to off-site mental health services? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box]

Options:

- Self-referral
- Referral by staff member
- Drop-in service
- Referral by other agency (e.g. probation service)
- Other (please specify) [free text box provided]

Q18. What is the typical waiting time for an appointment with an off-site mental health practitioner?

[Tick-box list of options; respondents able to select one option only]

Options:

- Two weeks or less
- Two to four weeks
- Four to six weeks
- Six weeks or more
- Other (please specify) [free text box provided]

Section 3 – Client profile

Q19. How many women have used your women's service in the past month?

[Free text box]

Q20. Please indicate the ages of the women who have used your service within the past month (total numbers for each category). If you do not record or do not wish to provide this information, please put an 'x' in the relevant box below.

[Free text box for each category]

Options:

- Aged 16–24
- Aged 25–64
- Aged 65 and over
- Do not wish to provide these details
- Do not record these details

Q21. Please indicate the ethnicity of the women who have used your service in the past month (total numbers for each category). If you do not record or do not wish to provide this information, please put an 'x' in the relevant box below.

[Free text box for each category]

Options:

- Asian or Asian British
- Black or Black British
- White
- Mixed Ethnicity
- Chinese or other Asian ethnic group
- Other ethnicity
- Do not wish to provide these details
- Do not record these details

Q22. How many of the women using your centre in the past month have dependents under the age of 18? If you do not record or do not wish to provide this information, please put an 'x' in the relevant box below.

[Free text box for each category]

Options:

- Total number of women with dependents
- Do not wish to provide this information
- Do not record this information

Q23. Please indicate the domestic arrangements of women who have used your service within the past month (total numbers). If you do not record or do not wish to provide this information, please put an 'x' in the relevant box below.

[Free text box for each category]

Options:

- Living with a partner as a couple
- Living with family members
- Living with friends
- Living alone
- Do not wish to provide these details
- Do not record these details

Q24. Please indicate the presenting issue(s) experienced by women using your service within the past month which have required mental health interventions, and whether the treatment(s) took place in-house and/or off-site.

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box]

Options:

	In-house	Off-site
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Personality disorders	<input type="checkbox"/>	<input type="checkbox"/>
Self-harm	<input type="checkbox"/>	<input type="checkbox"/>
Relationship issues	<input type="checkbox"/>	<input type="checkbox"/>
Anger management	<input type="checkbox"/>	<input type="checkbox"/>
Substance/alcohol misuse	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
Domestic abuse	<input type="checkbox"/>	<input type="checkbox"/>

Other (please specify) [free text box provided]

Q25. How do you store the data from questions 19–13 within your service?

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box]

Options:

- Electronic database
- Paper copies
- Other (please specify) [free text box provided]

Section 4 – Evaluation of interventions

Q26. Do you undertake any evaluations of the in-house mental health interventions provided by your service?

[Tick-box list of options; respondents able to select one option only. Those who selected 'No' or 'Don't know' were routed to question 29 of the survey; those answering 'Yes' continued with Section 4.]

Options:

- Yes
- No
- Don't know

Q27. Please provide details of the evaluations you undertake:

[Free text box]

Q28. How do you use the information collected by your evaluations? (Please choose all that apply)

[Tick-box list of options; respondents able to select multiple options and enter information into the free text box]

Options:

- To improve interventions provided
- To develop new interventions
- To secure funding/bid for commissions
- To justify service provision
- To maintain client
- Other (please specify) [free text box provided]

Q29. Would you be interested in helping to evaluate mental health provision within women's community services?

[Tick-box list of options; respondents able to select one option only.]

Options:

- Yes
- No

Q30. Would you be willing to take part in a more in-depth interview about mental health provision in your service?

[Tick-box list of options; respondents able to select one option only. Those who selected 'No' were routed to question 32 of the survey; those answering 'Yes' continued with Section 4.]

Options:

- Yes
- No

Q31. Please provide contact details below:

[Free text box for each category]

Options:

- Name
- Company
- Email Address
- Phone Number

Q32. If you have any further comments, please use the space below:

[Free text box]

Thank you.

Thank you for taking the time to complete this survey, we are grateful for your participation.

Appendix 2: Invitation to complete the survey

The British Association for Counselling and Psychotherapy (BACP) is collaborating with Women's Breakout and Centre for Mental Health on a survey project looking at the provision of mental health interventions across women's community services (women's centres/projects) in England and Wales.

The survey aims to provide a clearer understanding of current service provision to identify and promote best practice, and highlight potential areas for service development. A secondary aim of the survey is to gain a snapshot of the clients who use women's services in order to better understand their needs and service requirements.

We would be grateful if you could help us with this project by taking part in the survey. Your participation will assist us in achieving our aims and we value the unique insights you can provide in this area. As some of the questions ask about client characteristics (such as age, ethnicity, etc.) you may find it helpful to have this information to hand.

Please follow the link provided in the email to access and complete the survey. The deadline for survey completion is Monday 18 November. All survey responses will be kept anonymous, and will not be attributed to a particular organisation in any subsequent reports. We will send out a copy of the final report for information to everyone invited to take part.

Thank you for your support and co-operation.

Kind regards,

Nancy Rowland

BACP Director of Research, Policy and Professional Practice

On behalf of the collaboration between BACP, Women's Breakout, and Centre for Mental Health



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