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1. **Preface**

This report outlines a partnership project that was initiated to acknowledge the difficulties for women who have a range of complex needs and to look at their access to appropriate mental health services. The group of women identified were those in attendance at a Birmingham women's centre; Anawim. The project was funded for two years and aimed to ensure equality of access to timely, sensitive and appropriate levels of mental health support for this group of women. A female qualified mental health practitioner (MHP) was seconded from Birmingham and Solihull Mental Health NHS Foundation Trust to Anawim for one day a week and offered a combination of appointment slots and drop–in time for the women and the staff.

The women seen by the MHP during the project were typically in their mid-thirties and considered themselves to be white British. The women were often referred into Anawim from the probation service and were seen for an informal chat or a mental health assessment. They were generally not under mental health services with only around half being registered with a GP. The women generally presented with depression or low mood, anxiety, alcohol or drug problems and social issues. High numbers of women were currently using alcohol or drugs, were on a community order or were experiencing relationship difficulties.

Questionnaire data highlighted that the staff at Anawim were already working with mental health issues and were doing so in a variety of ways, and although they felt that this was important, they also felt that they needed more knowledge to do so competently. Staff highlighted that in order to increase their competence they needed specialist mental health training, better care pathways and referral routes, a MHP based at Anawim and regular supervision.

This piece of work demonstrates the positive results achieved through partnership working in Birmingham, and suggests that recognising and acknowledging the needs of these women, and providing a coordinated response to them, is a major achievement and one that is on track to continue.
2. Introduction

2.1 Background

This report outlines a partnership project that was initiated to acknowledge the difficulties for women who have a range of complex needs and to 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’.

This 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 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 (Corston, 2007). She highlighted three 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 (Corston, 2007), ministerial champion Maria Eagle and the National Offender Management Service (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 and resources 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 and their transient and generally chaotic lifestyles, meant they were often unable to attend their local GP in order to access services, and if they did, consistent attendance at appointments appeared to be a difficulty.

They often did not meet the criteria needed to be seen by secondary mental health services, and primary care services were unable to meet their needs. Often, the only contact with mental health services this group of women had was when in crisis or 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 Anawim 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; which 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 issues such as depression, anxiety, post-traumatic stress disorder, self-harm issues, and low self-esteem are often prevalent and are 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; however, do not identify the experiences that may have preceded them or understand the behaviours that are often associated with and exhibited by this group. Mental health practitioners are not always equipped with knowledge about the impact of these experiences and services are not designed or developed to enable this group of women to successfully access support, or to sustain it.

The response from all healthcare professionals needs to be one that acknowledges the underlying causes, not just the consequences of the abuse and lifestyle of this client group. Understanding the dynamics of power inequality and persistent systematic violence and abuse on their physical and mental health will enable appropriate responses and intervention; whilst ensuring 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 or service can successfully ‘go it alone’.
2.2 The initial partnership

2.2.1 Anawim:

This is a charitable service for women that was founded in 1986 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.

In addition to this, Anawim now offers support to women over the age of 18 years 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 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 a holistic service to women with complex needs and their children. Mental health provision was one area that was missing and needed to be addressed.

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 them to access a range of services using an integrated framework.

Women are also attending as part of community sentences via Staffordshire and West Midlands Probation Trust. This has increased the amount of women attending the centre who are on community payback and specified activity schemes. Between October 2009 and October 2011 a total of 209 women were referred to Anawim.

2.1.2 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 their lives and the lives of others.
RDA agreed funding to enable this project to get up and running for the first 12 months and for it to be a part of a wider network of pilot projects under the national development programme. This enabled the work to be recognised nationally, evaluated and the learning disseminated. There was also an expectation that any learning would be embedded within mainstream local services.

2.1.3 Birmingham and Solihull Mental Health Foundation Trust (BSMHFT):

BSMHFT is commissioned to deliver many of the mental health services available to people living in Birmingham and Solihull who are experiencing mental health difficulties. The population covered is 1.2 million spread over 172 square miles and is very culturally and socially diverse.

The Trust has committed itself to ensuring that equality is at the heart of all its functions and so recognise that gender equal services do not mean ‘same’ services for both women and men. One size does not fit all and 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.

2.1.4 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.

2.1.5 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.
2.1.6 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.

2.3 Aims of the project

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 differences and consider service design and delivery in light of these differences. In order 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 is required. 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 made clear 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 initially funded for 12 months and aimed to be able to identify:

- The mental health needs of the women in attendance at Anawim
- The numbers of these 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
At the end of the first year the steering group was dissolved, however funding was secured from BSMHFT to extend the project for a further 12 months. This provided the opportunity to work on the recommendations generated from the first year and also to:

- Develop sustainable ways of maintaining the partnership in the absence of the mental health practitioner
- Develop links with community mental health teams
- Continue to raise awareness of the centre and its services both locally and nationally
- Develop and deliver a comprehensive training package to staff based on their needs
3. **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 four meetings were agreed as a starting point (January, March, May and September 2010).

A female qualified mental health practitioner (MHP) was identified from the dual diagnosis field; she was then seconded from Birmingham and Solihull Mental Health Foundation Trust and based at Anawim’s centre for one 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 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, in addition to tasks such as admin and 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 first couple of weeks 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 (see appendix 1); this tool provided a means by which they could refer women to her. This particular assessment tool was chosen for its design and ease of use and because it is not just intended for trained mental health professionals.

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 questionnaire (see appendix 2) to
Anawim staff as a way of establishing a baseline. This clearly showed the need for a training and development programme for the staff group. The results are presented in detail in section five of the report.

The MHP began taking referrals during the last two weeks of October 2009. 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 conducted. Each of these sessions were evaluated to ensure that they were effective at raising staff awareness and confidence.

Anawim as a service was not well known to local mental health teams. The MHP coordinated an open afternoon at the centre specifically for mental health practitioners, to raise the profile of the centre and their services as well as knowledge of the local CMHTs. 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 what the views of Anawim staff were on the issue of mental health need in their client group, the MHP distributed a questionnaire (see appendix 3) to all staff that asked about their perceptions of their clients’ mental health needs. A database was set up and a data collection form (see appendix 4) was designed as a way of recording information about the women that were referred, including information such as:

- 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 staff whose clients had been seen by the MHP and from the women themselves about the intervention. After the initial 12 month project reached an end, the Steering group dissolved and it was agreed by the service director
from BSMHFT Addictions Programme to extend the MHP’s secondment for a further 12 months. The focus for the second year was on further development of care pathways and continued support to Anawim staff and clients.

The aim of this final report is to look at the data collected both qualitative and quantitative over the two year project period from October 2009 to October 2011 and to draw out any key themes, experiences, recommendations and implications for future joint working projects.
4. Client information

This section of the report will provide a detailed description of the client group seen by the MHP over the 2 year period, highlighting referral information, demographic details, mental health information, presenting issues and outcomes.

4.1 Referrals

A total of 209 clients were referred to Anawim between October 2009 and October 2011. The majority of referrals came from the probation service (n = 112, 53.6%), with high numbers also being self-referrals (n = 36, 17.2%) or referrals from the prison service (n = 18, 8.6%). The high proportion of women referred to Anawim via the probation service reflects the fact that Anawim is partly funded by the Criminal Justice System, and due to this, high numbers of women were in attendance at Anawim following the receipt of a Specified Activity Order. Unfortunately, a number of clients did not specify their referral route (n = 20, 26.7%).

Across the same time period a total of 75 clients were referred to the MHP at Anawim, representing 35.9% of the total number of referrals. Of the 75 referrals, 56 were seen by the MHP; the remaining 19 did not attend their appointment. Similarly to the pattern of referrals to the service, the highest number of referrals to the MHP were women that had been referred to Anawim via the probation service (n = 29, 38.7%), followed by self-referrals (n = 7, 9.3%). The referral routes of the clients seen by the MHP are displayed in Figure 1.
The clients referred to the MHP were mainly referred by other staff within the service (n = 59, 78.7%), however a small number of clients referred themselves (n = 4, 5.3%) or were referred by their CPN (n = 1, 1.3%). Eleven (14.7%) clients did not specify how they were referred to the MHP. The clients were referred to the MHP for various reasons, as displayed in Figure 2.
Figure 2 indicates that a high number of women requested an informal chat (n = 28, 37.3%) with the MHP rather than a structured mental health assessment or advice. This suggests that an informal chat may be a useful starting point and a good engagement strategy when working with this client group.

4.2 **Client demographics**

The clients referred to the MHP had a mean age of 36, with a range of 19 to 60. The highest number of clients fell into the 26 to 35 age group (n = 20, 26.7%), with the smallest number of clients falling into the 56 to 65 age group (n = 2, 2.7%). The age groups of the clients are presented in Figure 3.

Figure 3. Client age.

![Client age chart]

Client ethnicity was specified for 72 (96.0%) of the clients seen by the MHP. As presented in Figure 4, the majority of clients were considered to be white British (n = 38, 50.6%).

![Client ethnicity chart]
4.3 Client mental health status

Of the 75 clients referred to the MHP, 18 (24.0%) stated that they had been under secondary mental health services in the past and 14 (18.7%) stated that they were currently with a mental health team (16 (21.3%) did not specify), and had been for between one week and ten years. Twelve (85.7%) of these clients were with a community mental health team, one client (7.1%) was with the mother and baby team and one client (7.1%) did not specify which team they were with. Of the fourteen clients who were under secondary services, two (14.3%) stated that they had a care coordinator and eight (57.1%) were seen as outpatients (four (28.6%) did not specify). Further, three (21.4%) clients stated that they had a care plan and three (21.4%) stated that they did not (eight (57.1%) did not specify). Thirty seven (49.3%) of the 75 referrals stated that they were registered with a GP and three (4.0%) had a mental health primary care worker; eight (10.7%) women stated that they had neither and 27 (36.0%) did not specify.

Thirty-two (42.6%) of the clients stated that they were on medication for their mental health issues. Twenty-four (32%) clients stated that they were not on any medication and 19 (25.3%) did not specify. Of the clients who stated that they were on medication, the majority of clients were being prescribed antidepressants (n = 27, 36.0%), although a
number of clients were being prescribed more than one type of medication. The number of clients on various medications is presented in Figure 5.

Figure 5. Client medication.

4.4 Client parental status

Forty (53.3%) of the women stated that they had children, 15 (20.0%) that they did not have children and the remaining 20 (26.7%) did not specify. Of the 40 women who had children, 20 (50.0%) had their children living with them, 16 (21.3%) did not and 4 (5.3%) did not specify. The children who were not living with their mother were either with a significant other (n = 7, 43.8%), being looked after by social services (n = 4, 25%), had been adopted (n = 1, 6.3%) or had grown up and moved out (n = 4, 25.0%). Child protection issues were identified for 13 (32.5%) of the mothers.

4.5 Presenting problems

Upon initial contact with the client the MHP was required to record the reason why the client had been referred to her or why the client wanted to be seen. The most common presenting problems for the 56 women who were seen by the MHP are shown in Figure 6.

Figure 6. Presenting problem of women referred to the MHP.
Figure 6 highlights that there were many reasons for having contact with the MHP and often the women presented with multiple issues or concerns. The most common reason for the contact was depression or low mood (n = 24, 42.9%), followed by anxiety (n = 14, 25.0%), social issues (n = 11, 19.6%) and alcohol or drug issues (n = 10, 17.9%). The other reasons identified included grief, sleep problems, abuse, stress, emotional issues, fluctuating mood, memory problems, confusion, guilt and shame.

4.6 **Current and past experiences**

During the initial contact with the MHP the client was asked about their current and past experiences. The clients’ current experiences are displayed in Figure 7.
As shown in Figure 7 approximately half of the clients referred to the MHP were using alcohol and/or drugs (n = 32, 42.7%). There were a number of other current experiences reported, including over a third of the women being on a community order (n = 26, 34.7%) and a third presented with relationship difficulties (n = 25, 33.3%). A high number of women were experiencing more than one of these issues, or had experienced them in the past, as shown below in Figure 8.
Figure 8 suggests that over half the women referred to the mental health service at Anawim had past experiences of violence or abuse (n = 49, 65.3%), using alcohol and/or drugs (n = 45, 60.0%), relationship difficulties (n = 42, 56.0%), pregnancy (n = 41, 54.7%) and offending behaviour (n = 39, 52.0%). Slightly under half of the women had been given a community order (n = 34, 45.3 %), and approximately 1 in 5 of the women had been in prison (n = 14, 18.7%). A high percentage of the clients had a history of self-harm behaviour (n = 32, 42.7%).

4.7 Outcomes of client contact

Following the initial contact with the client, the MHP suggested the appropriate care pathway for the woman based on her needs. The recommended outcomes for the women seen by the MHP are presented in Figure 9.

As shown in Figure 9, following initial contact with the client it was recommended that around half of the women be seen again by the MHP (n = 41, 54.7%). The aim of this was to continue work around the clients mental health issues and to follow up any issues raised in the previous meeting. A high number of women were advised to see their GP (n = 35, 46.7%), which may have been in relation to medication issues or physical health problems, for example. A smaller number of women were referred to mental health services (n = 11, 14.7%) or to the Anawim counselling service (n =7, 9.3%) if it was felt that more intensive
input was required. Only two (2.7%) of the women seen by the MHP stated that they did not want any further input around their mental health.

4.8 Summary of client information

In summary, the clients referred to the MHP at Anawim between 2009 and 2011 were typically in their mid-thirties and considered themselves to be white British. Fifty percent of the women had children, of which half were living with them. The women were typically referred to Anawim from the probation service and were seen by the MHP for an informal chat or mental health assessment. They were generally not under mental health services, with only around half being registered with a GP. Approximately half of the women were on medication, the majority of which were being prescribed antidepressants. The women generally presented with depression or low mood, anxiety, alcohol or drug problems and social issues. High numbers of women were currently using alcohol and / or drugs, were on a community order or were experiencing relationship difficulties.
5. **Staff training and support needs**

This section of the report focuses on the training needs of the staff at Anawim, via exploration of the results of the training needs analysis that was conducted in 2009 and repeated in 2011.

Staff at Anawim were asked to complete a training and support needs questionnaire at the start and end of the MHP’s secondment. The questionnaire aimed to identify how staff were currently working with clients with mental health problems and what they felt they needed in terms of training or support to better equip them to work with mental health difficulties.

The questionnaire was adapted from the training and support needs questionnaire developed by Maslin et al., (2001) to identify staff needs when working with dual diagnosis clients. The measure has ten items consisting of both open and closed questions, which can be divided into five sub-sections. These include: the staff members experience of working with mental health; their current needs; their knowledge of, competence in and perceived importance of mental health; their attitude, role and responsibilities; and their need for additional support.

A total of eleven members of staff completed the initial questionnaire in 2009 and ten completed the final questionnaire in 2011; however due to staff turnover it is unlikely that the same members of staff completed the questionnaire at both time points. A variety of professionals completed the questionnaires, including management, support workers, outreach workers, counsellors, volunteers and admin staff. In 2009, the staff who completed the questionnaire had been working at Anawim for an average of 3 years and 9 months, compared to 4 years 4 months in 2011.
5.1 Training and support need questionnaire results

5.1.1 Current ways of working with mental health.

The staff were asked to indicate whether or not they worked with clients who experienced mental health problems. The majority of staff stated that they did, and this was consistent across the two year period (81.8% in 2009 and 80.0% in 2011). They were then asked to highlight how they worked with these clients from a list of options. The results are displayed in Figure 10.

Figure 10. Staff ways of working with clients with mental health problems.

Figure 10 suggests that in 2009 staff at Anawim were more likely to work jointly with other professionals in order to address their clients’ mental health issues (63.6%). Clients were advised to see their GP in around 45% of cases, and approximately a third of the women were referred to mental health services (36.4%). In 2011, staff were still working jointly with other professionals (60.0%); however the number of staff who advised their client to see their GP increased to 60.0%. This may be because the MHP completed work with the staff around care pathways into mental health services and using the system more appropriately; highlighting the GP as the gate keeper to mental health services. Although the percentage of staff who referred to mental health services decreased to 30.0% in 2011, the number of staff who stated other ways of working increased from 18.2% in 2009 to 50.0% in 2011. When asked to specify what this was, all members of staff stated that they would refer the client to the MHP based at Anawim.
5.1.2 **Service and personal needs.**

At both time points staff were asked to indicate what they felt their needs were in order to work with clients who are experiencing mental health problems, both in terms of their personal needs and those of the service. Due to similarities between the two sets of answers, the personal and service needs have been amalgamated below under subheadings for each data collection point.

**Service and personal needs 2009**
- Knowledge of care pathways; who and where to refer.
- Client engagement strategies.
- A trained mental health nurse or specialist at Anawim to work with the clients.
- Specialist knowledge and training around recognising mental health problems.
- An appropriate space in which to work with the clients.
- Someone to provide supervision, support and advice to staff.
- Training around personality disorder.

**Service and personal needs 2011**
- Access to mental health services and mental health assessments.
- A trained mental health nurse or specialist based at Anawim.
- Better links with Community Mental Health Teams.
- Supervision and support for staff.
- Mental health awareness training.
- Clear policies and procedures in place, particularly in crisis situations.
- Recognition of Anawim by other services.

5.1.3 **Staff knowledge of, competence in and importance of working with mental health.**

Staff were asked to self-rate their knowledge of mental health issues, their competence in working with these issues and their perceived importance of addressing mental health issues. Each of these were rated on a six point scale from 0 to 5, with a score of 5 indicating the highest level of knowledge, competence or importance. The results of these three questions at each time point are presented in Figure 11.
Figure 11 suggests that in 2009 staff knowledge (mean = 2.10) and competence (mean = 2.18) were low, however staff perceived the importance of addressing mental health issues as high (mean = 4.18). In 2011 an increase was seen across all areas, with staff rating their knowledge (mean = 2.90) and competence (mean = 2.90) as higher than at baseline, and rating the importance of addressing mental health issues as the maximum (mean = 5.00).

5.1.4 Staff attitudes, roles and responsibilities.

Staff were presented with several statements and asked to rate how much they agreed with these using a 7 point scale ranging from 0 (strongly disagree) to 6 (strongly agree). The results are presented in Figure 12.
Figure 12 suggests that the staff members’ self-rated level of satisfaction gained from working with clients with mental health problems increased between 2009 (mean = 4.50) and 2011 (mean = 5.00). Staff felt that they had a greater responsibility to address mental health problems in 2011 (mean = 4.50) compared to 2009 (mean = 3.64), and similarly they agreed more strongly that it was part of their job role to do so in 2011 (mean = 5.00) compared to 2009 (mean = 4.73). Staff also felt that they had better knowledge of referral pathways for mental health clients in 2011 (mean = 4.10) than they did 2 years previously (mean = 3.09). Despite these improvements, in 2011 staff were uncertain that they could work as well with women with mental health problems as with those without mental health problems. Furthermore, their confidence to do so decreased between 2011 and 2009 (mean = 3.60 and 3.20 respectively). Staff generally agreed that they could find somebody to help them to clarify their boundaries and responsibilities, and this remained consistent between 2009 and 2011 (mean = 3.70 and 3.67 respectively), as did their high level of interest in mental health problems (mean = 5.55 and 5.60 respectively).

5.1.5 Additional support

Finally, staff were asked to indicate whether or not they felt that any additional support was needed in order to work with clients who were experiencing mental health problems, and if so what this support might be. In 2009, 10 (90.9%) of the 11 members of staff
indicated that they would like additional support, with the other 9.1% representing missing data. The support required included:

- Training around the identification of mental health symptoms and problems.
- A professional supervisor to discuss mental health cases and concerns with.
- Knowledge around care pathways and signposting; knowing what other services are available.

In 2011 8 (80.0%) members of staff stated that they would like additional support; with the remaining 20% representing missing data. The support required at this time point included:

- Specialist training around mental health problems.
- A specialist mental health practitioner on site.
- Other professionals on site, to enable Anawim to become a ‘one stop shop’.

5.1.6 Summary of staff training and support needs results

The training and support needs analysis highlighted that the staff at Anawim were already working with mental health issues and were doing so in a variety of ways. Whilst this was felt to be important, staff also felt they needed more knowledge to do so competently. Staff highlighted that in order to increase their competence they needed specialist mental health training, better care pathways and referral routes, a MHP based at Anawim and regular supervision. The comparison of data across the two year period suggests that staff improved in several areas related to mental health, for example they became clearer about their responsibilities towards this client group and more aware of who and where to refer to. Their self-rated level of knowledge and competence also increased. Despite this, they still felt that they could not work with clients with mental health problems as well as they could work with those without.
6. **Mental Health Audit**

The mental health audit (see appendix 3) was completed by the staff for 11 of the clients. The questionnaire aimed to highlight the clients’ drug and/or alcohol use and their mental health status. The clients were typically white British (n = 8, 72.2%) and had a mean age of 39, with a range of 23 to 49 years. On average the women had been attending Anawim for six years, with a range of one month to 18 years.

Eight (72.7%) members of staff stated that their client had been under mental health services in the past and six (54.5%) stated that their client was currently under services. Four (36.4%) of the women had a care coordinator and seven (63.6%) were on medication. Seven (63.6%) of the women had a mental health diagnosis and four (36.4%) had a diagnosis of personality disorder; although in the staff members opinion, seven (63.6%) women had an undiagnosed mental health problem and six (54.5%) had an undiagnosed personality disorder. Only one (9.1%) member of staff had tried to access mental health services for their client, and was successful, although ten (90.9%) members of staff felt that their client would benefit from a referral to mental health services. Figure 13 presents the level of drug use by these clients.

![Figure 13. Client level of drug use](image)

Figure 13 highlights that seven of the eleven (63.6%) women were using drugs, three (27.3%) were not using any drugs and for one client this was unknown (9.1%). Of the
seven clients who were using drugs, three (42.9%) were considered to be using recreationally and four (57.1%) problematically; of which two were receiving treatment for their drug use and two of which were not. Figure 14 displays the level of alcohol use amongst the same sample of clients.

Figure 14. Client level of alcohol use

![Pie chart showing levels of alcohol use among clients.]

Figure 14 suggests that nine of the eleven (81.8%) women were using alcohol at varying levels. Of the women who were using alcohol, three (33.3%) were considered to be using alcohol recreationally and six (88.9%) problematically; with five of these not receiving any treatment and only one being in treatment. Five (45.5%) members of staff believed that their client was using substances (either drugs or alcohol) to cope with their mental health problems.
7. **Conclusion**

The needs of women who present with complex issues can be extensive, and this is something that agencies set up to support them have historically struggled with. This piece of work demonstrates the success and true spirit of partnership working in Birmingham, which has made significant inroads in ensuring that women can access services they need and achieve positive outcomes across all areas of their lives.

Anawim begun this work long before this project; however addressing the mental health needs of this group and negotiating the pathways into mental health services had proved a challenge. This report highlights that multi-agency commitment has been pivotal in addressing this area, in an attempt to facilitate and maintain this aspect of Anawim’s important work.

The positive outcomes highlighted in this report are perceived to result from a number of factors, including: the services being accessible, timely and tailored; the engagement of the women; the flexibility of the approach; and the understanding and accepting attitude of the staff. The women having access to a qualified, knowledgeable, professional and a safe space to explore their options is considered to be a vital factor. Here it is possible that the women felt they had someone who could walk a little way of their journey with them and that this made a difference to them.

The enhancement of staff knowledge, confidence and skills, and an increase in their ability to see mental health issues as part of the whole picture was seen as a significant development which needs to be on-going. The lynch pin to success is the practitioner herself; her commitment and dedication, skills, knowledge, attitude and understanding. An important step to achieving this continued commitment to partnership working and mental health input within Anawim is that funding has now been secured from the Department of Health for a full time mental health practitioner at Anawim.

Challenging attitudes, developing care pathways and finding extra resources to work with challenging client groups is always a difficult task, especially in the current economic climate; however, through this partnership, the needs of these women have been highlighted and acknowledged and a coordinated response has been delivered. This is a major achievement and one that is on track to continue now funding has been secured from the Department of Health; so that the mental health needs of this vulnerable client
group can be identified and appropriate support given to help facilitate positive outcomes for these women.
8. Recommendations

8.1 Previous recommendations

The report compiled after 12 months of the MHPs secondment at Anawim generated nine recommendations. These recommendations will now be considered in turn, including consideration of whether the recommendation has been implemented and, if so, the impact that this has had on the project.

1. To review the data collection method and to amalgamate the daily contact sheet information.

Daily contact sheets (see appendix 4) were reviewed which provided a useful insight into data that was not being captured elsewhere, for example support and advice given to staff. This helped to give a broader picture of the role of the MHP within Anawim in addition to the client support provided.

2. 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).

The project manager and MHP met with CMHT service managers and team managers at the start of the week meetings and another separate meeting. During these meetings it was agreed that all CMHT’s across the trust would accept referrals from the MHP based at Anawim.

3. To follow up on the mental health psychological services with regard to their input into Anawim staff development with an aim to get a programme ready for the second year of this work.

The project manager approached psychological services with regard to input into Anawim in the form of support and supervision to staff. Support has been agreed and this is currently in the negotiation stages.

4. 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.
During the second year the MHP practitioner continued to take every opportunity to develop staff knowledge and skills in relation to mental health and care pathways; through modelling and the sharing of information on a client by client basis. This is perhaps demonstrated by the increase in the number of referrals to the GP during the second year of the project via Anawim staff (see Figure 10.).

During the second year there were a number of staff who moved on to work elsewhere and also a number of new staff recruited. Towards the end of the second year there were no further plans to extend the secondment. At this point however Anawim was approached by MIND Women’s service with a proposal to give input into the centre via group work, one to one sessions and signposting.

5. To continue in the final four months of this year to get feedback from the women that the MHP has contact with to ensure that we are focusing on their needs and are clear about what does and doesn’t help.

Ongoing informal feedback was received from the women and Anawim support workers following individual sessions. Where appropriate, informal feedback was also elicited from the clients following a referral back to their GP or into mental health services.

6. To try and address the practical arrangements at the centre with the MHP and the manager 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.

Space continued to be an issue at the centre not only for the MHP but for other visiting services. During the second year the MHP was given remote working status from BSMHFT which enabled her to access trust systems whilst at Anawim. During the second year Anawim developed better organised systems for the storage of files, which made it easier for the MHP to access key information. The use of the TAG was abolished in favour of an internal referral form developed by Anawim for referral to visiting agencies (see appendix 5).

7. To revisit the staff questionnaire about their clients’ mental health issues.
The MHP revisited the Training and Support Needs Questionnaire with the staff and the results are presented in section 5 of the report.

8. **To ensure support and supervision is in place for the MHP and embedded into ongoing work.**

Clinical supervision continued to be provided at monthly intervals by the project manager throughout the course of the second year.

9. **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.**

During the second year of the secondment Anawim's policies and procedures were further developed. The MHP gained deeper insight into some of the challenges faced by the voluntary sector in terms of e.g. funding. The second year also gave Anawim staff further insight into the responsibilities and challenges that the MHP had, as a qualified person with professional registration working between a statutory public sector organisation and a voluntary service. Of particular significance was the realisation by Anawim staff that at times the MHP also faced challenges in the interfacing with statutory services. This appeared to benefit Anawim staff as it helped them to feel more confident in that it was not necessarily their inexperience regarding mental health but that care pathways were often not straightforward; furthermore, that frequently the Anawim clients did not fit neatly into ‘pigeon holes’ due to their often complex, diverse needs.

### 8.2 Recommendations for the future and next steps

**Update:** As of April 2012 funding has been secured for a band 7 clinical nurse specialist (full time equivalent) to continue and further develop the role of the mental health practitioner at Anawim. This has been secured via the Department of Health ‘Alternatives’ funding until March 2014, as part of the Anawim Alternatives Project.

1. For the Anawim staff to continue to use the Homeless Outcome Star (Triangle Consulting & the London Housing Foundation, 2008) tool to measure client outcomes and to regularly review the outcomes for emotional and mental health of the women that received support and signposting from the MHP.
2. For the Anawim staff to support the women to access a GP at the earliest convenience and to record the referrals that they make to GPs for their clients to access mental health services.

3. For the Anawim staff to keep a record of the number of women referred specifically by mental health services to Anawim for support.

4. For Anawim staff to have access to regular training in mental health, particularly where there are new employees to the service. This should focus on the areas identified by the staff in the training and support needs analysis.

5. To monitor and evaluate the role of the band 7 clinical nurse specialist provided as part of the Anawim alternatives project funded by the Department of Health Alternatives Project. The key characteristics, knowledge and experience required for this position are outlined in a person specification (see appendix 6) and a job description (see appendix 7).

6. The staff at Anawim should have access to monthly team supervision from a qualified MHP.

7. To develop and deliver a ‘Stop and Think’ group programme (McMurran et al., 2001) accessible to all women in attendance at the centre.

8. Staff and the service should continue to network and establish links with both statutory and voluntary services in an attempt to raise the profile and knowledge of Anawim both locally and nationally.
9. Bibliography


10. References


Maslin, J., Graham, H., Cawley, M., Copello, A., Birchwood, M., Georgiou, G. … Orford, J. (2001). Combined severe mental health and substance use problems: what are the training and support needs of staff working with this client group?. *Journal of Mental Health, 10*(2), 131-140.


11. Appendices

Appendix 1    Threshold Assessment Grid (TAG)
Appendix 2    Training needs questionnaire
Appendix 3    Mental health audit questionnaire
Appendix 4    Client contact sheet
Appendix 5    Anawim referral form
Appendix 6    Person specification for registered mental health nurse position
Appendix 7    Job description for registered mental health nurse position
**Threshold Assessment Grid (TAG)**

**Score Sheet**

TAG assesses the severity of a person’s mental health problems.

For each domain (numbered 1 to 7), tick ONE statement that best applies to the person being assessed. There should be a total of 7 ticks on the completed grid (one for each domain). Then for each level of severity (e.g., ‘None’, ‘Very Severe’) add the number of ticks and record in the box at the bottom of the column. ‘Very Severe’ is only available for domains where life-saving emergency action by specialist mental health teams may be required. The checklists overleaf provide some guidance on the issues to consider when assessing each domain - they are not intended to be prescriptive. Further information on the TAG is available from www.iop.kcl.ac.uk/prism/tag.

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>MILD</th>
<th>MODERATE</th>
<th>SEVERE</th>
<th>VERY SEVERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intentional self harm</td>
<td>No concerns about risk of deliberate self-harm or suicide attempt</td>
<td>Minor concerns about risk of deliberate self-harm or suicide attempt</td>
<td>High risk to physical safety as a result of deliberate self-harm or suicide attempt</td>
<td>Immediate risk to physical safety as a result of deliberate self-harm or suicide attempt</td>
</tr>
<tr>
<td>Unintentional self harm</td>
<td>No concerns about unintentional risk to physical safety</td>
<td>Minor concerns about unintentional risk to physical safety</td>
<td>High risk to physical safety as a result of self-neglect, unsafe behaviour or inability to maintain a safe environment</td>
<td></td>
</tr>
</tbody>
</table>

**Domain 2**

Risk from others

No concerns about risk of abuse or exploitation from other individuals or society

None

Minor concerns about risk of abuse or exploitation from other individuals or society

Risk to property and/or minor risk to physical safety of others

Positive evidence of abuse or exploitation from other individuals or society

Immediate risk to physical safety of others as a result of dangerous behaviour

Risk to others

No concerns about risk to physical safety or property of others

None

Minor concerns about risk to physical safety or property of others

Risk to property or minor risk to physical safety of others

High risk to physical safety of others as a result of dangerous behaviour

Immediate risk to physical safety of others as a result of dangerous behaviour

**Domain 5**

Survival

No concerns about basic amenities, resources or living skills

None

Minor concerns about basic amenities, resources or living skills

Marked lack of basic amenities, resources or living skills

Serious lack of basic amenities, resources or living skills

Life-threatening lack of basic amenities, resources or living skills

**Domain 6**

Psychological

No disabling or distressing problems with thinking, feeling or behaviour

None

Minor disabling or distressing problems with thinking, feeling or behaviour

Disabling or distressing problems with thinking, feeling or behaviour

Very disabling or distressing problems with thinking, feeling or behaviour

Disabling problems with activities or in relationships with other people

Very disabling problems with activities or in relationships with other people

**Domain 7**

Social

No disabling problems with activities or in relationships with other people

None

Minor disabling problems with activities or in relationships with other people

Disabling problems with activities or in relationships with other people

Very disabling problems with activities or in relationships with other people

<table>
<thead>
<tr>
<th>No. of ticks</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAG score</td>
<td>0</td>
</tr>
</tbody>
</table>

9 points for each Mild rating: 2 points for each Moderate: 3 points for each Severe: 4 points for each V. Severe:
# Threshold Assessment Grid (TAG)

Also consider any other aspects which are relevant. The tick-boxes are provided for optional use to identify concerns, but the TAG rating is made on the score sheet.

## 1. Intentional Self-Harm

**Individual factors:**
- expressing suicidal intent
- clear plan
- available means
- preparations
- hopelessness
- no confidant, e.g. partner, friends, professionals
- poor coping resources
- lack of blocks to self-harm

**Consider risk factors:**
- past history of deliberate self-harm
- (i) alcohol/drug abuse OR (ii) diagnosis (e.g. depression, schizophrenia, personality disorder)
- (i) AND (ii) = increased risk
- physical illness/disability
- recent GP contact
- recent psychiatric hospitalisation
- recent loss
- no friends/family
- living alone
- unskilled worker
- unemployment
- older people
- male (especially young males)

## 2. Unintentional Self-Harm

**Consider self-neglect:**
- lack of self-care
- not eating or drinking appropriately

**Consider unsafe behaviour:**
- not seeking help for problems posing risk
- refusing appropriate help e.g. not taking medication
- not claiming benefits
- lack of awareness of own safety in home e.g. fire risk
- risky sexual behaviour
- substance misuse
- wandering

**Consider the inability to maintain a safe environment:**
- unable to manage accommodation
- not paying rent
- running up debts

## 3. Risk From Others

**Consider different types of abuse or exploitation:**
- physical
- sexual
- emotional
- racial
- financial
- neglect

**Consider risk from:**
- staff
- relatives
- friends
- neighbours
- strangers
- treatments

**Consider risk of abuse by carer:**
- severe stress
- mental illness/alcohol/drug abuse in carer
- carer refusing help
- history of abuse by or to carer

**Consider risk from society:**
- history of abusive/exploitative relationships
- harassment from public
- use of home by unwanted others
- fear of retaliation for reporting abuse

## 4. Risk To Others

**Consider risk to:**
- children & other dependents
- partners
- carers
- staff
- neighbours
- strangers

**Consider risk factors:**
- current threats, especially to a named person
- history of violence to people/property
- carer’s concern
- access to weapons
- no blocks to violence e.g. fear of consequences
- history of arson
- unemployment
- drug/alcohol abuse
- stress
- voices telling person to harm someone
- paranoia
- risky sexual behaviour
- anti-social behaviour e.g. unsafe driving
- lack of information about person’s history
- no trusting relationship with professionals

## 5. Survival

Consider whether the person has problems with:
- a home
- heating for the home
- essential amenities (e.g. washing facilities, toilet, cooker, bed)
- the ability to look after their home
- the ability to keep adequately clean and tidy
- enough food & fluids
- clothing
- enough money to live on
- mobility
- the ability to use public transport
- the ability to cope with physical health problems

## 6. Psychological

**Consider:**
- overactive, aggressive, disruptive or agitation behaviour
- problems with hallucinations & delusions
- cognitive problems with memory, orientation & understanding
- mood problems e.g. depressed, manic, anxious
- problems with reading or writing
- a lack of coping strategies
- attitude to problems
- help seeking behaviour
- spiritual problems
- feelings of alienation

## 7. Social

**Consider problems in relationships with others:**
- lack of ability to make or maintain friendships
- lack of supportive relationships
- lack of intimate relationship
- sexual problems
- communication problems
- unable to handle daily hassles

**Consider problems in activities:**
- leisure
- unpaid work
- paid work
- education
- travel
- lack of personally meaningful life

Further information on the Threshold Assessment Grid is available from www.iop.kcl.ac.uk/prism/tag
THRESHOLD ASSESSMENT GRID (TAG)

PURPOSE OF TAG

TAG is a brief assessment of the severity of an individual’s mental health problems. Instructions for completing it are contained on the score sheet, and this page provides further guidance. TAG is very easy to complete, requiring seven ticks on the Score Sheet. It is rated by staff for people who have (or are believed to have) mental health problems. Information on diagnosis should be recorded separately, if required.

TAG can be used in different ways, including:

- by GPs and other agencies (e.g. social services) who think someone has mental health problems and want to refer to a specialist mental health team - by appending a TAG to their referral letter, specialist mental health services will be helped to prioritise those most in need of help.
- to give a means of agreeing between agencies at what point in the care system people should receive help - this might be done by locally agreeing thresholds for referral.
- as a routine outcome measure for patients on the caseload of a mental health team
- to give commissioners a means of specifying the way in which community mental health teams are to focus on the severely mentally ill

COMPLETING TAG

TAG has seven domains covering the areas of Safety (two domains), Risk (two domains), and Needs and Disabilities (three domains). In each domain on the Score Sheet, you should tick one box, to indicate the rating of severity for that domain (ranging from ‘None’ to ‘Very Severe’). A checklist is provided for each domain, to indicate some of the important aspects to consider. The checklists are based on evidence and current practice, but must be used in conjunction with clinical judgement. If an aspect which is relevant to the person is not on the checklist, it should still inform the ratings made.

The rating chosen should be the one that best applies to the person being assessed. The time frame is not specified, since problems (e.g. violence) may only occasionally occur, but still be ongoing causes of concern. As a general guide, however, consider problems in the last month, but also include current concerns which originate from before this period.

Example - Domain 1. Intentional Self-Harm

Looking across the row, if ‘High risk to physical safety as a result of deliberate self-harm or suicide attempt’ is the statement that best applies to the person, then tick this box. This rating is classified as ‘Severe’ (shown at the top of the grid).

When all seven domains have been ticked (once in each domain), the assessment is complete. If desired, the number of ticks for each column can be recorded in the first row at the bottom. (The total should then add up to seven). Example: if there are three ticks in the ‘Severe’ column, write ‘3’ in the box at the bottom of the ‘Severe’ column. Also, if desired, the TAG score can be calculated, by recording the total weighted score for each domain (e.g. 2 points for each Moderate rating) in the second row at the bottom, and then adding those scores together. The maximum TAG score is 24.

HOW TO USE A TAG ASSESSMENT

The two rows at the bottom of the Score Sheet indicate the severity of mental health problems. 445 TAG referrals to mental health services across London were analysed to provide guidance on referral thresholds. If the goal is to ensure that all referrals are suitable, then a threshold of at least 1 severe or very severe domain will ensure that 95% of referrals are suitable, but 74% of referrals not meeting this criterion will in fact be suitable - a high false negative rate. If the concern is to ensure that all suitable referrals are offered assessment, then using a threshold TAG score of 3 or more will ensure that 91% of suitable referrals are identified. However, 80% of unsuitable referrals will also meet this criterion - a high false positive rate. The best cut-off is found using either a TAG score of 5 or more, or at least 2 moderate domains.

Example: A team may agree with its referrers that a TAG will be completed for all referrals, and that the team will assess anyone referred with a Very Severe rating within 24 hours, with 2 or more Severe ratings within 72 hours, and anyone else with at least 2 Moderate rating within 2 weeks. For patients with less than 2 Moderate ratings, the referral letter will state why the patient’s mental health problems are not of a severity to warrant specialist mental health service.

Further information on the Threshold Assessment Grid is available from www.iop.kcl.ac.uk/prism/tag
Appendix 2  

Training needs questionnaire

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 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.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Quite Strongly Agree</th>
<th>Agree</th>
<th>Neither Agree or Disagree</th>
<th>Disagree</th>
<th>Quite Strongly Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) I am interested in the nature of mental health problems and the responses that can be made to them.</td>
<td></td>
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</tr>
<tr>
<td>b) In general, one can get satisfaction from working with clients who have a mental health problem.</td>
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<tr>
<td>c) I feel I have a working knowledge of mental health difficulties.</td>
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</tr>
<tr>
<td>d) I feel I have a clear idea of my responsibilities in helping clients who have mental health problems.</td>
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<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>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.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f) If I 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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>g) I feel it is part of my role to work with clients who have mental health problems.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h) If I feel that I have concerns about a client’s mental health I am aware of where to refer for specialist help.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Please note this training and support needs questionnaire was first developed by COMPASS, part of Birmingham and Solihull Mental Health Foundation NHS Trust.
# Audit of the Mental Health Needs of Clients Accessing Anawim Services

<table>
<thead>
<tr>
<th>About the auditor</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Name</td>
<td>Date of Your role</td>
</tr>
</tbody>
</table>

Service user initials.................................. Age.................. Ethnicity .........................

Approximate length of time since clients first contact with Anawim..........................

Does the service user use drugs: Not at all □ Recreationally □ Problematically not in current treatment □ Problematically & in treatment □

Does the service user use alcohol: Not at all □ Recreationally □ Problematically not in current treatment □ Problematically & in treatment □

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you aware of any previous contact with mental health services including initial assessments, even if the patient has since been discharged</td>
<td></td>
</tr>
<tr>
<td>2. Does the client have a documented diagnosis of a mental health problem?</td>
<td></td>
</tr>
<tr>
<td>3. Does the client have a documented diagnosis of a personality disorder?</td>
<td></td>
</tr>
<tr>
<td>4. Does the client currently have a care coordinator from a mental health service?</td>
<td></td>
</tr>
<tr>
<td>5. Does the client have current involvement from mental health services?</td>
<td></td>
</tr>
<tr>
<td>6. If so, please circle the type of team they are involved with:</td>
<td></td>
</tr>
<tr>
<td>(i.e. Community Mental Health Team, Early Intervention Team, Assertive Outreach Team, Homeless Mental Health Team, Home Treatment Team, Other unsure)?</td>
<td></td>
</tr>
<tr>
<td>7. In your opinion does the service user have an undiagnosed mental health problem? If so, state what...</td>
<td></td>
</tr>
<tr>
<td>8. In your opinion does the service user have an undiagnosed personality disorder?</td>
<td></td>
</tr>
<tr>
<td>9. Is the service user prescribed any psychiatric medication.</td>
<td></td>
</tr>
<tr>
<td>11. Please list any prescribed psychiatric medication. If unsure, list all medication</td>
<td></td>
</tr>
</tbody>
</table>
12. Please list all non-prescribed psychiatric medication the service user buys illicitly

<table>
<thead>
<tr>
<th>13. Have you attempted to access a mental health service for the service user?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please state the kind of service.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14. If so, were you successful?</th>
<th>Yes/No</th>
<th>Please delete</th>
</tr>
</thead>
<tbody>
<tr>
<td>If not successful, please state reason why:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| 15. In your opinion would the service user benefit from access to a mental health professional? | | |

| 16. Has the service user reported that one of the reasons they use substances is to help cope with a mental health problem or its treatment? | | |

Any additional comments.__________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________________________________________________________________________
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

<table>
<thead>
<tr>
<th></th>
<th>Ever</th>
<th>Current</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Harm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Use</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Offending Behaviour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Been In Prison</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence and abuse experience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(please specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship difficulties</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(specify who with)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 ☐
Woman does not want anything more ☐

Outline of Pathway
Include any issues/barriers/time/finance etc.
Brief Summary

Contacts
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
Appendix 5  Anawim referral Form

Internal/External Referral Form

Referral to (please tick):

- Family Support
- Counselling
- Mental Health
- Next Steps Employment
- Birmingham Settlement
- Course/Group (specify)
- Addiction
- Aquarius
- Housing Neighbourhood office
- Prison
- Mentoring
- Other: Please state

If referring to a course or group activity please specify and enter on relevant course/group register

Name of Support worker making the referral

Date of Referral

Name of Client

Address

Contact Number

Any other useful information

Please place this in the provider’s in-tray and keep a copy for the client file.
**Anawim Clinical Practitioner Band 7**

**Person Specification**

<table>
<thead>
<tr>
<th>EDUCATION, QUALIFICATIONS AND TRAINING</th>
<th>Essential</th>
<th>Desirable</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Mental Health Nurse.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Evidence of significant post registration education and development.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EXPERIENCE</th>
<th>Essential</th>
<th>Desirable</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum of two years post registration, experience in managing a client caseload in a multi-disciplinary mental health field, and working autonomously to conduct assessments, deliver interventions and assess and manage risk.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Advanced knowledge in one of the following areas, Mental Health, Substance Misuse, Personality Disorder Services, Safeguarding, Criminal justice and clinical interventions i.e. CBT, psycho-education</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Willingness to enhance knowledge/skills in areas required to carry out the role effectively.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Demonstrable experience of clinical and professional governance issues.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Experience of liaison, networking and/or working with partner organisations, such as third sector organisations.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Sound knowledge of and experience of patient assessment tools and assessment methodology, including experience and knowledge regarding relevant referral care pathways and processes from primary and secondary care to specialist mental health services.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
</tbody>
</table>
Experience of preparing assessment information, care plans, CPA and risk assessment documents, letters etc. including patient reports such as court reports.

<table>
<thead>
<tr>
<th>SKILLS, KNOWLEDGE, APTITUDES</th>
<th>Essential</th>
<th>Desirable</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current knowledge of relevant professional and NHS policy initiatives within mental health, substance misuse and offender health.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Good knowledge of recovery based models and care pathways and interventions within mental health and substance misuse.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Sound knowledge and experience of conducting comprehensive mental health assessments, and referral pathways into mental health, primary care and substance misuse services.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Sound knowledge and experience of gender sensitive care, including experience of working with vulnerable women in mental health settings.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Sound knowledge and experience of safeguarding processes and procedures, including knowledge and experience of Adult and Children’s safeguarding procedures, including referrals.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Experience of liaison, partnership working, networking and joint working with and across external organisations to deliver a shared care approach.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Experience of working with women within the criminal justice system, including offender health.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Experience of delivering training, including the use of power point presentations.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Understanding of the importance of involvement of a diverse group of service users and carers in service planning and monitoring.</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Demonstrable knowledge of</td>
<td>X</td>
<td></td>
<td>Application/Interview</td>
</tr>
</tbody>
</table>
recovery planning & Clinical Governance.

<table>
<thead>
<tr>
<th>Good knowledge of mental health, personality disorder and substance misuse treatment systems that make up an integrated recovery model.</th>
<th>X</th>
<th>Interview/application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of the ability to challenge and change practice.</td>
<td>X</td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Computer literate, excellent oral and written communication skills.</td>
<td>X</td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Able to communicate with and engage front line clinical staff and clinical leaders, including GPs.</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Ability to work effectively and cooperatively with user and carer groups.</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Understanding of equal opportunities policies, including dynamics of disability, discrimination, sexism, racism.</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Evidence of the ability to work across traditional boundaries and think ‘outside the box’.</td>
<td>X</td>
<td>Application/Interview</td>
</tr>
<tr>
<td>Understanding of the interface within other services including mental health services and the criminal justice system.</td>
<td>X</td>
<td>Application/Interview</td>
</tr>
</tbody>
</table>

**Personal Qualities & Attributes**

<table>
<thead>
<tr>
<th>Essential</th>
<th>Desirable</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible and adaptable working practice with a proactive approach to problem solving</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Approachable, helpful and encouraging with excellent interpersonal skills</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Ability to work as a team member and individually</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Self awareness of own strengths &amp; weaknesses and impact on others</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>Motivation</td>
<td>X</td>
<td>Interview</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----</td>
<td>-----------</td>
</tr>
<tr>
<td>A deep motivation to improve performance &amp; make a difference to others’ health &amp; quality of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal integrity - strongly held commitment to openness, honesty, inclusiveness and high standards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A determination to achieve positive service outcomes for users</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Prepared By: Sarah Fellows / Derek Tobin
Designation: COMPASS
Date: May 2012
OUTLINE JOB DESCRIPTION

Job Title: ANAWIM Mental Health Practitioner
Grade: Agenda for Change Band 7
Reporting to: COMPASS Team Manager / Joy Doal
Accountable to: COMPASS Team Manager
Location: ANAWIM Balsall Heath

Job Purpose

Establish and develop services to meet the mental health needs of service users within the ANAWIM project, which are, non-stigmatising, accessible and responsive to the needs of the women who attend the project.

Work as part of the ANAWIM team as a source of specialist advice on mental health issues, including the development of robust care pathways for ANAWIM service users into other services/agencies that are best placed to meet their needs.

Maintain and improve knowledge and skills of ANAWIM staff based on best practice, particularly knowledge and skills in mental health in relation to designated role.

Job Summary

The post holder will take responsibility to provide a service for people with mental health problems within the ANAWIM Project; this will be achieved through integrating mental health interventions within the project and close liaison with other services/agencies to enhance service user care pathways and to provide a positive experience of services.

The post-holder will be responsible for providing effective consultation and liaison, aiming to bridge the gap between primary and secondary care, and to facilitate and improve access to appropriate services for service users who attend ANAWIM. Clinical provision will include assessment and brief time-limited evidence based interventions as and when appropriate. The post holder will also play a role in the provision of training and support in mental health issues for ANAWIM staff.

The post holder will play a key role in supporting the role of the Anawim project in terms of providing an alternative to custody by providing assessment, support and interventions to meet the mental health treatment requirement of any order/s placed on individuals by the courts.

The post holder will play a key role in auditing and evaluating the role to include impact of interventions on service users, effectiveness of care pathways and the impact of training delivered within the ANAWIM project and to partner agencies.
Interim Organisational Chart

Joy Doal
ANAWIM Project Manager

COMPASS Programme Team Manager

ANAWIM Mental Health Practitioner

Key Communications and Working Relationships

Internal: ANAWIM Project Manager, ANAWIM colleagues, service users, other specialist mental health teams, addiction services, Personality Disorder Services.

External: Service users and carers, Primary Care, GPs, Probation, Prison In-reach Teams, voluntary and statutory services, Department of Health Offender Health.

Principle Duties and Responsibilities

Clinical

- Provide a liaison and consultation service for referrers, including the provision of pre-referral advice to relevant agencies.
- Undertake comprehensive mental health assessments of service users, including risk assessment and management.
- Provide supportive therapeutic interventions, including one to one work, psycho-educational work, and CBT based interventions.
- Identify the most appropriate intervention to promote recovery.
- Identify and access appropriate care pathways for service users, including those within mental health services and primary care.
- Co-facilitate psycho-educational and therapeutic group work.
- To make appropriate referrals as necessary to other teams and to external agencies (statutory and non-statutory).
- Provide a range of brief evidence based interventions, either on an individual or group basis, within an inclusive stepped care approach.
- Co-ordinate and participate in health promotion activities.
- Contribute to health education initiatives and be a resource for mental health issues for other members of the ANAWIM team.
- Participate in clinical reviews within Primary Care and CMHTs and others as required.
- Liaise with criminal justice services as appropriate, including Prison In-reach and Prison Health services and Probation.

**Professional**

- Responsible for maintaining contemporaneous patients’ records in accordance with relevant code of ethics and practice, confidentiality guidelines and Trust policy.
- Operate within the relevant professional Code of Practice/Ethical Framework and will comply with relevant Trust and ANAWIM policies and procedures.
- Maintain clinical practice that reflects the diverse cultural, religious and ethnic needs of the patient population, accounting also for the needs of carers and significant others.
- Engage in regular clinical supervision – individual and/or group i.e. ANAWIM team.
- Develop and maintain an expert knowledge base in relation to resources that can be used to meet the needs of service users with mental health needs within the ANAWIM project.
- Engage in ongoing, continuous professional development in order to maintain and develop relevant professional skills.
- Participate in managerial supervision with line manager.
- Promote a positive image of mental health and mental health services with members of the primary care team, the wider community and partnership organisations
- Observe all relevant National and local policies and procedures.
- Utilise a non-judgemental approach towards working with a client group who present with a range of complex needs.

**Research, Development and Training**

- Participate in audit; service evaluation and research including implementation of local evaluations within the ANAWIM project
- Offer advice and support and participate in the training and education of the ANAWIM Team in relation to mental health issues when required.
- Maintain up to date knowledge of research and other developments in the mental health field, with particular regard to primary care.
- Fully engage in the Trust appraisal processes
- Provide clinical supervision and mentorship to pre/post registration students

**Organisational**

- Participate in designated meetings and conferences to promote the work of the team.
- Complete database information in adherence with the identified process.

**Communication**

- Establish and maintain meaningful and effective working relationships with
relevant Primary Care and Mental Health Trust colleagues, and other relevant statutory and non-statutory agencies for the benefit of service users

- Bridge the gap between ANAWIM and mental Health service providers
- Maintain up to date IT skills. The minimum set to include keyboard, typing, internet, email skills and knowledge of the operating systems in practise
- Communicate effectively and in a manner consistent with your therapeutic skills and professional code, with patients with mental health and complex difficulties in order to build therapeutic alliances.

**Managerial**

- Plan, prioritise and manage own workload in line with National and local targets

**GENERAL**

**Clinical Posts only**
Candidates should demonstrate a commitment to working with families and carers and to practicing family intervention according to government and Trust policies.

**Confidentiality**
It is a condition of employment that staff will not disclose any information obtained in the course of their duties other than to those entitled to receive it. The post holder must ensure that the confidentiality of personal data remains secure and the terms of the Data Protection Act and relevant trust policies are met in respect of information held on the Trust’s computerised systems.

**Equal Opportunities**
The Trust is committed to being an equal opportunities employer and welcomes applicants from people irrespective of age, gender, race and disability. All staff are required to comply with current legislation, trust policies and national guidance good practice.

**Conduct**
It is expected that all members of staff will conduct themselves and represent the Trust in a responsible manner complying with polices and procedures.

**Health and Safety**
Staff must ensure that they are familiar with the requirements of the Health and Safety at Work Act (1974), the Trust’s Health & Safety policies/codes of practice or regulations applicable to the work place.

**Safeguarding**
Every member of staff has a responsibility to be aware of and follow at all times, the relevant national and local policy in relation to safeguarding children and safeguarding adults. This includes attending the statutory/mandatory training (including refresher and update training within the specified timescale) at the level relevant to the job.

**Training, Education and Development**
All employees have a responsibility to participate in regular appraisal with their manager and to identify performance standards of the post. As part of the appraisal process every employee is responsible for participating in identifying his or her own training and development need to meet their KSF outline.

**Research Governance**

Research and Development is at the heart of providing effective treatments and high quality services, supporting a culture of evidence based practice and innovation amongst staff. All staff have a duty to be aware of and comply with their responsibilities for research governance, whether as researchers, as part of the team caring for those participating in research, or as research participants themselves.

**Infection Control**

The post holder is required to ensure as a manager / supervisor that

- infection control responsibilities are clearly identified, allocated and understood within their team and that appropriate resource, training and support is provided to ensure that they are compliant with Trust policies and procedures
- staff are supported to attend necessary training and ongoing professional development to support their responsibilities and ensure full awareness
- arrangements are reviewed with staff through the Trust appraisal / development review process
- adequate mechanisms for supervision and monitoring exist to ensure that arrangements are effective.

**Smoking**

This Trust operates a No smoking policy.

This job description is indicative only, and the post will continue to evolve as the Trust’s priorities develop. It will therefore be revised in consultation with the post holder from time to time and not less than annually. You may also be required to provide cover in other areas following appropriate discussion.

**Job Description Agreement**

<table>
<thead>
<tr>
<th>Budget Holder</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Post Holder</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Name</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
</table>

Birmingham and Solihull Mental Health NHS Foundation Trust is a major NHS Trust located conveniently to the centre of Birmingham. As a Trust we pride ourselves on the unique environment, which exists, for all our staff.
An environment where innovation is encouraged, hard work rewarded and where our staff play an inclusive role in new developments.