Women's Counselling and Therapy Service

WOMEN'S CIRCLE PROJECT EVALUATION

COMMUNITY FUND

March 2021

Acknowledgements

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This external evaluation was undertaken by:

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1. Introduction

Women's Counselling and Therapy Services (WCTS) offers a safe and supportive space for women and girls to talk through the difficulties they experience and access therapy and support. In particular, the organisation seeks to engage disadvantaged and marginalised women and help them recover from experiences of abuse, violence, neglect, trauma, and mental ill health.

The organisation seeks to enable women to benefit from:

- Improved mental health and wellbeing;
- Better resilience;
- Healthier choices;
- Increased self-confidence, self-esteem, and self-care;
- Effective, loving parenting;
- More positive thoughts, feelings and understanding;

These target outcomes are achieved through the delivery of:

- Counselling for stabilisation and resilience; building internal strength and safety;
- Case work for practical issues impinging on therapy: domestic abuse relate housing, benefits, accessing wider health services, legal advice, parenting, and schools etc;
- Community provision in 'deprived' Leeds reaching isolated and marginalised communities of women and girls. Training and support for community leaders and peer supporters;
- Psychotherapy to gain better understandings of how we think and act, the ongoing impacts of formative years and of traumatic experiences;
- Fast access, brief intervention, face to face support and signposting service around mental health;
- Improving access – supporting the professional development of trainee BME counsellors (partnership with Leeds and York Partnership NHS Foundation Trust);

Counselling, therapy and other kinds of support can help with a range of problems including, feeling low, feeling confused, troubling memories, difficulties in relationships, lack of confidence and changes in life that are hard to accept.

Counsellors and therapists are trained to offer confidential support to help women improve their health and well-being.

"It was helpful to talk to somebody outside my situation who did not know me."

"It was my first opportunity to speak about myself."

Call or e-mail us to find out more about support in your area. Ask for the Community Team.

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Image: Project Promotional Flyer – Front and Rear

2. Project Context

2.1. Leeds Demographics

According to the last Census (2011), 18.9% of the city's population come from a minority ethnic background, with 12.5% being born outside of the UK and 4.5% of households not having any residents who speak English as their main language.

2.2. Domestic Abuse

It is estimated that 1 in 4 women in the UK will experience domestic abuse in their lifetime. In 2018/19, the Crime Survey for England and Wales (ONS 2019) reported that around 7.5% of women (1.6 million) and 3.8% of men (786,000) experienced domestic abuse, though it is acknowledged that there is significant under-reporting of all incidents and so these figures could be much higher. Adults who lived in urban areas (such as the target communities for this project) were more likely to have experienced domestic abuse in the last year (6.0%) compared to those who lived in rural areas (4.2%). More than one in ten of all offences recorded by the police are domestic abuse related.

Data provided by the West Yorkshire Police Performance Unit for 2017/18 found that in Leeds there were 20,434 domestic abuse incidents. Of these, 18,770 had a victim identified (77% were female). In terms of ethnicity of victims:

- 37% were 'White',
- 3% were 'Asian',
- 3% were 'Black',
- 56% 'Not Stated' or 'Unknown'.

The UK government defines domestic abuse as:

> *"Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. It can encompass, but is not limited to, the following types of abuse: psychological, physical, sexual, financial, emotional."*

Of course, not all abuse is violent. For example, coercive control is a form of non-violent domestic abuse which describes a range of behaviours or patterns of behaviour to enable a perpetrator to maintain or regain control [of their victim]. Examples of coercive behaviours include; isolating a victim from friends/family, depriving them of basic needs such as food, monitoring a person's time and controlling their actions (such as where they go, what they wear, who they spend time with) and finances, intimidating and humiliating them. Organisations such as Women's Aid and others have successfully campaigned to make coercive control a criminal offence.

Key National Statistics regarding Domestic Abuse

- On average, two women are murdered each week;
- Whilst domestic abuse accounts for around 16% of violent crime, it is least likely to be reported;
- On average an abuse victim will suffer 35 assaults before calling the police;
- In 2010, the Forced Marriage Unit responded to 1,735 cases of possible forced marriage.
- The police in the UK receive one call from the public every minute for assistance for domestic violence.
- One in five people experience financial abuse by their partners. 60% of whom are women; This can prevent them accessing support/travelling outside of their neighbourhood.

2.2.1. Experience of South Asian Women

The Crime Survey for England and Wales (ONS 2019) reports that for partner abuse, the highest prevalence was found amongst people who were of Mixed ethnicity. The survey also found that for family abuse, there were no differences by ethnicity found. However, statistics based on crime figures or those which rely on surveys within a wider context and/or face to face interviews may under-report the incidence of domestic abuse.

For example, targeted research within South Asian Muslim communities (particularly those which are of Pakistani and Bangladeshi heritage) reveals a very different picture, suggesting that in reality it can be far more difficult for women in Asian/South Asian communities to report domestic abuse, leading to significant levels of underreporting. For example, research by the University of Hull (2018) found that "Powerful cultural norms" within British South Asian communities resulted in far lower rates of reporting by this group than by other women. This research also highlighted other culturally limiting factors which lead to the under-reporting of abuse – language barriers which prevent access to services, the onus of purity being the woman's responsibility, the belief that a woman's assault/rape is her fault and the lack of culturally responsive support infrastructure.

Key recommendations from this research included the provision of compulsory education within schools, community workers/peer support attached to venues that women are 'allowed' to go to, new approaches to awareness raising including community led debates and introduction of more 'safe' venues where several charities/services can be housed under one roof.

Women's Aid's "Day and Week to Count (2017) reports Asian/Asian British women as the second highest ethnic group utilising domestic abuse refuges (10.4%), but the group least likely to use community services at 3.5%.

	Community-based services (out of 12,175)	Refuge services (out of 2,182)
White British	50.4%	42.2%
White Irish	0.8%	0.4%
White Gypsy or Irish Traveller	0.4%	0.5%
White any other background	6.0%	5.1%
Mixed/multiple ethnic group White and Black Caribbean	1.4%	3.1%
Mixed/multiple ethnic group White and Black African	0.4%	1.1%
Mixed/multiple ethnic group White and Asian	0.4%	0.8%
Mixed/multiple ethnic group any other background	1.1%	1.4%
Asian/Asian British Indian	1.7%	2.7%
Asian/Asian British Pakistani	3.5%	10.4%
Asian/Asian British Bangladeshi	0.9%	3.3%
Asian/Asian British Chinese	0.6%	0.2%
Asian/Asian British any other background	1.8%	3.8%
Black/African/Caribbean/Black British African	3.8%	6.8%
Black/African/Caribbean/Black British Caribbean	2.3%	3.1%
Black/African/Caribbean/Black British any other background	1.9%	2.0%
Other ethnic group Arab	0.5%	1.6%
Any other ethnic group	2.2%	2.5%
Ethnic group unknown	9.3%	0.8%
Missing data	10.5%	8.3%

Table 1: Women's Aid -The ethnic backgrounds of service users during the Day and Week to Count 2017 [https://www.womensaid.org.uk/wp-content/uploads/2018/03/Survival-and-Beyond.pdf]

This disparity between the use of refuge and community based services by Asian women suggests a need for innovative means of both raising awareness of what constitutes domestic abuse in communities and ensuring accessible services that complement their daily living and family life. E.g.: availability of more 'drop-in' style

services which do not rely on women having to either make appointments or routinely access support on a specific day/time which can conflict with other commitments.

The lack of good data in this regard demonstrates the real need for sensitivity, lived experience and knowledge of South Asian women in both the delivery of support services, research and criminal justice, so that South Asian women are able to feel safe and supported to speak out. Building trusting relationships within such communities is essential to reveal the true experiences of South Asian women.

2.2.2. Current Statutory measures to prevent violence against women in the UK

In 2010 the government published "Our Call to End Violence against Women and Girls (VAWG)". The strategy stated that no women should live in fear of violence, and every girl should grow up knowing she is safe to ensure they have the best start in life. This saw the implementation of new legislation to tackle stalking and make forced marriage a crime as well as a financial pledge to invest £80 million in funding for frontline services and charities.

Also, the Domestic Violence Disclosure Scheme: 'Clare's Law' was introduced to enable people to request police checks for abusive offences on 'their partner or the partner of a member of their family or friend who they believe may be at risk'.

The government introduced their refreshed VAWG National Strategy (2016-2020); with the strategic aim of making VAWG 'everyone's business'. This new focus was intended to ensure that everyone, including boys, men and bystanders should be engaged to challenge and understand VAWG. By 2018 it was reported that statutory Practices and Policy were still severely at odds with this aim, whereby reform was still focused on victim-survivors rather than perpetrators.

Leeds City Council does not appear to have established its own Violence Against Women and Girls Strategy but does include priorities for addressing domestic abuse within the Best Council Plan (2018-21).

2.2.3. Mental Health

There is broad consensus across statutory and voluntary services that mental health problems impact upon 1 in 4 people at some point in their lives.

Research suggests women experiencing domestic abuse are more likely to experience a mental health problem and that it is likely to cause long-term mental health issues. Also, women with mental health problems are more likely to be domestically abused (30-60%). [https://www.mentalhealth.org.uk/statistics/mental-health-statistics-domestic-violence]

SafeLives report [Safe and Well, 2019] highlighted the link between domestic abuse and mental health, but also found that not all domestic abuse services are equipped to provide mental health support. Conversely mental health organisations, despite evidence of strong associations between the two, do not always detect incidences of domestic abuse in respect of their service users. This suggests a need for a more collaborative/joined-up approach across the sector.

Research undertaken by Memon et al (2017) found that people from diverse ethnic backgrounds with mental health problems face several additional barriers accessing mental health services. These could be separated into two main themes: Personal and Environmental Factors and Relationship between service users and healthcare provider.

Personal and environmental factors	Relationship between service users and health care providers
Recognition of mental health problems	Waiting times
Social networks	Language
Sex differences	Communication
Cultural identity and stigma	Responding to needs
Financial factors	Cultural naivety, insensitivity, and discrimination

Clearly, issues of social isolation, stigma, language barriers, poor understanding of mental health combine with the barriers which mainstream services unintentionally create to make it very difficult for individuals to seek help.

The UK Government Guidance: *Mental Health: Environmental Factors* notes that:

> *"It is well established that deprivation (a lack of money, resources and access to life opportunities) or being in a position of relative disadvantage (having significantly less resource than others) is associated with poorer health, including mental health."*

There are multiple factors which underpin the relationship between mental health and deprivation. The guidance referred to above highlights the "spiral of adversity" which people with mental health problems face such as unemployment, low incomes and chaotic or abusive relationships. Furthermore, one of the key issues noted by the guidance and of particular relevance to women from diverse ethnic backgrounds and from deprived neighbourhoods is the fact that people in these areas are least able to access support and therefore are least able to recover, thus exacerbating the mental health problems they face.

2.2.4. Covid-19

The Covid-19 Crisis has had a severe impact on both disadvantaged women and girls and the services that exist to support them. Levels of domestic abuse incidence has significantly increased as has incidence of poor mental health. Individuals who were already disadvantaged prior to the crisis have found themselves particularly vulnerable and have been even more at risk of slipping through the net as services have struggled to continue provision and meet rising demand.

Research by Agenda (Voices from Lockdown – 2020) found that:

- 63% of surveyed organisations reported an increase in demand for their support;
- The largest group of organisations that had reported increased demand were those that specialised in supporting individuals experiencing domestic abuse;
- 89% of organisations surveyed reported higher levels and greater complexity of need;

Services such as those delivered by WCTS have had to repurpose their provision - moving away from face-face support and delivering services online. This has presented huge challenges for both staff and beneficiaries, particularly for WCTS' target group where levels of digital exclusion remain stubbornly high. These challenges and WCTS' response will be explored in more detail later in this report.

3. Evaluation Methodology

3.1. Project Outcomes and Indicators

In order to monitor and evaluate the progress and impact of the project, the following outcomes and indicators were established at the outset.

Outcome	Indicator
Women suffering from trauma and abuse have improved mental health and wellbeing and reduced isolation	• 312 women participate in the project • Women will report reduced isolation (target 231 women report this improvement – 74%) • Women will report improved mental wellbeing (target 197 women report this improvement – 63%) • Women will report improved mental health (target 218 women report this improvement – 70%)
Women suffering from trauma and abuse have increased self-confidence and self-esteem to better manage and make changes to their lives	• 312 women participate in the project • Women will report increased self-confidence (target 231 women report this improvement – 74%) • Women will report increased satisfaction that their life is in tune with their beliefs and values (target 243 women report this improvement – 78%) • Women will report managing difficult situations better (target 250 women report this improvement – 80%)
Volunteers who have suffered from trauma and abuse have greater self-confidence, increased life skills and are more active in their community	• 38 women provided with volunteer training • Volunteers will have greater confidence (measured through volunteer feedback) – 33 women by the end of the project (88%) • Volunteers will report increased life skills (measured through volunteer feedback) – 30 women by the end of the project (79%) • Volunteers will report being more active in their community (measured through volunteer feedback) –33 women by the end of the project (88%)

3.2. Monitoring methods

The project originally sought to use 3 tools to track client progress. These included:

- CORE Outcome Measure Framework;
- Authenticity Measure
- Feedback forms

During the first year of the project, it was found that the Authenticity Measure was not appropriate for use with women of Asian heritage. This is because the language and approach the measure uses is not translatable or relatable to this target group. Therefore, the project team developed their own Reflective Space questionnaire to better capture data relating to the indicators:

- Women will report 'increased satisfaction that their life is in tune with their beliefs and values';
- Women will report 'increased self-confidence';

In addition, the team also introduced questionnaires based upon the Warwick-Edinburgh Mental Wellbeing Scale in Year Two in order to better capture data related to changes in participants' wellbeing throughout the project.

It should be noted that different approaches were utilised throughout the project, depending upon the needs of the individual. This means that each data-set reflects a specific sample of individuals and not the overall cohort.

3.3. Evaluation Team and Approach

WCTS commissioned Charity Fundraising Ltd to undertake the evaluation of the Women's Circle project. This evaluation has taken place during September and October 2020 and has mostly reflected on project delivery up to March 2020. This is because the impact of the Covid-19 crisis prevented the project from continuing as an outreach, group based model. In order to gain consistency and enable fair conclusions to be made, it was felt appropriate to focus on Years 1-4. A section on the impact of Covid-19 has been included later in this document.

WCTS had originally planned to commission a qualitative evaluation that would have focused on the production of a film about the project, providing a real platform for and amplification of participant voice. However, this was again prevented by the Covid-19 crisis and social distancing measures which disallowed the kind of interaction and participation that such a film would require. Furthermore, direct consultation with

participants of the project through this evaluation has also not been possible for the same reasons.

Given the challenges presented by social distancing measures in place during the evaluation period, the research has focused on:

- Review of monitoring data and case studies collected by the project team;
- Interview with a former service user;
- Group discussion with two Community Access Workers;
- Interviews with three project therapists and the Chief Executive;

4. Women's Circle Project

4.1. History

A key strategic priority for WCTS is to improve inclusion and diversity both within its engagement of service users but also across its governance, management, and delivery teams. The organisation had recognised that it could be more effective in its engagement of women from BAME communities and that its centre-based approaches may have unwittingly excluded people from deprived communities and diverse backgrounds. As a result of this, the organisation had considered a number of opportunities for addressing this problem, when they were approached by Hamara in South Leeds to discuss potential partnership work to tackle domestic abuse within the South Asian community.

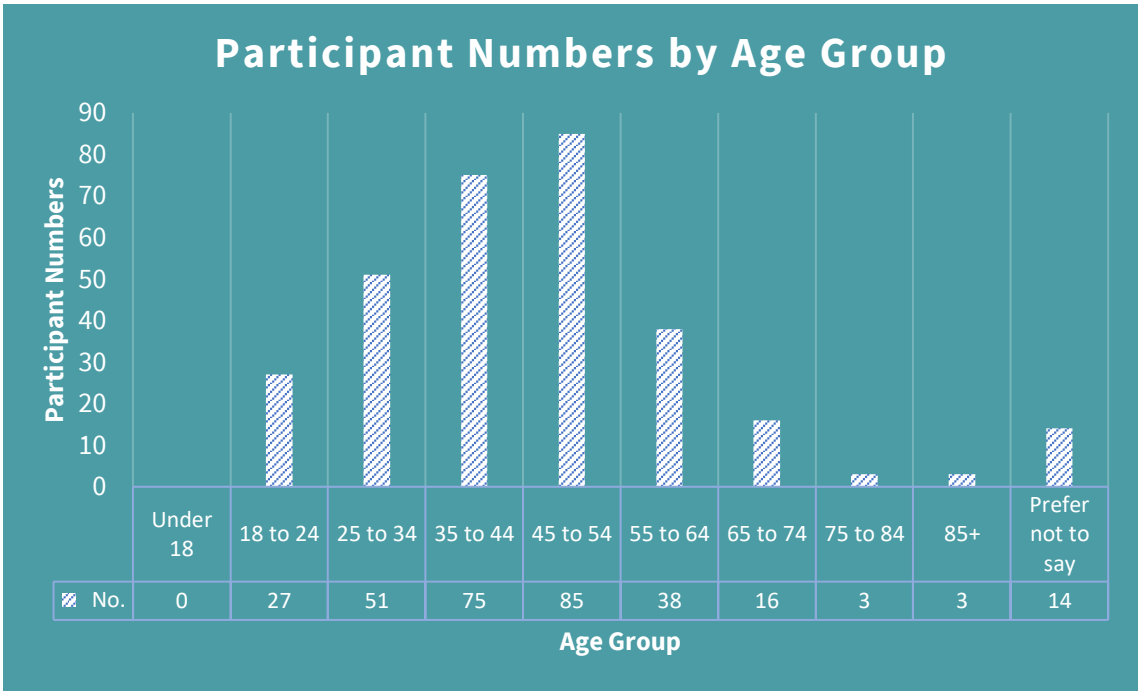
In 2015, funding was secured from the National Lottery Community Fund (the then Big Lottery Fund) to deliver a 5 year programme based upon the learning gained through WCTS' core services and an outreach project for mothers with children receiving psychological therapies. The proposed model sought to deliver 1-1 and group therapy using outreach mechanisms, targeting individuals in Beeston, Armley, Harehills, Chapeltown and Seacroft. Crucially, the model was underpinned by close partnership work with local organisations with significant levels of existing engagement of women who were likely to benefit from this support. In addition, the project opted to build capacity for the provision of peer support in the target areas.

4.2. Target Group and Demographics

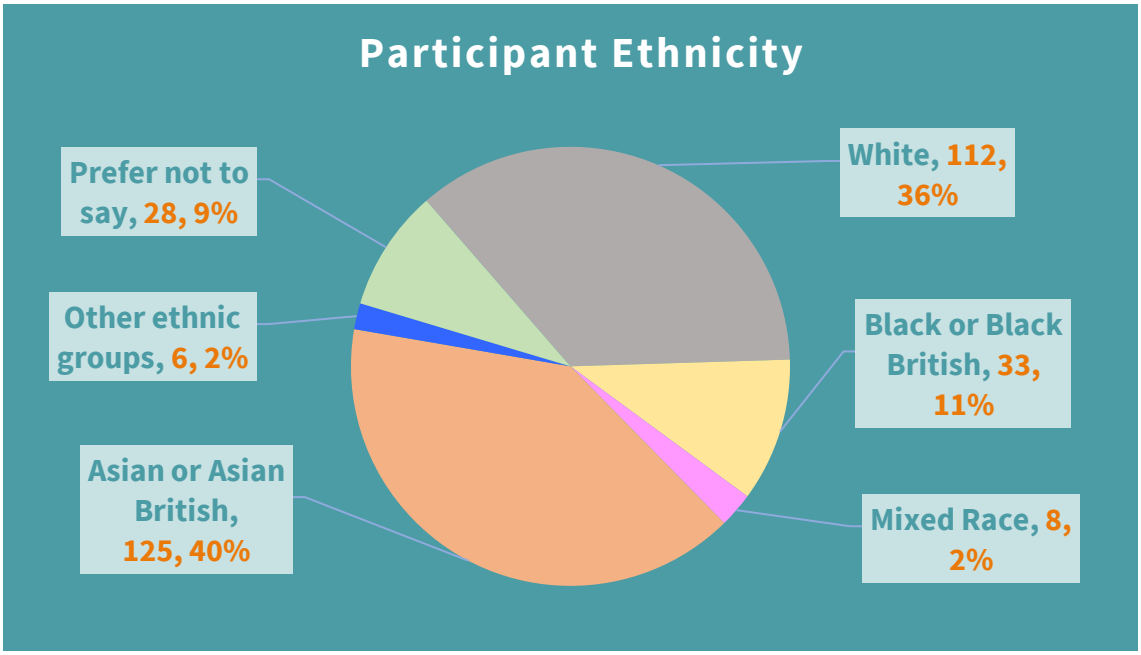
The target group for this project included traumatised women who were unable or unwilling to access therapy in central Leeds. The focus was therefore on engaging women from BAME communities and those individuals who lacked the financial and personal resources to travel into the city centre to access support. A formal target of 35% of the overall cohort was set for engaging with South Asian women. The demographic analysis of those engaged is provided in the sections which follow.

Analysis by the project team shows that the demographic breakdown of the project up to and including September 2020 was as follows:

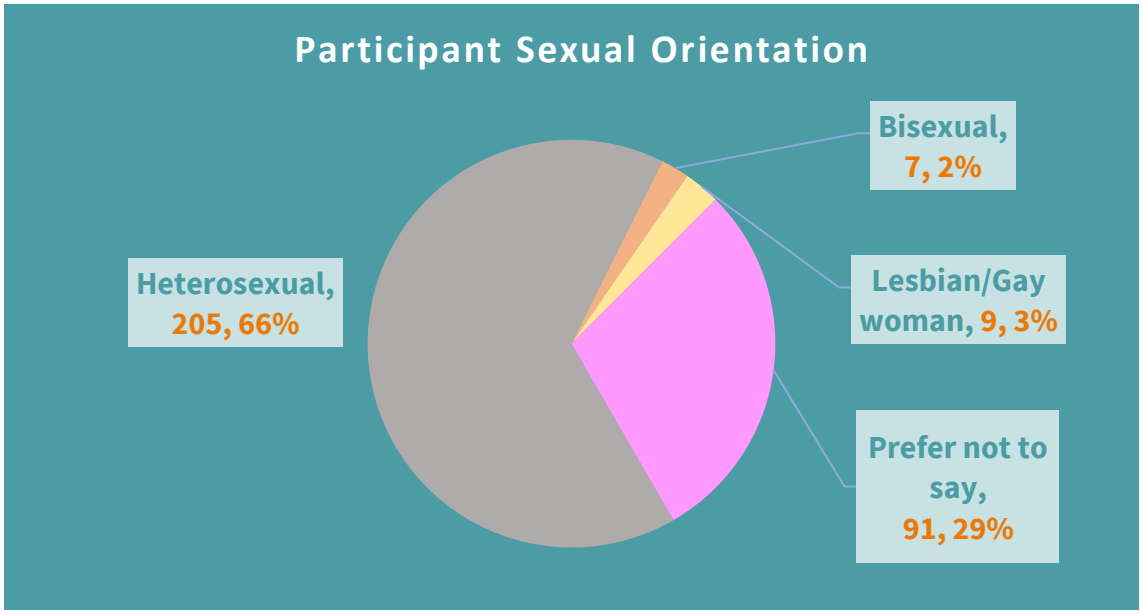
4.2.1. Age Range



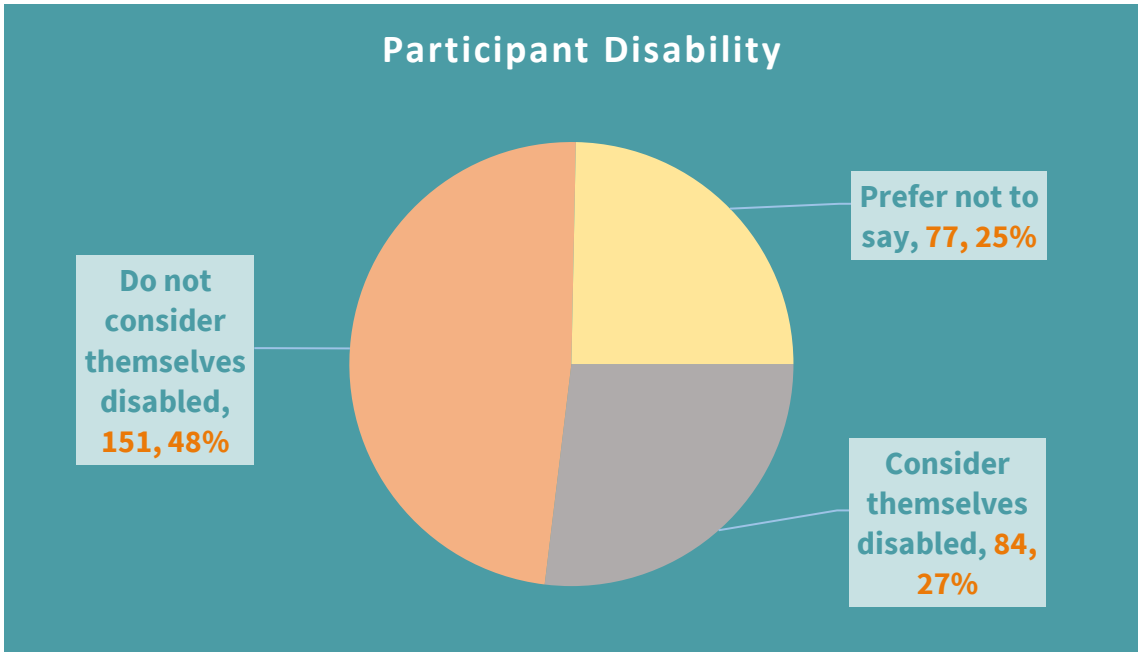
4.2.2. Ethnicity



4.2.3. Sexual Orientation



4.2.4. Disability



4.3. Activities and Partnerships

The overall approach of the project team was to provide 1-1 and group therapeutic support on an outreach basis. To this end, the project developed partnerships with a number of organisations to establish outreach locations in community settings that the target group would feel comfortable about using. This is particularly important for individuals whose safety may be at risk if it became known they had accessed support for women who had experienced abuse or those who are particularly vulnerable to community-based stigma about mental health.

The partners involved in the project included:

- The Grange – Seacroft;
- Hamara Centre – Beeston;
- Bangladeshi Centre – Harehills;
- Dosti (Stocks Hill Hub) – Armley;
- Lovell Park Hub – Harehills;
- Westfield Medical Centre - Chapeltown

Once a partnership had been developed between the therapist and the community organisation, two main types of groups formed:

- Those in which the therapist worked within an existing activity, working alongside the session leader (such as sewing and cooking groups);
- Those in which the therapist led the activity group – these tended to be those which involved poetry, art, clay and sand, yoga;

In both groups, mental health awareness and support was embedded within the activities to avoid the sessions being labelled as “a mental health group” and thereby avoid the stigma associated with mental health problems in the communities the project was trying to reach.

The group activities were provided on a drop-in basis at the outreach venues. They primarily featured arts based therapies using poetry, sewing, clay work, sand tray. Over the course of the project, the Support Workers established their own peer support groups so that women could develop new networks and share experience and coping strategies with each other. These groups were also attended by a therapist or sessional worker (such as a Yoga teacher) to provide guidance on chair-based yoga, mindfulness, and self-care.

Image: Art therapy session

The groups provided the opportunity for participants to learn more about mental health, the support available and they acted as a gateway to other services provided by WCTS. Individuals who self-referred or were identified as in need by project staff were given a full assessment of need and then formal referral into a psycho-educational group (such as a confidence building group) or into individual counselling.

The project has also created referral pathways into counselling for sex-workers through partnership work with BASIS. This has been delivered on a 1-1 basis by a trained and qualified therapist.

In Year 4, the project piloted a personal development training course for women interested in (or already running) their own peer support activities in the community. The intention behind this work was to provide individuals with the tools and supervision they needed to plan and develop their own sessions or take their learning into volunteer roles in other organisations.

The Covid-19 Crisis has had a major impact on the delivery of project activities in 2020 (the final year of the project). For example, all group sessions were paused in March

and 1-1 support has mostly been delivered over the telephone (30 minute emotional support calls and telephone counselling). Some of the groups have been able to arrange their own activities with each other (such as a walk in the park). Interviewees reported that although challenging, the use of different media such as Zoom, or the telephone has demonstrated the potential to reach people who are housebound and who would normally be unable to access face-face counselling.

> *"It's been a hard year definitely, but it has shown us what we can do if think outside the box a bit. Telephone counselling means that we can help people who can't get out of the house, which is great"*

4.4. Engagement Methods

The project approach to engagement recognised the range of difficulties that the target group experienced in accessing support. These barriers can be categorised as follows (and these are covered in more detail in the Learning section of this report):

- Risk to safety associated with seeking help for domestic abuse;
- Concerns about seeking help due to other factors such as worries about immigration status;
- Personal reluctance to seek help due to stigma about mental health;
- Difficulties acknowledging need for support due to personal attitudes and beliefs;
- Not being able to travel into the city centre or across Leeds to access services;
- Not being aware that support services are available;

At the outset, the project team understood that they needed to learn more about their target group, the barriers they faced and their needs if they were to successful launch and deliver this project.

In Year 1, the therapists undertook extensive outreach work with the partners to consult with women in their communities. For example, they consulted with people through:

- The 'Chit-Chat' group at Hamara for older women as well as the sewing class and Job Shop;
- Attending the Drop-In at Dosti and an Afghani support group for women;
- A meeting with volunteer migrant community leaders;
- Hosting an information stall at Beeston Festival;

- Consulting with individuals who had a mental health diagnosis at Inkwell;
- Running two MarketPlace sessions at Hamara to develop early contact with participants and learn more about the kinds of things they would like to do;

This early engagement supported the development of the project and provided an opportunity to build the relationships with the partner organisations and within the communities to be targeted.

Images: Engagement activity promotional materials

The model adopted focused upon integrating the project within the existing structures in local areas. So, for example, the team joined the Chit Chat group at Hamara, co-located services with Dosti and in GP surgeries in Chapeltown and Seacroft, as well as launching and running peer support group at the Bangladeshi Centre in Harehills.

The project was also promoted through statutory and voluntary organisations as well as using print and online resources.

Analysis undertaken by the project team shows that referrals were mostly "self-referrals" which really does evidence the effectiveness of the promotional and engagement activities in the target communities.

The two Community Access Workers involved in the project were also local residents and individuals who had formerly been service users. They both provided a pivotal role in connecting the target communities with the services offered, developing activities which were relevant and engaging for potential service users and encouraging and reassuring individuals as they participated in support, to enable better retention.

Referral Source	No.
Self referral	131
Voluntary and community organisation	32
GP	14
Health service	12
Social Care	11
School	2
Family	1
Other (alternative sources not indicated)	109
Total	**312**

Case Study

Ms A referred herself following an outreach session at Dosti. She was suffering with feelings of terror and panic, depression, difficulties sleeping, exhaustion, suicidal thoughts, and plans.

Ms A's mother had recently died; she had not seen her mother since the day she left her country of origin fourteen years previously to live in the community of her husband's family. She had four children and a husband twenty years older suffering with undiagnosed memory loss and mental health issues. As the wife of the eldest son, she was also expected to care for her elderly parents in law, both suffering with dementia and to cook for and host all family gatherings with the extended family.

Early in the work it became apparent that Ms A also faced huge insecurity as she was without a visa, despite having lived with England for 14 years with her British husband and was threatened with being removed by The Home Office. As a non-English speaker, unable to read and write in her own language, without legal status, dependant on a husband who was himself vulnerable and dependant her life was

very difficult practically, and understandably frightening. Some benefits had been suspended due to her lack of status and she was distraught that she was unable to buy food for her children. In addition, her teenage daughter was refusing to go to school because she was frightened of losing her mother, the family were threatened with absence fines and there was social care involvement.

Working with Ms A necessarily involved work alongside counselling for example initially gathering and delivering emergency food and then working with many other agencies: emergency food parcels from the voluntary sector, contact with the benefits agency, the first (ineffective) solicitor, sourcing and working with the second, The Home office, children's social care, the local MP's office, support for carers in the BME community. This activity was necessary to address basic needs before therapeutic needs could be addressed and also reflects the absence of an advocacy service for which Dosti had lost funding earlier in the year.

Ms A worked with her grief about the loss of her mother, her sense of herself as a mother and the need to take care of herself so she had the energy to continue to look after her own children. Ms A started to assert her need to grieve in her wider family and the necessity of others taking the turn in the cooking and hospitality. She reached out to find support within her sister and brother in laws for support with ideas about how to cope with her husband and his illness. She explored her sense of shame around her illegal status and her suicidal feelings at the thought of being separated from her children, as she thought this would be the ultimate failure, and there would be no point in existing without them.

Her spiritual beliefs were a fundamental theme in the counselling as she believed she was deserving of her difficulties for defending her mother against her father's brutal attacks when she was a child. She believed her pain was Karma for challenging her father's authority. However, the process of talking about these experiences was a huge relief to her as she realised she had been in an impossible position; her shame lessened considerably, and she felt that she did not regret defending her mother . She began to see this experience as more about the hardship of being a woman.

Thankfully Ms A was granted a visa following an application made under the human rights act through the involvement of the MP's office. By the end of the counselling Ms A was travelling on buses on her own, planning a trip to Pakistan to visit her mother's grave, planning to study, enjoying her children, and working on how to encourage her husband to recognise his medical needs. She was more persistently asserting that she was not able to take care of her in-laws on her own and enjoying greater support within the wider family. She was feeling more confident about approaching teachers. She retained the values she had learnt from her mother and she knew she would always feel her mother was with her.

5. Impact

5.1. Outputs

Summary of the quantitative data for four years of this five year project demonstrates the effectiveness of the work in engaging with women and in particular engaging South Asian women.

Outputs as at Year 4	Actual
Total number of women reached/engaged	**260**
Number of initial assessments	**260**
Total number taking part in individual or group therapy	**215**
Total number taking part in short courses of therapy	**113**
Beneficiaries reached that were Asian/Asian British women (average)	**50%**
Beneficiaries reached that were from all BAME communities (average)	**67%**

Prior to the Lottery funded project only 25% of women supported were from BAME communities. Not only has this increased to 67% across all ethnic minorities; the project has also consistently surpassed its annual target of 35% of women reached through this outreach project being Asian/Asian British beneficiaries, with an average of 50% of all beneficiaries between Year 1 and Year 4 coming from this ethnic group.

The total number of women engaged through the project has consistently surpassed annual targets – reaching 260 women from all ethnicities/cultures against an anticipated target of 247 by end of Year 4. The percentage of women completing an intervention averaged 82% across the four years.

5.2. Women suffering from trauma and abuse have improved mental health and wellbeing and reduced isolation

Indicator Target	Indicator Achieved
74% women will report reduced isolation	• 86% of Reflective Space respondents reported that they felt less on their own with their problems • 64% of Reflective Space respondents reported feeling better connected to people • 55% of WEMWBS respondents reported improvements to feeling loved and in feeling close to other people
63% women will report improved mental wellbeing	• 77% of WEMWBS respondents reported positive change to their mental wellbeing
70% women will report improved mental health	• 57% of those who completed the CORE Outcomes Measurement Framework Questionnaires reported positive change to their mental health

5.2.1. Improved Mental Health

The CORE data provides the relevant information for this indicator. However, it only includes individuals accessing counselling from 2017 onwards and therefore those with the most complex needs. Different measures such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) were used for those participating in the groups.

The table below provides an indication of the presenting issues that the project team supported individuals to address.

Issue	Min	Mild	Moderate	Severe	All
Anxiety/Stress	1	23	39	24	**87**
Depression	3	22	41	19	**85**
Self Esteem	7	19	31	20	**77**
Relationships	8	22	25	14	**69**
Bereavement/Loss	3	9	14	8	**34**
Trauma/Abuse	2	19	29	19	**69**
Physical Probs	6	10	18	8	**42**
Living/Welfare	5	14	11	9	**36**
Work/Academic	4	13	8	5	**30**

The data above shows that the most common presenting issues were:

- Anxiety and stress;
- Depression;
- Self-esteem;
- Relationships;
- Trauma and abuse;

	Pre Therapy Average (T1)	During Therapy Average	Post Therapy Average (T2)	Domain Cut-Off	T1 to T2 Change
Well-being	27	23	18	18	**- 9**
Problems	27	21	18	16	**- 9**
Functioning	22	18	15	13	**- 7**
Risk	7	6	3	3	**- 4**
All Items	22	17	15	10	**- 7**

It must be borne in mind that a significant proportion of the cohort were individuals with whom the project had to work intensively through the group sessions and through pre-counselling support to prepare them for this type of work. This has meant that the process of counselling has taken longer, and many individuals have not yet

completed this aspect of the support. The CORE Outcomes Measurement Framework data only reflects those whose cases have been closed and therefore does not account for the progress of individuals whose cases are still ongoing.

In total the cohort for data analysis includes 67 individuals whose cases were closed and who were able to provide an exit score following completion of counselling. Of these:

- 4 had an initial CORE score below the clinical threshold leaving little scope for reliable improvement to be achieved.
- Of the remaining 63, a total of 36 met the criteria for reliable improvement (57%) of which 12 (19%) met the criteria for clinical and reliable change (i.e., recovery).

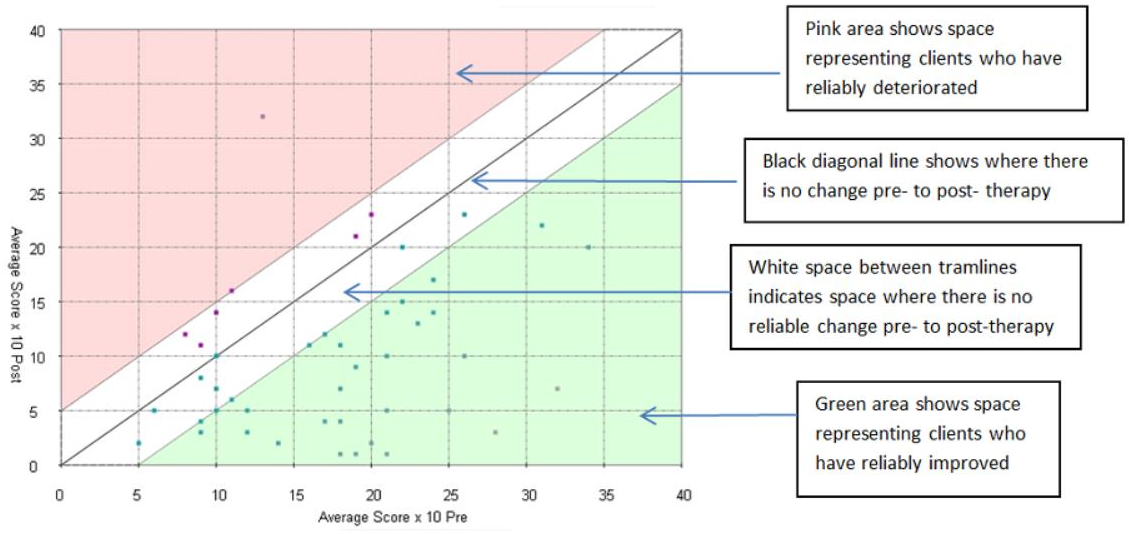


Chart: pre to post therapy CORE score change

The above scatter chart demonstrates clearly that the vast majority of individuals who accessed counselling from the project were recovering as a result of the interventions they received. Recovery in this context refers to reliable and/or clinical improvement which offers a better measure for understanding the huge strides individuals take forward given the high levels of mental health problems and emotional distress they were experiencing on entry to the project.

> *Counselling has helped me bear my situation much better. If I didn't come I would be in a much worse situation.*
> *Ms A (counselling client)*

5.2.2. Improved Wellbeing and Reduced Isolation

In total, 62 service users participating in the groups completed initial and review Warwick-Edinburgh Mental Wellbeing Scale questionnaires between 2017 and 2020. Analysis of this data also demonstrates that overall, these individuals experienced improved mental wellbeing as a result of participation.

Proportion of individuals who reported positive change	**77% (48)**
Range of positive change	**0% - 188%**
Median change	**33%**

The interviews with the project team highlighted the fact that the women who took part demonstrably improved their wellbeing. Staff observed that the participants' mood improved as the groups developed and that they self-reported feeling happier.

The quantitative data available does not specifically measure changes to the levels of isolation experienced by individuals who participated. The Warwick-Edinburgh Mental Wellbeing Scales questionnaire data suggests that around 55% of respondents reporting improvements in their sense of being loved and in feeling close to other people. However, additional information provided from those who completed Reflective Space Questionnaires demonstrates significant improvements for those who participated in the groups as we can see in the table below.

	Strongly agree	**Agree**	**Neither Agree / Disagree**	**Disagree**	**Strongly disagree**
Feel connected to other people	21% (3)	43% (6)	21% (3)	7% (1)	7% (1)
Feel less on my own with my problems	36% (5)	50% (7)	14% (2)	0% (0)	0% (0)

> *I have enjoyed being with women from different backgrounds and ages. Having the support and compassion from Andrea and all the other members of the group has been touching. Being validated and having people encourage me to talk about my feelings and learning that how I feel is important has been the best thing.*

The interviewees were able to report their observations regarding the strength and support that the clients gained from each other. They felt that the individuals were very isolated and lonely people – some have not spoken to another person other than their therapist for many weeks. The group therapies and courses in particular enabled individuals to form new friendships and build up their own social and support networks. Furthermore, the opportunity to talk to another person about their thoughts and feelings through counselling also meant that individuals felt less lonely and reported this to their therapist.

> *"I do look forward to come and discuss my problems. I don't feel as lonely as I used to do. I am trying to do things what I believe in rather than what I think is right, but it doesn't come easy for me to do that."*

Image: Clay modelling therapy session

5.3. Women suffering from trauma and abuse increase self-confidence and self-esteem to better manage and make changes to their lives

Indicator Target	Indicator Achieved
74% women report increased self-confidence	• 94% of women responding to course questionnaires reported increased confidence • 86% of those completing the Reflective Space questionnaires also reported increased confidence
80% of women report managing difficult situations better	• 68% of individuals reported improved ability to manage difficult situations.

5.3.1. Increased self-confidence

Information gathered from course feedback forms (12 people completed the course) demonstrates the positive changes experienced by those involved in relation to their confidence, self-esteem, self-belief, and inclusion, where the vast majority of the cohort agreed they had experienced improvements.

	Strongly agree	Agree	Neither Agree / Disagree	Disagree	Strongly Disagree
Feel more confident	61%	33%	0%	6%	0%
Learn about myself	59%	41%	0%	0%	0%
Learn skills and knowledge	47%	41%	12%	0%	0%
Believe in myself	61%	22%	11%	6%	0%
Be more active in the community	53%	29%	0%	12%	6%
Be more active in my life	61%	28%	0%	11%	0%

Image: Activity Promotional Flyer

If we aggregate the responses for "strongly agree" and "agree" we can see that individuals were able to report:

- Increased confidence (94%);
- Having learned more about themselves (100%);
- Having gained new skills and knowledge (88%);
- Increased self-belief (83%);
- Increased activity in the community (82%);
- Being more active in their lives (89%);

5.3.2. Ability to tackle difficult situations

Data from the Reflective Space questionnaire that was completed by individuals earlier in the project also demonstrates positive change in this area amongst the cohort (14 people).

	Strongly agree	Agree	Neither Agree / Disagree	Disagree	Strongly Disagree
Feel more confident about who I am	29% (4)	57% (8)	14% (2)	0% (0)	0% (0)
Express myself	43% (6)	50% (7)	7% (1)	0% (0)	0% (0)
Tackle difficult situations	14% (2)	57% (8)	29% (4)	0% (0)	0% (0)
Know what is important to me	29% (4)	50% (7)	0% (0)	21% (3)	0% (0)
Do what I believe in or think is right	29% (4)	36% (5)	36% (5)	0% (0)	0% (0)

This data clearly indicates positive change in terms of individuals' levels of self-advocacy, ability to manage challenge. For example, if we aggregate the "strongly agree" and "agree" responses, we can clearly see that individuals were able to report improved:

- Confidence (86%);
- Ability to express themselves (93%);
- Capacity to tackle difficult situations (68%);
- Knowledge about the things that are important to them (79%);
- Ability to do what they believe in or think is right (64%);

> *I never realised that I needed this. Thank you for inviting me to do this. Your organisation saved me and helped me carry on. You have been a can opener and you opened me up and let me out.*
> Group Participant

The project team were able to describe eloquently the significant changes which a number of women were able to make following support. For example, some women gained the confidence to leave abusive relationships, others were able to be assertive in other aspects of their lives, such as learning to drive, gaining skills and confidence, developing better self-awareness. Individuals moved on from the project into volunteering, employment, and further education courses. In other less tangible ways, the participants made changes to their attitudes about themselves and others. For example, one of our interviewees reported her own changed attitudes and a reduction in the stigma associated with mental health problems. It was also reported that some individuals joined the project with a diminished sense of their own self-worth. For some, this was reinforced by attitudes within their community which under-valued the role of women in society. Individuals initially reported feeling they were "not worth" supporting when the therapists and team first joined the groups, but this changed steadily over time as individuals gained strength and a sense of value from their group.

> *I feel it has helped me face some difficult situations in the last few months, grieve a little and to think clearly sometimes... It just keeps me going and I don't give up.*
> Mrs B – course participant

5.4. Volunteers who've suffered from trauma and abuse have greater self-confidence, increased life skills and are more active in their community

Indicator Target	Indicator Achieved
32 women provided with volunteer training	• 12 women accessed training • 66 accessed peer support groups
88% volunteers report greater confidence	• 99% of training participants reported increased confidence
79% volunteers report increased life-skills	• 88% of training participants reported increased skills
88% report being more active in their community	• 82% of training participants reported being more active in their community

The project sought to increase capacity for the managed and supervised provision of peer support in the target communities. In this way, the focus was less about recruiting volunteers into the service itself, but towards developing individuals in their communities and ensuring that they had proper supervision, training, and support to lead their own activities in their areas. Following discussions with the funder, a target of 32 women was agreed, with plans to roll out the activity mid-way through the project.

Due to staff vacancies and the impact of the Covid-19 Crisis in 2020, the project found it difficult to deliver this area of work as planned. However, some personal development training was provided during Year 3, in which 12 women participated. Furthermore, 66 women have attended a weekly peer support group. In addition, the project recruited 2 volunteer therapists who supported the smooth delivery of counselling and group work. Furthermore, the peer support groups were established by 2 Community Access Workers who joined the project originally as service users.

Feedback forms from the personal development training sessions has also yielded the following results which clearly demonstrates increased skills, activity in the community, confidence, and self-belief.

A fantastic example of this aspect of the project has been the development and support of a former service user who has joined the WCTS Board. This individual has been able to not only move on from her own experience with the support of WCTS but is now able to use this to better inform the work of WCTS as a whole.

	Strongly agree	Agree	Neither Agree / Disagree	Disagree	Strongly Disagree
Feel more confident	61%	33%	0%	6%	0%
Learn about myself	59%	41%	0%	0%	0%
Learn skills and knowledge	47%	41%	12%	0%	0%
Believe in myself	61%	22%	11%	6%	0%
Be more active in the community	53%	29%	0%	12%	6%
Be more active in my life	61%	28%	0%	11%	0%

Case Study

Ms J accessed support from Women's Counselling and Therapy Service in Leeds a few years ago. Ms J had been persistently denied support from other statutory agencies. Ms J fought hard to access the support she knew she was entitled to and was eventually given a Support Worker. It was this Support Worker who recommended to Ms J that she tried group counselling with WCTS.

Apprehensive at first, Ms J attended her first session. Ms J told the evaluation team that the first session helped to put her at ease and that she felt so fortunate to have a great group, willing to support one another. They became their own community, a family of individuals whose experiences and backgrounds differed in many ways, but who were able to develop bonds of trust, share coping strategies.

Ms J said that she learned a lot about herself through the sessions and was able to draw inspiration from the other members of her group. Importantly Ms J said that she also learned a great deal about mental health, was able to adjust her own attitudes towards mental health.

At the beginning of this year, Ms J felt that she wanted to give something back, to help other people with mental health problems and those suffering emotional distress. Ms J has joined the NHS Recovery College as a volunteer and has just started running her own online support sessions in the WRAP programme. When a trustee vacancy developed at WCTS, Ms J applied straight away, keen to support WCTS in its work with women who have suffered trauma and abuse. Ms J has had her induction and attended her first Board meeting.

> *"Being a Trustee for the WCTS has enabled me to give back and contribute in a meaningful way to a charity that had a profound effect on my life when I needed it most. I love being surrounded by strong, intelligent, highly competent, compassionate women who are just as passionate as I am about helping women access excellent psychological therapies regardless of their socioeconomic background. I am proud to be part of a team that adds great value to the lives of others."* Ms J

5.5. Summary of impact against targets

5.5.1. Outcome 1: Women suffering from trauma and abuse have improved mental health and wellbeing and reduced isolation

- Against a target of 74% - the data shows that 86% of Reflective Space questionnaire respondents said that they felt less on their own with their problems, 64% reported feeling better connected to people and 55% of WEMWBS respondents reported improvements to feeling loved and in feeling close to other people.
- Against a target of 70%, of those who completed WEMWBS questionnaires, 77% reported positive change to their mental wellbeing and 57% of those who participated in counselling and who completed the CORE Outcomes Measurement Framework Questionnaires reported positive change to their mental health.

5.5.2. Outcome 2: Women suffering from trauma and abuse have increased self-confidence and self-esteem to better manage and make changes to their lives

- Against a target of 74%, the data in the feedback questionnaires shows that 94% of individuals reported increased confidence and 86% of those completing the Reflective Space questionnaires also reported increased confidence;
- Against a target of 80%, the results from the Reflective Space questionnaires also show that 68% of individuals reported improved ability to manage difficult situations.

Whilst the project did fall somewhat short of the planned target for those reporting improved ability to manage difficult situations, other data collected through the Reflective Space questionnaires points towards increased levels of self-efficacy and empowerment amongst the cohort such as: increased ability to express themselves (93%) and knowledge about what is important to them (79%).

5.5.3. Outcome 3: Volunteers who've suffered from trauma and abuse have greater self-confidence, increased life skills and are more active in their community

Due to the challenges in delivering the related activities for this outcome, it has not been possible for the project to achieve the planned targets. However, the interviews with project staff and particularly the three individuals who were former service users demonstrated that the project has improved the confidence, skills, and community involvement of individuals. Furthermore, the feedback forms completed by course participants shows that:

- 99% reported increased confidence;
- 88% reported increased skills and knowledge;
- 82% reported being more active in their community;

Case Study

Mrs D was of Indian origin, in her early fifties who had two children over the age of 18. Mrs D was unable to work due to a recent car accident, which had limited her mobility and was referred to the Women's Circle project by Dosti after reporting feeling depression and isolated. Mrs D was offered counselling at Westfield Surgery (one of the project's outreach venues).

Mrs D presented with low mood, negative self-appraisals, social isolation, and loss of identity. Mrs D's therapist focused on supporting her to gain an understanding of her difficulties and to be able to contextualise them. Core techniques of unconditional positive regard and being non-judgemental strengthened the

therapeutic relationship and soon D was able to reflect effectively and identify clear goals.
The counselling she received enabled her to make a number of positive changes in her life. She was able to address the negative self-appraisals by focusing on positive and meaningful activities which gave her a sense of achievement. She worked on developing her identity, having struggled with a change in her role as a mother, after her children had moved out of the family home. Relaxation and emotion regulation techniques were also implemented to help Mrs D to cope effectively with stress and emotions such as anger.

There have been some difficulties associated with using the quantitative data collected by the project. The monitoring approaches evolved over time in order to better meet the needs of individual participants and the staff team found it difficult to ensure that service users completed the questionnaires consistently, as a result of language barriers and difficulties understanding the concepts and issues. Furthermore, the impact of Covid-19 meant that it was not possible to undertake further research with the service users to enable them to reflect on their progress as had been planned which would have enabled a more deeper exploration of the project's impact.

Notwithstanding these issues, the evaluation team has been able to use data from a range of sources which demonstrates the impact achieved. This evaluation finds that the project made a significant and positive difference in the lives of the women who accessed it, enabling them to benefit from improved mental health, reduced isolation and increased confidence and self-esteem. These are huge achievements for individuals who joined the project as traumatised and highly vulnerable individuals with very low feelings of self-worth. The project made a significant intervention in widening access for under-represented and marginalised women and has brokered and established productive partnerships and relationships in the city's most deprived communities which will serve well for future projects and activities for vulnerable women.

6. Learning

6.1. Enabling access to women from diverse communities and vulnerable backgrounds

The Women's Circle project highlighted a number of issues faced by South Asian women in Leeds, particularly in terms of their role within relationships and within their communities. Those interviewed for this evaluation, reported observing amongst participants high thresholds for abuse within their relationships, with some participants finding it hard to recognise abusive behaviours from family members or partners. Whilst some individuals later reported experiencing abusive relationships to their therapies, this was rarely the presenting issue or indeed the focus of counselling. Some participants demonstrated normalising attitudes about domestic abuse as well as fears about the stigma and loss of identity which seeking support could entail. Individuals leaving an abusive relationship could in some instances also face losing their family and community bonds and for many these were unsurmountable obstacles.

The South Asian women involved in this project were also observed by the project team as experiencing further limiting factors which were culturally different to those experienced by the White British cohort. Caution here is essential as it has not been possible to engage directly with the participants about these issues. However, the interviewees included women from the South Asian community and the following sections are based upon their experience as community members *and* as project staff.

For example, the therapists who were interviewed found that aspects of their training and experience were Eurocentric in approach and not always easily adaptable to the needs of South Asian women in particular. We have noted above the different ways some of the women viewed relationships and this further translated into their perspectives about their role in society and what this meant for the promotion and protection of their wellbeing. Individuals demonstrated limited understanding of the value and relevance of therapy, particularly in a context where their needs were typically deemed subordinate to the needs of their families and wider community. The team encountered women who had little or no concept of boundaries between themselves and others, normative definitions of "self" had little application in this context. Some individuals would take phone calls during sessions, turn up to sessions late because of other responsibilities and find it hard to commit to support overall.

Image: Promotional materials in community languages

There remains an ongoing stigma associated with mental health within some South Asian communities. This stigma results from difficulties translating current concepts about mental health into other languages and also from cultural perspectives where there are beliefs that mental health problems can be result of supernatural forces. The need to maintain reputation within communities that have often faced racism and stereotyping in other ways is also a major factor and mental health problems can be cast as an illness to be hidden from view. The project team certainly encountered attitudes about mental health that resulted from this stigma.

There were also tensions and challenges between the different generations, resulting from the different expectations placed on each other. For example, the project worked with a number of women from younger generations who had grown up in a mostly westernised setting only to find that as they reached adulthood their families expected them to take up a more traditional role. Some had to be supported to overcome the prospect of forced marriages. The older women, having dedicated their lives to their families, reported feeling under-valued in their community and lonely and isolated. Middle-aged women reported finding themselves trapped somewhere in the middle – they felt they had given up their hopes and dreams for their families, at the behest of their mothers in many ways, and were now faced with daughters with different attitudes and beliefs who were resistant to traditional values. Across the generations though a loss of identity and low levels of self-worth were evident.

During initial engagement, some of the women were sceptical about the offer – in terms of its suitability for them, the need for it to be provided and the financial incentives for the organisation associated with delivery (some participants evidenced a belief that they were doing the team a "favour" by taking part as it would mean that the therapists would be paid and the organisation receive funding!).

Some of these challenges were anticipated prior to project design, but the extent to which these impacted upon delivery was unexpected and the team quickly learned that a different approach was required. To respond to these challenges, the team adapted the project design and intensified the soft-engagement work in the community – running activity groups or working alongside existing activities of partner organisations to build trust, open up new gateways into support and work with individuals prior to counselling to make it more accessible.

Interviewees reported needing to:

- work more intensively prior to therapy in order to prepare individuals for referrals,
- be innovative about approaches to group therapy,

- offer emotional and practical support that wasn't necessarily therapeutic in nature, but was more focused on providing advice, guidance, and signposting in many cases;
- adjust their therapeutic approach to move from a focus on individual empowerment, to empowerment gained from other networks.

Women from younger generations were more receptive to the notion of individual therapy, whilst the older women's group really thrived on being with each other. They experienced real increases and improvements to their wellbeing as a result of the group work and the opportunities to share experience and have their own supportive women-only space. The interviewees highlighted in particular the use of clay work in one of the groups as a good example of the creative ways they enabled individuals to open up and share experiences with each other. Themes of home, loss and belonging were explored by the participants as they used the clay to recreate memories of their lives before coming to the UK and this then opened up the space through which individuals could then talk about their experiences collectively.

Image: Therapy session props

6.2. Challenges to monitoring and evaluation

A related matter to the issues raised in 6.1 above is the fact that the use of validated measures such as the Authenticity Survey and CORE-OM were found to be difficult to use in the community settings and with women from South Asian communities. An unforeseen issue both in the monitoring and the evaluation of this project is the eurocentrism of validated measures. This led to the use of multiple frameworks at different stages within the project, which has in turn impacted upon the consistency of data collected.

The terminology used in the CORE-OM framework and Authenticity Survey is difficult to translate into Urdu. Furthermore, in many ways, the terminology used in these frameworks is also not relatable to the experience and cultural background of the women participating. For example, individuals reported that the concept of "tackling difficult situations" as a positive outcome ran contrary to their concepts of themselves and their roles as women in their communities where challenging situations were identified as routine rather than difficult. They found this statement to be too combative. Furthermore, the project also worked with many women who were born overseas and who were not able to read or write in English. Indeed, many women were also illiterate in their own languages due to an interrupted education or having no education at all.

The Covid-19 pandemic resulted in the project having to suspend all activity on 23rd March 2020. As the women being targeted were highly disadvantaged, isolated and vulnerable, the levels of digital exclusion amongst the cohort were very high. This prevented WCTS from being able to rapidly pivot delivery towards online services and so the focus has been delivering telephone support to women, prioritised against complexity of need and level of risk. This led to the suspension of the group activity (although the Community Access Workers and staff have sought to remain in contact and run some small scale activities such as socially distanced walk in neighbouring parks).

Whilst younger generations had some levels of digital inclusion (such as through smartphones and their own tablets) there was a sizeable cohort of older and more isolated women who did not have access to this technology or the skills and knowledge to use it. In addition, some women were purposefully hiding their involvement in the project from other members of their household. WCTS have supported individuals to access the technology they need to participate and have provided 1-1 training to those who have limited digital skills. This work has taken time

to embed, but WCTS is now able to rollout online provision to support individuals as lockdown periods continue. However, for the purposes of this report, the impact of Covid-19 alongside the digital exclusion of service users has prevented the completion of feedback forms or further research, which would have helped develop a more detailed view of the impact achieved.

6.3. Delivering outreach and working in partnership

There were some complexities to delivering outreach therapeutic support and the use of partner venues for activities. Several interviewees noted the porous nature of outreach work in community settings, where it became difficult to establish boundaries around services and staff compared to those which are intrinsic to the delivery of support at WCTS' central office.

Interviewees highlighted difficulties associated with use of community buildings and difficulties arising from rooms not being pre-booked, issues associated with the quality of the buildings themselves. Several interviewees referred to the same example of male staff at a partner organisation walking in and out of the women's group sessions. This they felt highlighted both a lack of understanding of the need for a safe and contained female-only space and a failure to respect the contribution the Women's Circle project was making to the lives of their service users and the strategic objective of their own organisation.

It was also noted during a number of interviews about the isolation that can be experienced by project workers undertaking outreach work. Individuals did not have the same network of colleagues with them whilst delivering in the community as they would working from the central office and it was understood by interviewees that this created some additional pressures for the project team.

Furthermore, there were also some unforeseen challenges associated with the deployment of therapists from the South Asian community on an outreach basis. These challenges included:

- Concerns about the overlap between the networks of the therapists and those of the participants and worries about individual knowledge of each other outside of the project settings;
- Some individuals preferring to be supported by therapists from different ethnicities

- Challenges associated with some of the participants not recognising the therapist as a professional and respecting the boundaries which are necessary and required. This created significant burdens for the therapists and demanded a greater level of management and supervision

Gaining substantive referrals from the partner organisations was also a challenge. In so many cases, the partner organisation would refer individuals to WCTS but fail to collect relevant information about the needs of the individual and their suitability for the project. WCTS staff found that they would need to spend a lot of time with the individual not only to prepare them for inclusion in the project (as referred to above) but also in terms of developing and building a relationship with them first before formally referring them into the project.

There were also some issues of trust between partner organisations and the project. As mentioned above, in one organisation, the women-only space required for the project was often interrupted by male staff. There were also some difficulties arising from the fact that the partner organisations went through major restructures (including several changes of leadership team in one organisation and a merger in another) and the ongoing challenge of limited resources and funding. The fact that WCTS had secured funding in part to support BAME women, when many BAME-led organisations in Leeds had lost their funding was often a vexed issue.

Case Study

Mrs M is a 70 year old Indian woman referred by an Asian women's support organisation for individual counselling. She presented with anxiety and memory problems, difficulties sleeping, feeling confused, overwhelmed, tearful, and frightened.

Mrs M's attendance at counselling sessions was intermittent. When she did come she arrived many hours before the session anxious to be there on time. She often would not stay for the full session because she was anxious to get home, worried about getting two buses, that she may have forgotten to lock her door or that she may lose her way on the way home. English was her second language. She was very worried about money. She thought the roof of her council house was leaking but would not use her phone because of the cost and confusion about the system on the phone. She was also not sleeping because of a letter she had received from pension credit about a review of her payments that again required her to use the phone for a 'phone interview'. She seemed very isolated, estranged from family with nobody to help her.

Her counsellor quickly became concerned that she may be suffering with dementia and may need additional support. With her permission she contacted her doctor and asked for a referral to the memory clinic. A referral was made to Women's Lives Leeds service for a Complex Needs Worker to visit her at home, assess her needs, offer practical support and help her to access other relevant services for isolated, elderly people who may be losing their capacity.

There was an 8 week delay before this referral could be picked up, and Mrs M stopped attending counselling, because she was becoming increasingly agitated and struggling with the travelling. We therefore found a temporary venue in a community centre close to her home and offered her counselling until the other services were involved. I also helped her to phone both the Council about her roof and the pension credit agency.

Mrs M then attended regularly and very quickly we could see the value of offering a service close to her home. Her anxiety gradually decreased, and her memory appeared to be less debilitating as she explained her fears of growing older and frailer without anybody she could depend on. Mrs M had four adult children with their own families, and with great sadness she told me how she had become separated from them. She was born in India and was sent to the UK for an arranged marriage when she was 17. Her aunts told her she was marrying into a bad family, but she had no choice because her father had died when she was eight, so her

mother was keen to find anybody to marry her. In her marriage she suffered domestic abuse from her mother in law, and when her youngest child was eight her husband took a new 17 year old wife from India and she was made to leave the family home, and her children.

She was housed in a hostel for the homeless and eventually became a cleaner but had always struggled in poverty. Her children remained with their father, and she was ostracised by the community as the divorced woman. Whilst she had recovered contact with some of her children in their adult lives these relationships remained fragile. When she retired when she was 60 she had become very isolated and depressed, made several suicide attempts ending up in psychiatric care. Again, she was rejected by her family and considered to have brought shame on the family for having mental health issues. A recent upset with one of her younger sons had resulted in her losing contact with one of her sons and grandchild. This was reminding her of the previous losses of her children and the shame and blame that she experienced from the community.

Mrs M grieved the loss of her relationships with her children and became less ashamed and blaming of herself for not being as present in their lives as she would like. She explored her fears of growing old on her own, with her increased dependency needs and sense of vulnerability. She gradually became more active again, contacting friends, accepting neighbours' invitations, going back to Church and attending GP and hospital appointments for a range of physical health issues. As her confidence and sense of self-worth increased she began to initiate more contact with two of her children and although the contact was minimal she started to appreciate the relationships that were still possible. The work ended as Women's Lives Leeds became involved with a plan to build more support locally for her.

7. Critical Success Factors

This evaluation has concluded that the Women's Circle project was successful in achieving its aims of reaching more women from South Asian communities and supporting those who had experienced trauma and mental distress to improve confidence, wellbeing and reduce isolation. Covid-19 had a direct and limiting impact upon the ability of the project to deliver the training courses to women wishing to become peer volunteers in the community. However, the results from the course that was delivered in Year 4, suggests that had the project been able to roll out the courses further over Year 5, these too would have been successful in delivering the planned outcomes.

The following points demonstrate the critical success factors that enabled the project to work well and would be ideal places to begin for any organisation seeking to replicate the Women's Circle model or for further iterations of this project.

Build relationships within the community and with partner organisations

The project design acknowledged the difficulties that WCTS had in engaging with communities who lack the resources and knowledge to access counselling and sought to work in partnership with local organisations with high levels of engagement with the target group. This was effective in ensuring that outreach settings were hyper-local and able to reach individuals on their doorstep. Taking the time to build relationships with the participants was resource intensive and meant that it took longer to achieve positive outcomes for each individual. Furthermore, building relationships with partner staff was also critical in ensuring that everyone had agreement to shared objectives, an understanding of expectations and responsibilities. The project team found that once this had been achieved, delivery and referral issues could be avoided and dealt with effectively.

Investment in the recruitment and supervision of candidates from diverse backgrounds

WCTS recognised at the outset that if they were to be able to engage and support women from BAME communities, particularly those with language and cultural barriers, that they would need staff who understood those communities. A review of the Job Description and Person Specifications commonly used within the organisation for recruitment of therapists identified that some requirements were creating a barrier for some groups. Most notably, the requirement for individuals to BACP registered or to hold Masters qualifications prevented individuals from lower socio-economic and BAME communities from applying as they typically could not afford to complete these courses. WCTS had developed a partnership with the NHS Psychology Service to create better career pathways for new therapists from diverse communities in the NHS and so had the structures in place to appoint therapists without these qualifications and support them to gain these whilst working with them. This has had a fantastic impact on the organisation which has a much more diverse workforce and for the sector as a whole which has benefitted from a throughput of well trained, qualified therapists from BAME communities.

Building relationships across communities

One of the areas of impact that was not inbuilt into project targets was the improvement to community cohesion and understanding gained by people from different ethnicities working with each other (both between staff members and between staff and participants). Some of the interviewees reflected positively on the relationships they had developed with each other, noting the differences in attitude and experiences they had prior to the project. They said that they felt they had learned a lot about different communities, particularly the heterogeneity of ethnicity. They also reported feedback from women in the project who had found that they had learned a lot about White British women too, with their own stereotypes being dispelled.

Enabling access

Participants were reported to have improved their understanding of mental health as a result of participation. It was also noted that a lack of understanding and the stigma associated with mental health was a key barrier to support for women from all communities. So too was the issue of many women simply not knowing that support was available to them. Co-locating services within community settings and GPs was a

fantastic way to take therapeutic support out to individuals where they lived and enabled individuals to be able to access the service safely, in ways which could be embedded in their routine. It also meant that individuals accessing support could not be readily identified by their family or neighbours as doing so and so prevented damage to reputation, stigma and for some the prospect of further abuse.

Recognise the need for diverse approaches

The project team employed multiple approaches to the delivery of mental health support, involving outreach group and 1-1 sessions, counselling, personal development courses. The team also learned that women from diverse groups have different concepts of mental health and different perspectives about counselling and the relevance of that kind of support to their lives and experiences. The team also found that many individuals need several weeks of pre-counselling sessions to prepare them before work could commence. Furthermore, some of the women (as we have seen in the case studies) needed holistic support to address other needs, which demanded practical and emotional support rather than therapeutic interventions. Being prepared and appropriately resourced to respond to these types of needs first and/or alongside therapeutic interventions built trust and ensured that individuals achieved the outcomes that were important to them.

8. Recommendations for a future project

It is apparent that the project model can deliver real impact and change for disadvantaged and under-represented women. The recommendations which follow are intended to strengthen the approaches in a few areas in order to enable better co-design, improve monitoring and evaluation and raise awareness of domestic abuse services more broadly in Leeds.

Invest in co-production

The project team undertook extensive engagement with the partner organisations and with women in the communities as the project was being developed. However, in some ways, it was not until the project was launched and delivery commenced that some of the barriers to support encountered by the target women could be fully experienced. There is an element of self-selection in early engagement and project design work where individuals who already recognise the value of a programme are those who volunteer to be involved in its development. The key challenge is to engage those who are the furthest away from support, particularly where cultural limiting factors impact upon attitudes regarding self and others.

Furthermore, the interviewees (particularly the therapists) acknowledged the influence of euro-centric approaches in the project's early design and their own expectations about delivery. These were particularly exposed when seeking to use concepts of "empowerment" and "independence" which were found to be unrelatable to the experience of many of the women involved. These issues also influenced decision-making around the use of some of the outcomes frameworks and approaches which were later found to be inappropriate, thus creating some inconsistency in data collection.

The project team worked very hard to create a model with the participants that was effective and that they all felt a sense of ownership over. The future project should build on this learning, but crucially continue to engage and consult with target communities to refine and shape delivery. This may mean that the subsequent project plan includes further development time and additional resources to ensure that those

who are furthest away from support are able to be involved at as early a stage as possible.

Ensure outcome measures are suitable for diverse communities

One of the key issues experienced by the project team was in collecting data using questionnaires based upon validated outcome measures. It was found that the language and approaches used were not always relevant to the experience and understanding of the participants. It is recommended that in any future iteration of this project an advisory group including the project team and the project participants work with an experienced evaluator to create a bespoke monitoring and evaluation framework. Additional specialist training and development for staff in the capture of monitoring data from individuals with additional disadvantages may also be desirable.

Invest further in supervision for those delivering outreach support

It was also learned during this project that there are challenges experienced by BAME therapists working within BAME communities, particularly where they are working on an outreach basis. The experience can be isolating, particularly when things are not working as well as hoped. It can also be difficult for individuals to maintain boundaries with individuals who find it hard to respect their role as a professional rather than as a member of their community. Investing in the supervision and support of individuals, recognising the difficulties associated with outreach therapeutic practice is essential to both the safety and wellbeing of staff and the ability of the project to achieve good outcomes for participants.

Develop the monitoring and evaluation approach

A more simplified outcomes framework with broader recognition of other areas of impact would enable stronger evaluation. This could also be better coordinated through the use of a single platform for the recording and reporting of data too. In addition to assessing things such as improvements to mental health, confidence, wellbeing, isolation, the future project could also assess the impact of changed attitudes about ethnicity, mental health, and other stereotypes in any future project. It would also be useful to draw out differences in impact experienced by different target groups so as to gain a better understanding of how to differentiate approaches in the future.

Furthermore, it may be advantageous to adjust targets, especially for those accessing counselling where the pre-support interventions and the process as a whole can take longer for the target group and where they may be other practical and emotional forms of support needed too.

Broaden awareness of the project

It was noted by the interviewees that more work was needed to raise awareness about support available not just for this project but for women experiencing mental health problems and abuse generally. It is recommended that a similar outreach approach is undertaken, but with further relationship building work with local organisations so that they can signpost and refer individuals through their services too.

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