EVALUATION OF THE RELATIONSHIP SUPPORT PROGRAMME: BRIGHTON OASIS PROJECT

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1. EXECUTIVE SUMMARY

This report provides the results of an evaluation undertaken by the Health and Social Policy Research Centre (HSPRC) at the University of Brighton for the Brighton Oasis Project. The report was commissioned by Brighton Oasis; the University's Community University Partnership Programme (CUPP) provided additional match funding. The evaluation examines the Relationship Support Programme (RSP), which is funded by the Department for Education and Skills (DfES). The evaluation was carried out between October 2004 and March 2005.

1.1 Aims of the Evaluation

There were two main aims for the evaluation:

- To assess the impact and effectiveness of programme's management and operation
- To assess the programme's performance, achievement and quality of provision, as well as accessibility by the target client group.

1.2 Methodology

In undertaking this evaluation, HSPRC proposed the following evaluative techniques in order to collect data in relation to the project:

- Analysis of data provided by Brighton Oasis Project;
- Semi-structured interviews with a sample of project clients, user representatives and key workers;
- Participant Observation with a Relationship Support Group;
- Participant Observation with a small sample of clients in 1:1 key work sessions over a period of time.

Although the participant observation of a group meeting was carried out, it was in fact not possible to observe the 1:1 sessions as these sessions are of a sensitive nature and require trust to be built up between the worker and client. The individual interviews carried out complement the observation.

Qualitative data collection was the primary method used in this evaluation using two types of data collection:

<u>Semi-structured interviews</u>
This approach allows the evaluator to 'guide the discussion by asking specific questions' (Rubin and Rubin, 1995) and thereby focus on relevant areas. The interview schedules used for staff and clients are shown in Appendix One.

<u>Participant Observation</u>
This approach allows the evaluator to 'make regular observations, listen to and engage in conversations, develop an understanding of the culture of the organisation' (Bryman, 2001).

1.3 Evaluation Timetable

This study consisted of 4 phases:

- Scoping Phase
- Fieldwork Phase
- Data Analysis
- Report Writing

Phase 1 - Scoping Phase

- Briefing with Project Director – objectives and expectations, identify data sources, identify linkages, agree roles, agree support and resources
- Identification of key stakeholders and individuals
- Development of an understanding of the Relationship Support Programme and how it was operating – document review, project visit
- Identification of previous evaluation/research reports and examination of impact on service
- Agree with Project Director the approach and methodology, including discussion of how this evaluation could inform service provision.

Phase 2 – Fieldwork

This phase covered:

- A limited number of semi-structured interviews with a sample of project clients, key workers, programme managers and user representatives.
- Participant Observation with key workers and clients during group work

Interviews were tape recorded for background detail, with the permission of the participants. All interviews were confidential and responses used in the report have been anonymised. All participants signed a consent form before interviews were carried out.

Phase 3 - Data Analysis

Agency data (client questionnaires) was analysed with a suitable spreadsheet (SPSS) and qualitative data was analysed by identifying recurrent themes in the data and exploring these.

Phase 4 - Report Writing

This report is the final output of the evaluation.

1.4 Findings

- The programme has provided good health, social and economic outcomes with excellent results in improving self-confidence, improved family and personal relationships and entry into education.
- Data analysis found there were fewer arguments, less use of drugs, significant reductions in self harm and feeling suicidal, less verbal violence and less verbal abuse and violence by partners, post programme.
- Women in relationships were feeling less supported, less respected and less able to trust their partners after the programme, which implies the examination of these relationships during the programme had a challenging impact and made women less dependent upon a single partnership for defining their self esteem.
- Staff have the background, training and experience appropriate to deliver a Structured Day Care programme.
- Staff have opportunities to develop skills further with training and take up these opportunities.
- There are two User Representatives on the Board of Trustees who are elected to office and who hold user forums regularly. This demonstrates good user involvement in the organisation.
- The crèche provided by the Brighton Oasis Project works very well and is appreciated by clients and their children. It has proved to be a key factor in reducing barriers to women using the service.
- There is interest from both clients and staff in setting up a peer education programme, which will help to change the misconceptions women may have of the service.
- Staff appreciate that it is difficult for clients to disengage from the service and that dependency issues have to be worked on. Clients who have disengaged from the service found the structure worked well for them.
- Monitoring has been difficult towards the end of the programme due to clients' variable attendance at final key work sessions. The forms used are being revised and a more validated form will be used.
- Clients are both self -referring and being referred into the programme and this is working well.
- There are clear opportunities for clients who leave the project prematurely, because of their level of motivation and/or external factors, to approach the project for help at a later date.
- Outreach work with pregnant drug-using women needs some improvement
- The process of getting Information to, and referrals from, GPs needs improvement.
- The group work and key work session are well balanced and working well for the clients.

1.5 Report Structure

Section two examines the policy contexts of women drug users, relationship work, Structured Day Care (SDC) programmes, barriers to programme/service access, and examines how to measure service outcomes.

Section three outlines the findings and discusses findings.

Section four presents a summary and conclusions.

Section five contains the appendices

INTRODUCTION

2.1 Policy Context

Women Drug-users
There are approximately 280,000 'problematic' drug users in England and Wales (Audit Commission, 2004). Self assessments by Drug Action Team's (DAT) looking at progress in meeting the needs of vulnerable groups shows that further work is needed when working with women drug users (Audit Commission January 2004). Models of Care (2002) reports a ratio of 3:1 male: female in the take up of drug services.

The Motivation to Change
Motivation to change is a key issue to consider in drug treatment programmes (Beck et al., 1993). Beck et al. (1993) present the five stages of change identified by Prochaska et al. (1992) as being: precontemplation, contemplation, preparation, action, and maintenance. The action stage is where a definite decision has been taken to seek out ways of changing behaviour and where a commitment to a programme would be most likely to be given. It is during this stage that the most support is required, as it is the time when participants feel at their most vulnerable. One method of support is a Structured Day Care programme.

Structured Day Care programmes
The recommended treatment provision for an effective women-specific service should include:

- Day-care, childcare, play therapy
- Appropriate staffing
- Access to education and training
- Group/therapy counselling
- Women counsellors
- Extended treatment

Group work or therapy is a tool used in cognitive therapy.

Cognitive Therapy
Beck et al. (1993) describe the benefits of cognitive therapy in two ways: firstly, it helps the participant to identify what lies at the heart of their beliefs about their drug-taking and secondly, it exposes the participants to ways of managing their 'triggers' or pathways to drug-taking. In this way, participants can identify and reject the triggers, which may then be controlled. In other words, the old coping strategies of the drug-user are replaced with new strategies, using new skills that can also improve assertiveness in other areas of their lives.

Barriers to taking up service

In one study (Packer and Bottomley, 1996), it was reported that addicts often saw treatment as a remote or irrelevant possibility. Hser et al (2003) and Swift and Copeland (1996) found that 'stigma' was a barrier to entering treatment, along with other symptoms affecting mental health, e.g. depression and lower self-esteem. Tuten and Jones (2003) and Riehman et al (2003) found that the views of a sexual partner can influence a woman's decisions to enter a programme and that the potential loss of, or other impact on, that relationship may be the most important barrier. They suggest that this is the reason why an examination of drug use must take place in the context of that relationship. This may be because many women are introduced to drug taking by their partners and these partners, if not in treatment themselves, may oppose the attempts by the women to recover.

Women drug-users report that low self-esteem is a big issue (Opinion Leader Research, 2003). These ideas echo the *co-dependency* literature, where drug users in relationships can become trapped in unhealthy behaviour where drug taking is used to maintain a status quo (Beatty, 1989). Some studies have argued that co-dependency has gender implications (Lyon and Greenberg, 1991) and it has been variously defined as an emotional condition; a personal control issue; learned behaviour; suffering while enabling others; an addictive disease and a preoccupation with the needs of others (Harkness et al., 2001).

Rotherham DAT recently (February 2004) conducted some research into the needs of women drug-users. They found there were two key barriers to taking up treatment, child protection fears and shame. The fear of childcare proceedings is also identified by Models of Care (2002), as is the lack of trust in confidentiality.

Childcare is a barrier that has been identified by Models of Care (2002). Swift and Copeland (1996) identified childcare as a barrier to more than half the respondents in their study. They also found that the views of other users about an agency were key to choosing to approach a service for help.

A recent needs assessment study undertaken for the Home Office (Opinion Leader Research, 2003) looked at the information needs of women drug-users. They found that word-of-mouth (peer-to-peer) and outreach, were the most credible information sources in bringing women to services. Respondents in the study asked to see more ex-users involved in information provision. Models of Care (2002) reports that peer outreach is rare in the UK but that there is evidence that peer outreach workers better contact misusers in 'hard to reach' populations.

Swift and Copeland (1996) also found that the physical environment of a service had an impact on successful progression through treatment. Those who attend women only services felt that there was a better understanding of their needs and that the physical environment was safer.

Family Relationships
Recent research (Barnard, April 2005) looking at how drug use affects relationships, examined the impact of drugs on the family and found that 'significant family conflict' was evident where the drug-user was still at home. The family dynamics and relationships between all members of the family were affected and skewed so that siblings were given less time and attention.

Relapse Prevention
Studies reveal (Beck et al., 1993) that a large number of people treated for substance misuse are likely to relapse within a short time of completing treatment. It was also found that if clients are trained to plan the management of their relapse, and to seek help when they do relapse, the harm caused can be minimised and the risk of a negative spiral of decline reduced.

Service Outcomes
Models of Care (2002), defines monitoring as a process of checking progress against a plan. Outcome monitoring examines the effects of processes or measurable changes attributable to the intervention. These types of measures are critical when examining the ability of the programme to meet the goals.

The outcomes of treatment services, as defined by the Task Force Review of Services for Drug Misusers (1996) found in Models of Care and referred to as 'true' outcomes, include the following, which were useful in structuring some of the thematic analysis for this evaluation:

Drug use:
- Abstinence from drugs
- Near abstinence

Physical and psychological health:
- Improvement in physical health
- Improvement in psychological health

Social functioning and life context:
- Reduction in criminal activity
- Improvement in employment status
- Improved family relationships
- Improved personal relationships

These outcomes fall broadly into three categories, Health, Social and Economic.

Relationship Support
As recently as 1997, a survey found that only 8% of couples experiencing problems in their relationship sought support or advice (Simons, 1999). Simons (1999) suggests that there should be multi-agency awareness of available support and greater encouragement to use support should be given.

In light of evidence such as this, Moving Forward Together (2002), a government strategy for marriage and relationships, aims to enable adults and children to have access to information, advice and help when needed and to make available effective and appropriate support associated with relationship difficulties. The strategy outlines a key role for the voluntary sector in service delivery. The strategy emphasises the importance of marriage and relationship support in a healthy society and highlights how addiction, substance misuse and imprisonment can challenge relationships. It recognises different forms of support as important, including counselling, but reports that issues such as accessibility and stigma are barriers to those who may need support. The strategy's outcomes include two that relate well to the aims of the Brighton Oasis Project's Relationship Support Programme (RSP):

- An improvement in the quality of relationships and relationship skills
- A reduction in acrimony, blame and distress in relationships

In a recent study for the Home Office (Borrill 2003) of women in prison, the majority of women drug users were living with a partner (with or without children) in the year leading up to their sentence. These women reported that their partners also had drug problems, with this being more frequent in white women (50% compared with 22% of black/mixed race women). Family members and other friends were also identified as having drug or alcohol related problems in the majority of cases with many women reporting high levels of violence in the family.

Seventy per cent of the women in the Home Office study had children, with 46% having one or two children. Violence in their relationships, as well as behaviour with drug-using partners committing offences to maintain drug use, were common experiences among the women. The Home Office report states 'women's use of drugs and alcohol and their offending was reported to be exacerbated by their relationships with partners'. The Brighton Oasis Project RSP aims to tackle some of these problems.

2.2 Background to the Organisation – Brighton Oasis Project

Brighton Oasis Project aims to improve the quality of life of women and children in Brighton and Hove and surrounding areas, who are affected by substance misuse. Its clients are women with a current or former substance misuse issue. It provides a crèche and is a women only service. It works with female sex workers, women drug users and their children, and 8-16 year old children affected by familial drug use.

The services provided by the project include:

- A Relationship Support Programme (RSP) which includes group sessions on relapse prevention, the links between offending behaviours and the ability to create and sustain positive relationships and on positive parenting
- An open access drop in service

- An activities programme, designed to raise self-esteem including yoga, relaxation, creative writing, crafts and sport.
- An outreach programme

The project accepts women on probation orders and Drug Treatment Testing Orders (DTTOs). Appendix Two shows the full range of adult services, including activities such as yoga and acupuncture. Adult services provide a sixteen week RSP which comprises three groups; the Relationship Support Group, the Relapse Prevention Group and Mind over Mood (MOM). MOM uses cognitive behaviour therapeutic techniques.

The Brighton Oasis Project was used as a case study for a study of drugs service provision for women for the Home Office by Becker and Duffy (May 2002). This report highlighted the fact that the Brighton Oasis Project was the only example of a women-only community-based organisation in the country and that its service had been developed in response to client's needs.

This evaluation focussed on the Relationship Support Programme (RSP) funded by the Department for Education and Skills (DfES).

2.3 The Relationship Support Programme

The main aim of the programme, as stated in the funding bid to DfES, was to make relationship support more accessible to women drug users, who otherwise would not seek help through agencies such as Relate, due to the stigma attached to drug-use.

The programme aims and outcomes are:

- To raise women's self-esteem so that they believe they can have successful and healthy relationships
- To help women drug users establish, maintain and develop successful, positive and healthy relationships with current and future partners
- To enable women to identify relationships patterns, and how these contribute to drug-use, dependency and relapse
- To assist in developing relationship strategies which are healthy and life-affirming

This is achieved through the Structured Day Care (SDC) programme focusing on relationships, support groups, key-work sessions and an activities programme.

These aims were summarised by the staff during the evaluation as: looking at women's abilities to identify problems and supportive roles in relationships; building up their confidence in addressing and dealing with difficult relationships and also helping them to identify co-dependent relationships and work through changing these relationships.

> *It looks at all of that; are the women identifying that they're in a relationship that's supportive, that they feel secure, they feel happy,*

they feel respected - that in turn builds up their self confidence and self worth

It's actually a vital part within the drug using treatment programmes, and I think more services should look at how relationships can impact on drug use and not just on drug use, on self-worth, self-confidence, all of that.

The Relationship Support Programme (RSP) has been in operation since May 2003 and is funded by the DfES. The programme is a core part of the SDC programme and is staffed by a Programme Manager and three Project Workers. The RSP was developed to run over a sixteen-week period combining eight weeks of Relationship Support followed by eight weeks of Relapse Prevention. Due to the difficult nature of the issues being raised during the programme, it was decided to modify the programme and run a full sixteen-week RSP alongside a sixteen-week Relapse Prevention programme. Women were offered one-to-one key work to complement the group work. Modules were created so that some overlap between the two programmes could exist.

All the women in the RSP were offered a full assessment where their relationship history would be discussed.

Clients can join the RSP whenever they like as it is a rolling programme; this means clients who access the programme through drop-in can get a place straight away rather than wait for the next start date.

In the year April 2003 to March 2004, the following figures were provided looking at numbers of women accessing the programme:

Relationship support key work	32
Relationship support 8 week group	23

In the year April 2004 to March 2005, the following figures were provided:

Relationship support key work	51
Number of whom also attended Relationship group work	28

The majority of the women were White British with five women from Black and Minority Ethnic (BME) communities.

The total number of women involved in the programme over the two years from April 2003 to March 2005 was:

Relationship support key work	83
Number of whom also attended Relationship group work	51

Over the life of the programme, eleven women (or 13%) from BME communities were worked with and one bisexual woman was involved, the rest being heterosexual.

There are 20 places currently available, 5 reserved for DTTOs. The remaining 15 places are split between self-referrals and referrals from other services.

3. FINDINGS AND DISCUSSION

3.1 Programme Management

Staff Interviews
The staff interviewed for the evaluation comprised one Project Worker and the Programme Manager. An additional Project Worker had been recruited and would start after the evaluation timetable. The Project Worker was a qualified mental health nurse and the Manager had been working with homeless people with substance misuse problems. Their background, training and experience clearly represent what Models of Care (2002) suggest should be found in those who staff SDC programmes.

Staff Training
Staff felt training opportunities were well structured and appropriate for their needs. The Project Worker was planning to take a Diploma in Substance Misuse or a Masters Degree, and had taken a course on facilitating group work. The Programme Manager was trained in counselling and had almost completed an MSc in Addiction Behaviour. Future training may focus around staff management issues.

Clients felt that the staff were well trained but one cautioned that more experienced staff should be matched with clients with long-term use or those who had been introduced to using by their parents:

> *Some of these girls have been using for a long time, they're only young, but they've been exposed to it since they were 14, they need someone who knows what they're talking about, not someone who's just come out of college or is just starting out.*

User Involvement
The organisation has two user representatives on the Board of Trustees to represent the views of the women and to voice issues raised by them. There are user forums every six weeks and the representative is elected for a term of six months.

Two clients have become involved in the organisation as volunteers, cooking lunches for their peers:

> *I've interviewed people for new staff posts. I've done cooking. It did me a lot of good.*

Barriers to Accessing the Programme
One of the key barriers for women accessing services is a lack of childcare. Brighton Oasis Project runs a crèche on the premises and this is a key factor in enabling women to access the programmes they run, including the Relationship Support Programme. In addition to facilitating access, the clients also identified benefits for their children:

> *My child gets to play in the crèche, which is brilliant for her so when she goes to nursery, she's gonna be one step ahead and*

it's a really good crèche. The only day I don't come in is Tuesday because there's no crèche.

My child goes to nursery three times a week which enables me to go to meetings. He's benefited from it so much because he was a bit violent sometimes. They've noticed a change in the last few months.

One client expressed a view similar to those found in other studies, referred to earlier in this report. Her perception of the service before attending, and the impact it would have on her, were negative, she belived that everyone '*had to be clean'* and not using. Two clients expressed interest in being involved in peer education.

I didn't want to come to somewhere like this because I thought they were gonna be straight on the phone to social services saying 'this girl's a drug user, she's got children'. I thought that's what it would be like, that's what's kept me away from a lot of things like this. They need to get that message across that its not like that, they're not gonna look at you as a dirty drug user… cos they think you're a bad parent, its not like that. People are frightened I think. I thought, I can't join that, they're not gonna want me coming here. It's getting that across to other people. Maybe there's a way of us getting it across, I don't know.

Staff are aware of these perceptions and are working on ways to change this:

The slow way is people coming here can pass on that we don't automatically contact social services or whatever preconceptions people have. I think that is the most powerful way. Peers tell each other what we can offer. I overheard someone at the Substance Misuse Service telling a woman 'oh you don't want to go there, they sit in a circle and hold hands'. It's getting over what we actually offer here.

Dependency Issues

Once clients have completed eight weeks of the RSP and eight weeks of Relapse Prevention they do not receive key-work but there is After Care where they can come in once a week for an hour, this includes a weekly group as well as activities, lunch, acupuncture and check in. Some clients then stay on as volunteers and all can still access the activities on offer such as yoga, kickboxing, and acupuncture. There is a realisation by staff that dependency can be an issue but they try to discourage this, emphasising future choices and unearthing interest's clients wish to pursue. On the other hand, there are some clients who simply make the break.

They become very dependent. We offer them a lot of self-confidence. They come to a safe place where they feel good about themselves.

In the client interviews, there was evidence that this approach had worked, with two women saying this meant they felt they were not 'out on a limb'. Those still in the programme expressed doubt at their ability to withdraw:

> *I've moved away (from the project) which is great cos I never thought I would. I'm not so dependent on them. This was like my lifeline so I'd come in every day, I did every group going here and cos of the crèche I could bring my child in, even if I just came in and talked to people. It broke my day up.*
> *Quite a lot of people do become dependent on here and when its shut, its like, oh what can we do, we need support.*
>
> *I felt like that, really dependent and 'oh no, what am I gonna do?' but I then I made new friends outside, and eventually, week by week, I could say I don't need to come in, but it's a good safe environment to come, even if its just to come in for a chat.*
>
> *The court order said I had to come onto the programme but I'm lost without this place – I come every day. Weekends I'm lost, I don't know what to do with myself, I'm bored.*

Staff felt they were working well with other agencies and were able to refer clients onto counselling or other services after they had completed the RSP and RPP.

> *What you try and do is identify things early on, as they've got some structure here and then hopefully they transition when they leave here into counselling. We're all talking to each other so that the care ideally is continuous and we all know what's going on and the client can choose the services that they feel they need. We're sharing care plans, but it's all very new.*

3.2 Monitoring within the Programme

A data-monitoring tool was developed to assist with evaluation. There are three forms used by the key-workers to monitor progress with the women.

The first form is a ***Group Session Sheet***. This form records the date and attendance at a group meeting; a brief description of the group e.g.

> *Group discussion focussing on how past relationships have impacted on drug use*

The key-worker records their own observations of participants in the group and this is filed.

The second form is an ***Evaluation Sheet.*** This form records the name, date and facilitator of the group; it is used during the 'check-in' and 'check-out' parts of the group sessions to record the participants' self-reported mood in the group at the start and end of the group.

In the observation, if an issue arose with a women during check-in that required exploration, this was noted and set aside to talk about outside of the group in a key-work session.

The third form is a ***Baseline Assessment***. This form was being used both by those women in relationships and those not currently in relationships. It contained twenty-eight statements about how they were feeling about their relationships. The women select responses to the statements on an ordinal scale e.g.:

Table 1: Baseline Statements

	Not at all *0*	*Only occasionally* *1*	*Sometimes* *2*	*Often* *3*	*Most or all the time* *4*
I have felt supported					

This form was then filled in again at the end of the programme and any changes in response are identified.

For the purposes of the evaluation a batch of forms were analysed. As there were 20 women still in the programme these numbers do not reflect the total possible number of responses, but those available during the evaluation. A total of 37 women filled in the initial form on entering the programme. There were 11 not currently in a relationship and 26 currently in a relationship. Of these, 7 women not in a relationship and 12 women in a relationship filled in a form at the end of the programme. On entering the programme, some general trends can be seen in the women's responses. An analysis of 32 pre programme forms shows that:

- More than 50% of the women felt alone or isolated in their relationship
- More than 50% of the women said they rarely spent time with friends
- More than 50% of the women said they rarely took time and space for themselves
- More than 50% of the women had used drugs as a result of an argument in the preceding month as a result of their relationship

3.2.1 Data Analysis

A more detailed analysis of 12 pairs of forms (where women in a relationship had completed both an initial form and a final form) was carried out for the evaluation. We found that at the start of the programme eight women were in a relationship, four had been in a relationship in the last twelve months and of these, two were living with their partners. At the end of the programme, three women were in a relationship, one had been in a relationship and one of these was living with their partner. This suggests the women have become more confident about standing alone and working through their issues as a result of the RSP.
An analysis of the responses pre and post programme of the 12 pairs of forms show that, on average, improvements were felt by the women in feeling tense,

anxious or nervous, feeling OK about themselves, feeling able to cope when things go wrong, spending time with friends, taking time and space for themselves, being open and honest with their partner, and feeling secure and stable. There were reductions seen in feeling supported by their partner, feeling respected, feeling they could trust their partner, feeling insecure and unstable, feeling like crying and a small difference in feeling happy. This is shown in Table 2 below.

The finding that women in relationships were feeling less supported, less respected and less able to trust their partners implies the examination of these relationships during the programme had a challenging impact and made women less dependent upon a single partnership for defining their self esteem.

Table 2: Over the last month in my relationship

	Pre Programme Average	Post Programme Average
Felt supported	2.2500	1.5000
Felt respect	2.3333	2.1667
Positive communication	2.0833	2.0000
Felt alone	1.5000	1.5000
Felt tense	2.0833	1.8333
Felt OK	1.5833	2.5833
Felt able to cope	1.8182	2.5000
Spent time with friends	1.2500	2.1667
Taken time for myself	.8182	1.8333
Felt warmth from my partner	2.5833	2.2500
Open and honest with my partner	2.0909	2.4167
Trust my partner	2.8333	1.5000
Felt secure and stable	2.3333	2.2500
Felt insecure	1.6667	1.4545
Felt happy	2.5833	2.2727
Felt like crying	2.3333	1.4545

(These scores relate to the ordinal scale in Table 1)

When looking at the results of the data, pre and post programme, relating to conflicts in the relationships over the last month, we found there were less arguments, less use of drugs, significant reductions in self harm and feeling suicidal, less verbal violence and also less verbal abuse and violence by partners. There was a very small increase in those using alcohol as the result of an argument and a very slight increase in those being physically violent to their partners. These changes look likely to relate to one woman only. This is shown in Table 3 below.

Table 3: Over the last month as a result of conflict

	Pre Programme Average	Post Programme Average
I have argued with my partner	1.4545	1.3333
I have craved drugs	1.8182	1.3333
I have used alcohol	.5000	.8333
I have used drugs	1.4545	.6667
I have thought of hurting myself	.9091	.3333
I have hurt myself	.7273	.0000
I have felt suicidal	.5455	.0833
I have been verbally violent	1.7273	1.0000
I have been physically violent	.1818	.3333
I have felt bullied	1.0909	.5000
My partner has been violent	.5455	.3333
My partner has been verbally abusive	.6364	.5000

(These scores relate to the ordinal scale in Table 1)

The data can be broken down into two simple groupings of positive and negative behaviours. This is shown in Tables 4 and 5 below.

Table 4: Positive Attributes

	Pre Programme Average	Post Programme Average
I felt supported	2.2500	1.5000
I felt respect	2.3333	2.1667
I had positive communication	2.0833	2.0000
I felt OK	1.5833	2.5833
I felt able to cope	1.8182	2.5000
I felt warmth	2.5833	2.2500
I have been open and honest	2.0909	2.4167
I felt able to trust	2.8333	1.5000

(These scores relate to the ordinal scale in Table 1)

Table 5: Negative Behaviours

	Pre Programme Average	Post Programme Average
I felt like crying	2.3333	1.4545
I have argued	1.4545	1.3333
I have craved drugs	1.8182	1.3333
I have used alcohol	.5000	.8333
I have used drugs	1.4545	.6667
I have thought of hurting myself	.9091	.3333
I have hurt myself	.7273	.0000
I have felt suicidal	.5455	.0833
I have been verbally violent	1.7273	1.0000
I have been physically violent	.1818	.3333
I have felt bullied	1.0909	.5000
My partner has been physically violent	.5455	.3333
My partner has been verbally abusive	.6364	.5000

(These scores relate to the ordinal scale in Table 1)

3.2.2 Improvements in Data Collection

In interviews with staff these forms were discussed and they identified there had been some difficulty in using the forms with women not in relationships so some of the statements were adjusted to focus more on the future and how they feel in themselves. The end of programme evaluation process was being reviewed during the evaluation period with a view to using a more 'validated' form, e.g. the Christo Inventory system.

In the year April 2003 to March 2004, twenty-three women filled in the initial questionnaire at the start of the programme but only eleven filled it in at the end of the programme. This was discussed with staff, as there were issues around using the final key-work session for evaluation:

> *We want them to complete all their key-work sessions and not to take them up with evaluation so we ask them to come back on another date. It's not attractive and they know exactly what we're getting them in for, we are trying to look at this.*
>
> *Its harder because people tend not to turn up for the last key-work – especially if they've been through before and they know*

that all we're gonna be doing is saying goodbye and filling out forms.

One solution discussed was to try to complete the end baseline in the second to last key work session.

3.3 Programme operation and achievements

Clients interviewed
The four women interviewed were at different stages of involvement with the programme. One was at the beginning of the programme, one two weeks from the end and had been involved with the organisation for four months. Two women had completed the programme a year ago and were involved as volunteers in the organisation; one was also the elected service user representative on the Board. The women were all aged in their twenties and all had children, although one woman's child was living with a relative in another city.

One woman came from a family with several members suffering from depression. Three of the women had come from families where other members were taking drugs. One of these had parents who were both heroin users.

I've got a younger sister, she's in prison, she's an addict as well. She's clean in there but you know it's in us, my dad's an alcoholic.

Getting into the programme
Staff identified different routes for women entering the programme. Most were thought to have come via referral from the Substance Misuse Service (SMS) where they were being prescribed methadone, some had been in to talk before by themselves through the drop-in access, some came via outreach work at the ante-natal clinic for women drug users and a small number of clients came via a DTTO.

One client said she got involved through an outreach worker and started attending counselling sessions when pregnant:

She suggested I come here, cos I used to come in for chats with her and she said well, maybe see a counsellor and that wasn't too bad.

However, it wasn't until this client's child was two and a half years old and her relationship had broken down that she felt she needed help. It was suggested she start on the programme and she was assessed.

I used every facility going really and well, about a year and a half ago I started trying to take it seriously cos I didn't at first. I realised there's a lot more here that I could benefit from.

Another woman got involved when she was pregnant on the advice of her GP:

They got a midwife to come here and talk to me. It took me a while to get involved, I did the activities but had no key-work then they asked me if needed it and I did the Relationship Support Programme.

One woman got involved as a result of a DTTO and had been to prison in the past.

One woman heard about the programme from a client at the SMS. She had felt she needed support but did not find this on offer elsewhere.

I'd seen the leaflets on the wall at the SMS but a girl I knew, we got chatting and she said she was coming here. I thought I'd pop in. I plucked up the courage to come in on my own, which is very unusual and I spoke to one of the workers and now here I am. I knocked on the door – I was right nervous at first, but they made me welcome. I wanted to talk to someone and I felt really alone. I seemed to be the only person up there (at the SMS) with a child…I wasn't, but I felt that way.

Outreach

The Programme Manager identified outreach work in two ways; there is an Outreach Worker in post who works with women who are more 'chaotic' and who find group-work difficult and there are events, such as conferences, workshops etc., where staff can distribute information packs about the services on offer. If there was funding available, more work could be carried out on issues such as family working in the home and child protection.

I'd like to see some kind of service that could provide for women with children in care to slowly get the family unit back together

Staff explained that they were disappointed about the extent to which they were reaching drug-using pregnant women and identified this as an area to work on.

Another area needing improvement was the referral process from GPs:

Referral from GP surgeries is basically poor as of now, we hope that by doing more information work, it will help GPs refer because they're the only section of any public sector agency that doesn't.

Group work and Key work sessions

Working on self-esteem is a core principle of the group work sessions. In the observation of group work, the women sat around a large table and were relaxed, drinking coffee and tea. They listened to each other and were supportive of each other making positive verbal statements to other members of the group. The group observed was well facilitated with one quieter participant being drawn into the discussion by the worker. If a woman made a

statement about herself that was negative, the group facilitator would comment, for example:

> Participant
> *I'm feeling ill so I have cravings. I'm not feeling strong enough.*
>
> Worker
> *But you are strong, as you've given up. Use your new skills to help you.*

and

> Participant
> *I used to wake up feeling, oh no – what did I do? Now I feel, well, I didn't lie to my family, I didn't shoplift*
>
> Worker
> *What you've done is really quite amazing isn't it?*
>
> Participant
> *Yes, I guess. I've got through some difficult things - I've asked for help, I've got support.*

In the interviews, clients made positive statements about the work done in the groups. In one session participants drew lifelines that examined how past relationships had impacted on their drug use. For some this was a key point in the process where they identified 'triggers' for use and how a pattern had developed through their relationships. Generally the groups were described as trusting places where good relationships were built. Some women found it hard to talk in the group initially, but developed their confidence in speaking about themselves through this process. The key-work 1:1 sessions, where very personal issues are discussed in depth, were, for some, quite difficult to adjust to but they were seen as trusting, safe places to talk.

> *After the first group, it made such an impact. I was in a relationship with someone…he was a trigger for me.*
>
> *I wasn't good at speaking out in the group and speaking about my feelings. It was quite emotional. It was raw stuff. In the group, we became quite close because we were sharing difficult things. The 1:1s were a lot more personal and I talked about how I craved, how I used. It was always useful. Quite a few times I didn't come to key-work as it was quite difficult. We talked about why I did it and got to the root of it.*
>
> *The 1:1 gave me space, trust, it made me feel safe. The group is all about working through issues together.*
>
> *At first it's quite hard to talk about things 1:1, I've never done it before. I still feel uncomfortable but that's nothing to do with the actual session, that's me starting to open up and talk about things. I can't believe I'm actually doing it!*

Staff reported that a recent increase to four groups a week had made an improvement in the programme as staff were able to see more of the clients. Staff raised the possibility of increasing key-work sessions from one to two hours, but this would be dependent on time, space and staffing.

> *An hour is long enough but there's so much more that can come out. It'd be good for the clients to be given the opportunity to have 2 hours a week.*

Relationships with Key Workers
The relationships built up between the women and the key workers were generally perceived very positively:

> *I've come to trust her now and I've started to open up to her. Here they know you as a person.*

> *I've never had anyone to open up and talk to before so it took me a few weeks to start trusting her I suppose, actually opening up, and now when I come in I actually look forward to coming in and doing it. It's quite upsetting cos its bringing up things I've never wanted to deal with, but its very good. We do it at my pace, she goes with me and how I feel on the day.*

If, however, a client felt that they were not working well with the key worker, they were aware they could request a change. By the same token, if a key worker felt they were not achieving what they should with a client, they could ask the client if they wished to change. This demonstrated to the client that they were aware of problems but it was rare for a change to be requested.

One client had requested a change as she felt she needed more direction from the key-worker:

> *The first key-work session wasn't working out and an incident happened with me and someone else and another worker took over. I used to come in and talk to the key-worker and she'd just say 'yeah' and it was no use to me, whereas the second key-worker I had, sat me down and said, right, I'm gonna take over now and it was after that I started taking it all in.*

Relationship Outcomes
The four women interviewed demonstrated in their experiences the links between drug use and relationships.

One started using when her relationship broke down. Both the woman and her partner were heavy drug users.

> *We had a very violent relationship, there was a lot of police involved and it was since I made that break I needed to get my drug problem sorted out for the sake of my son*

One started using drugs when she was 16 years old. She had a baby when she was 15 years old and the child was sent to live with an aunt. She started using drugs when she lost her son '*to deal with the pain'*. The father of the child was selling drugs and went to prison. It was him that led her into using drugs.

> *I went to Prison and after I came out I carried on using again, then I was prostituting myself as a choice. I got 9 months DTTO.*

On entering the RSP she was still in a relationship with this man but after recognising that he was always in the background of her offending, and after discussing this with her key-worker, she ended the relationship:

> *We decided it wasn't healthy and that I needed a year to be by myself, to work out who I am, what I want. I loved him, but have moved.*

Another woman started using drugs because of a partner. Initially, she was unaware of his drug use and then one night he told her what he was doing and she asked to try something.

> *I started phoning him up every other day saying 'did you get something' and 'I'll come round' and it went on for a few months, then I'd go without. I was in a right mess. He did try and warn me but not strongly enough obviously.*

With four children, one of which was fathered by the man who introduced her to drugs, she lost her house, moved back to her mother's house and 'got clean'. She then met another man who she had a relationship with. This relationship caused a relapse and she began using heroin again.

> *Just looking at past relationships, they've always been for drugs, ways of supporting my drug habit and I never really looked at that before. I always thought I loved them, but it wasn't, it was more for what I was getting out of them I suppose. I can see I've used them to my advantage now. I couldn't at the time. In the future, if I do meet somebody, I can actually know that I am with them because I want to be, not because of past reasons.*

In the end of programme forms 75% of women reported that they had not felt bullied by their partners at all. Also, 91% of women reported that their partners had not been violent at all towards them. Finally, 75% of women felt their partners had not been verbally abusive at all towards them. This indicates a positive impact on their partners as a result of the programme.

Control issues in relationships

During the observation of group work, one woman discussed a recent problem where she had met a man at college, but he began causing problems and came to her flat. She was able to ask him to leave. She said:

I was with someone for the first time after a year and a half and I was clean, but it didn't mean anything to him. When that man used me, I felt like using. I upped my methadone to cope.

A second woman in the group discussed a problem where her partner, who was trying to stay clean but not attending a group regularly, had been trying to control her money and thought this was 'helping' her. The group discussed the differences between control and support and the woman was rehearsed through the difficult conversation she would have with her partner to break free of old 'coping mechanisms'.

Another woman discussed her relationship with her son's partner who had relapsed and how his blaming her, 'if it weren't for you, I'd be clean', was unhelpful behaviour to her.

Helpful is being supportive. Support me but don't criticise me. Praise me for changes I've made, look at the good things I've done, instead of criticising me.

Self-Confidence

This was an area where clients clearly identified positive changes in themselves. This self-confidence also enabled a clear look at what kind of relationships they wanted in future both personal and familial. Clients felt they were gaining new skills, becoming stronger, more confident, more assertive and more able to communicate what they wanted. They also expressed a growing sense of worth and of liking themselves.

We were looking at stuff and every relationship I'd had since I was younger was so unhealthy, disruptive. I think until you've learnt to like yourself, how can you give it to someone else.

Whenever I used to take drugs I was never happy because I felt guilty after. I've learnt I don't have to lie and put up a mask anymore, it's all right to be me. That was what was taught me here, it's all right to be yourself and be honest about your feelings. I used to do a lot of people pleasing and do everything for everyone, and now I can learn to say no to things and be quite assertive.

I could not look at myself in the mirror and like myself when I came here. I hated myself. On a daily basis now I can talk to myself. It was from here that I could learn about myself.

I've got an input here, I express my opinion and things like that and I've never done that before. People can see the difference in me, myself, and I can see it myself.

Improved Family Relationships
This was another area where clients identified significant change as a result of the programme. Some were talking to close relatives for the first time in years and others had resolved differences with their children's fathers.

> *I've got my family back in my life, my mum and sister, cos they didn't talk to me for a while. I was going off the rails and we have a really good relationship now. We talk honestly and openly about our past issues and we show affection to each other, which is something that we never did.*

> *My elder sister, who was ashamed of me for years, wouldn't talk to me, is now in my life and we speak three times a day. She's fantastic. She was my support when I was doing a lot of work here. She used to say to me, you're doing really well, because they could see results. They told me that they could see I calmed down a lot, started becoming honest, less manic, I started taking an interest in their lives as well, cos it was always about me, me, me, me. I actually ask how my sister is doing now and talk about her.*

> *I've got a fantastic relationship with my parents, they've been really supportive and I've also seen it from their point of view, the drug addiction, they've had to deal with it as well. I always thought it was just me going through it, but they went through quite a bit as well.*

> *My mum didn't think I'd keep it up, coming down here. She thought, what do you want to go down hanging around with people that are all of their head. Now, she sees the progress I'm making myself and she thinks I look much happier in myself, she thinks I look more confident, not always looking down at the floor.*

Improved Personal Relationships
A number of clients had ended their relationships while in the programme but felt this was beneficial as their partners were influencing and, in some cases, facilitating their drug use. Clients who had been through the RSP and RPP and After Care reported developing friendships outside the organisation through involvement in their children's education and through new experiences like attending church.

> *I've got friends from church, cos I go to church now as well. I started going last summer because of my child and I've got some really brilliant friends there now. I've got two really good friends from there and another I met at the park and I've known them about a year. Two of them know I'm in recovery, the other doesn't know anything about me, just knows me as a mum and I can be myself. It's been a bridge to normal living.*

When I started on the relationship programme I was in a relationship – he's my ex now. He was always in the background of my offending. We decided that I needed to break up with him. We decided that it wasn't healthy.

My partner noticed a change and he liked the changes. He was always telling me to carry on.

I was quite low, feeling really down, really alone. Since I've been coming here, I've actually made a few friends. I haven't had that for a long time.

Health Outcomes

Drug Use

One of the women interviewed, who had completed the programme, had been drug free for over twelve months. All of the women said they felt healthier and had a sense of living in a new way. Some women had also given up alcohol and smoking.

I'm drug free and alcohol free and have been for a while

I'd been taking drugs for about 10 years. I did attend the SMS about a year ago and they didn't have anything like this and I relapsed. I stayed clean for seven months and I relapsed again. This time I'm still using very small amounts every now and again but I was using about £20 every single day. I'm getting there.

I've got a lot more positive about things.

Since I've been coming here doing the yoga and the kickboxing, my asthma is a lot better for starters, my back's a lot better so my health's a lot better.

One staff member reported that the aim for reduction in drug use had to be balanced with other needs, for example:

Sometimes changes are very subtle. One client I work with, her drug use has not changed at all but her self-confidence has definitely increased. Her initial lack of self-esteem and self-worth seemed much more dangerous for her so I can see a lot of changes, but not in her drug use as yet – that may come.

There were clients for whom these issues overlapped with relationships within their families. This was demonstrated by one client whose parents were both drug users. The woman had been able to reduce her drug taking but had come to realise her parents' house was not 'a safe place' and had used her new skills to protect herself:

I'm able to say no now – if my mum phones up and said 'I've got a bag here, why don't you come round', before I would - now I say no. It's hard because it makes me feel bad because it's my mum but I can communicate now that I don't want that.

Social Outcomes

Offending Behaviour

The majority of clients interviewed for the evaluation admitted some form of criminal activity to fund their habit. In this small study, unlike those of Packer and Bottomley (1996), the majority were not involved in 'acquisitive' crime, for example shoplifting, but had become sex workers. For these women, the ability to create 'normal' relationships is a key issue to work on in the RSP.

I was a working girl for 10 years. I just wanted money but drugs went with it as well. I was earning a lot of money and I had a good lifestyle but…it wasn't glamorous any more because I did get heavily into drugs, a violent relationship and I was just never happy.

I went to Prison and after I came out I carried on using again, then I was prostituting myself as a choice, I didn't want to go shoplifting. Shoplifting is just one way to earn money to buy drugs, I know other people sell their bodies, use and steal credit cards, I chose prostitution. I did a street robbery – nicked a phone off a girl – and got arrested.

Entry into Education/training

Three of the women interviewed had taken up opportunities to attend courses. Clients praised the trainer from the College and expressed an interest in taking up further opportunities.

I did the college courses on offer here, Effective Communication, Time Management. I've got to stay drug free for two years and I'm hoping to do a bit of voluntary work somewhere else.

I'm going to college in September to do a Basic Skills course. I'm studying literacy from February to September. I was expelled from school at 13, so I can't do much.

In September, I'm hoping to start doing numeracy, reading and writing course at college. I walked away from school with no education at all, as I fell pregnant at 16.

The staff also felt that the courses, provided by City College Brighton and Hove, had worked well, the Basic Skills course, in particular, being well designed; taking into account abilities and self confidence issues. There can be an objective to get into training or employment in a care plan but this varies depending on the client.

One person I key work has been drug free for five months and she's going to college with a view to doing an access course, thinking about employment.

Economic Outcomes

Entry into Employment

Staff explained that the intention is to discuss during After Care what women might want to move onto, whether education, volunteer work or employment. One of the clients expressed her hopes as follows:

I haven't got much to offer except for life experiences. I'm doing a few courses, get myself something that I can put on a CV. I will look at getting into work once I'm ready. I don't want to take on too much too soon.

Retention in the Programme

In the staff interviews, the process was discussed whereby drop-outs could be discharged. If a client missed three key work sessions in a row, they were discharged. After one session was missed they were contacted. If they had not made contact after three times then after each missed appointment they were sent a letter, then discharged.

What you usually find is that the drop out is in the first couple of weeks – if they're going to drop out, that's when they will.

The final letter stated that the understanding of the project was that the client was not ready at that time, but urged them to make contact in the future. Some clients had been known to make several attempts before completing the programme.

You try and get them back into key-work to talk, but by then they've usually made a decision whether they're coming back or not.

In the client interviews, some women felt it was due to this being the first time someone might have to discuss these issues. The 'strangeness' of the experience meant some people could not deal with the programme.

It's talking about things that you don't really want to deal with and some people think, I can't deal with that and they leave, but the majority of them come back.

If a woman returns and attempts the programme again, they are reassessed and asked about the reasons for previous drop-out. As described earlier in this report, motivation for change is a key issue for consideration:

If nothing had changed, I might question motivations for coming this time. Some clients come in and want to make changes but realise they are not ready, you've just got to leave the door open for them to come back when they are.

The beauty of it is they know we're always here so they do come back and because of the open access sessions four times a week, they can just come in, so they do come back.

Moving on

Some of the women interviewed had moved on from the RSP to the Relapse Prevention Programme (RPP). Those who completed both programmes then received After Care. More recently the Structured Day Care programme had been expanded to include a complementary group called Mind over Mood. The RSP and RPP were linked so that what had been learnt in the first programme led naturally onto the ideas presented in the second.

I'm three weeks into the RPP now. It's taught me a few things really, like setting myself up, I've learnt a lot already. It's taught me a few ways of trying to deal with the cravings.

There's something called After Care – I said, you're not just gonna kick me out once I've finished the course! Hopefully there will be a few more groups and activities.

I'm gonna bring my son to the counsellor I was finding out about the other day, its for kids that are going through any sort of problems, they do art therapy. Hopefully he'll get involved with it now.

4. SUMMARY AND CONCLUSIONS

Summary

The Oasis Project provides a nationally unique structured day care programme for women with drug issues. There is evidence that the project improves the self-esteem and self-confidence of women. At the core of its work is the Relationship Support Programme (RSP). The RSP provides important opportunities for women to explore the basis of previous and current relationships with partners, who may be drug using themselves. With the support of the group, women can find space to question and challenge the basis of these relationships and develop a new and wider network of support.

Final Thoughts

During the interviews with staff and clients, there were many positive comments made about the programme. These are some of those comments:

> *I'm clean of drugs and alcohol and have been for a long time, which is fantastic! I've got a quality of life and clarity in my life, friends, family. I'm alive! I love it! I'm really pleased. This place has been the foundation for me really, I would never forget that because, without here, I wouldn't like to say where I would be.*
>
> *I've been doing drugs for 10 years and it's only recently that I found this. I wouldn't go anywhere that was full of people that were off their head. It's somewhere safe.*
>
> *I feel like I've built a little second home, its somewhere that I can come and actually be myself and not lie about my addiction. It still feels like stability, like I've got somewhere to go on certain days and I've got a little routine. I've actually got a little life, as what I call it now, doing something that I want to do and its really good.*
>
> *Its giving the women time to look at things, its sowing the seeds to change a pattern.*
>
> *Overall, we're getting it right, I think there's room for improvement, there's lots of things I still want to do like introducing peer education. The success rate gets better because people are being assessed and stay in the groups and a lot more people are getting involved.*
>
> *What we see is people going from just managing, to actually becoming stabilised on legal drugs. Women have become drug free, stabilising, moving into appropriate accommodation. Women going back to college, starting counselling, becoming clean. They feel respected, they start to build up their self-confidence, their self-worth, their belief in themselves.*

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GLOSSARY

BME	Black and Minority Ethnic groups
DAT	Drug Action Team
DfES	Department for Education and Skills
DTTO	Drug Treatment Testing Order
GP	General Practitioner
MOM	Mind over Mood
RPP	Relapse Prevention programme
RSP	Relationship Support programme
SDC	Structure Day Care programmes
SMS	Substance Misuse Service

APPENDIX 1
INTERVIEW SCHEDULES

OASIS CLIENT INTERVIEWS

1. Can you tell me about your background? – drug use, relationships etc

2. Tell me how you come to be involved in the organisation and the programme? – how did you hear about it?

3. What did you feel about group work? Any difficulties?

4. What did you feel about key work? Any difficulties? Describe what happens?

5. Is there a good balance between group and key work?

6. What can you tell me about your personal experience of the RSP programme – the changes/improvements in you? – changes in drug use? Changes in health etc. – what changes others have noticed? – changes in children etc.

7. Has attendance been a problem for you? - what about people dropping out?

8. What are the main barriers to the programme working effectively?

9. What can you tell me about the activities programme? Does this work?

10. What are your personal aims for the next six months?

11. Will you need further support after this programme?

12. If you could pick one accomplishment to tell me about hat would that be?

OASIS STAFF INTERVIEWS

13. Can you tell me about your role in the organisation?

14. What is your role in the relationship programmes?

15. What is your background?

16. What do you see as the main aims of the relationship support programme?

17. How does the programme operate –
    how do women become involved with it?

18. What methods are used to reach these vulnerable members of the community?

19. How well is the programme publicised with other organisations and the target group?

20. Is there a good balance between group work and key work support?

21. Do staff receive further training to support the programme?

22. How is the programme managed within the organisation?

23. What do you know about retention in the programme? How can this be improved?

24. How is the programme monitored internally?

25. What are the main barriers to the programme working effectively?

26. What are the main accomplishments of this programme?

APPENDIX 2
ADULT SERVICES PROVIDED BY BRIGHTON OASIS PROJECT

MONDAY 12/04/04		TUESDAY 13/04/04		WEDNESDAY 14/04/04		THURSDAY 15/04/04		FRIDAY 16/04/04		
STAFF MEETING/TRAINING		KEYWORK		10.30- 12.00 RELATIONSHIP SUPPORT KIM & LYNNE		10.30- 12.00 POSITIVE PARENTING DAWN	KEY WORK	10.30- 12.00 RELAPSE PREVENTION KIM & SUE		
				12.05- 12.30 LINCH				12.05- 12.30 LUNCH		
				12.35- 1.15 ACCUPUNTURE				12.35- 1.15 RELAXATION UPSTAIRS		
1.15-2.45 BREAKING THE CYCLE LYNNE	1.30- 2.30 YOGA MEET AT BOP 1.15P KIM	1.15-2.45 KEY WORK	1.15-3.15 O/A SUE	1.15-2.45 KEY WORK	1.15-3.15 O/A CORRINA	12.30- 2.30 CRAFT SARAH & LYNDSAY	KEY WORK	1.15-3.15 O/A	1.30- 2.30 KICK-BOXING MEET AT BOP SARAH	1.15-2.45 INTRODUCTION GROUP SUE
		1.15-2.15 REFLEXOLOGY	1.15-3.15 O/A KIM							