

Supporting Women Into The Mainstream

COMMISSIONING WOMEN-ONLY
COMMUNITY DAY SERVICES

DH INFORMATION READER BOX

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Document Purpose Best Practice Guidance**ROCR Ref:** **Gateway Ref:** 5357**Title** Supporting Women Into the Mainstream**Author** Karen Newbigging, HASCAS & Kathryn Abel, Centre for Women's Mental Health Research, University of Manchester**Publication Date** Spring 06**Target Audience** PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Directors of PH, PCT PEC Chairs, Communications Leads, Voluntary organisations**Circulation List** Local Authority CEs, Ds of Social Services**Description** This 'best practice guidance' is intended to support commissioners in delivering Section 6.1 of the Implementation Guidance; Mainstreaming Gender & Women's Mental Health on women-only community day services dovetailing with the recommendations set out in the Social Exclusion Report relating to day services.**Cross Ref** Implementation Guidance: Mainstreaming Gender and Women's Mental Health (DH 2003) / Mental Health and Social Exclusion: SEU Report (OPDM 2004).
DH/CSIP (2006) From segregation to inclusion.**Superseded Docs** N/A**Action Required** N/A**Timing** N/A**Contact Details** Karen Newbigging
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Contents

PAGE	
3	Foreword
4	Introduction
5	SECTION 1: WHAT ARE WOMEN-ONLY DAY SERVICES? <ul style="list-style-type: none">1.1 Definition1.2 Role of the voluntary and community sector1.3 Service specification1.4 Current context1.5 Day service options
7	SECTION 2: WOMEN'S MENTAL HEALTH: WHY SHOULD IT BE A PRIORITY? <ul style="list-style-type: none">2.1 Roots and context of women's distress2.2 Which women are at risk in your area?2.3 Expression and experience of women's distress2.4 Women sensitive provision
9	SECTION 3: WHAT DOES THE POLICY SAY ? <ul style="list-style-type: none">3.1 Tackling equalities<ul style="list-style-type: none">Delivering gender equalitySupporting women to survive and recover from violence and abuseDelivering race equalityWomen offenders in the community<ul style="list-style-type: none">Women in prison3.2 Promoting positive mental health3.3 Promoting inclusion and access to mainstream opportunities3.4 Increasing choice and control<ul style="list-style-type: none">Direct payments'Individual budgets'Meaningful choice3.5 Investment in supporting community and voluntary sector groups3.6 Developing the workforce: new workers and new styles of working
12	SECTION 4: COMMISSIONING <ul style="list-style-type: none">4.1 Commissioning process4.2 Foundations for change<ul style="list-style-type: none">LeadershipMulti-agency steering groupInvolvement of womenInvolvement of other key stakeholdersInformation
14	SECTION 5: MENTAL HEALTH NEEDS ASSESSMENT: UNDERSTANDING LOCAL NEED <ul style="list-style-type: none">5.1 Aim of a mental health needs assessment5.2 Understanding the diversity of need<ul style="list-style-type: none">Engage and seek information from key informantsDevelop a population profileDevelop a mental health profile of the wards within your areaReview data about the likely size and severity of women's mental health problems
15	SECTION 3: SERVICE AND RESOURCE MAPPING <ul style="list-style-type: none">6.1 All current forms of day provision6.2 Service mapping6.3 Resource mapping6.4 Other outcomes of service and resource mapping
16	SECTION 7: IDENTIFYING MODELS OF DAY SERVICES <ul style="list-style-type: none">7.1 Context for women-only provision7.2 Options for developing women-only day servicesWomen's Centres in the voluntary sector<ul style="list-style-type: none">NHS and local authority day centresPersonalised supportNetwork of services
19	SECTION 8: DEVELOPING AND CONFIRMING THE VISION AND STRATEGY
20	SECTION 9: DEVELOPING SERVICE SPECIFICATIONS <ul style="list-style-type: none">9.1 Service specification9.2 Service level agreement
20	SECTION 10: IDENTIFYING SERVICE DEVELOPMENTS/ PROVIDERS <ul style="list-style-type: none">10.1 Commissioning the voluntary sector<ul style="list-style-type: none">Incorporating the voluntary sector into the 'mental health map'Sustainability of funding<ul style="list-style-type: none">Eligibility and requirement for statutory funding10.2 Strengthening and developing NHS and Local Authority provision<ul style="list-style-type: none">Reconfiguring existing provisionStrengthening the co-ordination, quality and capacity of existing services10.3 Piloting innovative approaches10.4 Identifying new sources of investment
22	SECTION 11: MONITORING AND REVIEWING
22	APPENDICES <ul style="list-style-type: none">Appendix 1: Service specification for women-only day servicesAppendix 2: Commissioning women-only day services: Good practice checklistAppendix 3: Mapping stakeholder involvementAppendix 4: Assessing gender equality
33	References
34	Acknowledgements

Foreword

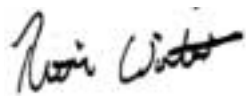
Tackling inequalities and providing opportunities for everyone is a key objective for this Government. People with mental health problems should not have to suffer from stigma, discrimination and ignorance. The Social Exclusion Unit's report *Mental Health and Social Inclusion*, published in June 2004, set in train a series of programmes to tackle this.

The inequalities that people face in their daily lives can add an even further challenge. Discrimination, for instance on the grounds of race, ethnicity, age or gender, can cause or exacerbate mental health problems. Five years ago, the NHS Plan recognised the need to support women in maintaining their mental health and recovering from mental ill health. We took this a step further with the Implementation Guidance: *Mainstreaming Gender and Women's Mental Health* that was launched in September 2003.

Supporting Women Into the Mainstream builds on this and provides a framework to support commissioners – primary care trusts, local implementation teams and local authorities – in developing women only community day services that are flexible, easy to access and appropriate for local needs.

I know that women who are feeling particularly vulnerable really value and appreciate services in a safe environment, by women for women. One of the main themes of the guidance is providing a safe space to help women engage in mainstream opportunities that the rest of us may take for granted. Women only services can offer tailored provision, such as support as a parent, and can offer an opportunity to talk about issues that might be difficult to discuss in a mixed environment.

I welcome this guidance as we move towards a society that provides individualised support for the many women who have mental health problems at some point in their lives.



Rosie Winterton
Minister for Mental Health

Introduction

In 2000, the NHS Plan¹ made a commitment to the provision of a women-only day centre in every health authority by 2004, recognising the need to develop distinctive approaches for women. The Implementation Guidance for the Women's Mental Health Strategy - *Mainstreaming Gender and Women's Mental Health*² – subsequently specified a range of approaches which would meet women's needs within the context of mainstream services and establish a more flexible target for primary care trusts (PCTs) to have a women-only community day service in place by 2004.

The above NHS deliverable remains a national priority for 2005/06, across all regions, in the delivery of the Implementation Guidance. In addition the *Public Sector Duty to promote gender equality (Gender Public Sector Duty)*, introduced as part of the Equality Bill (March 2005), will legally charge all public sector bodies to ensure **gender equality** as of April 2007 i.e. demonstrate equity of outcome for women and men in all aspects of policy, workforce issues and **service delivery**.

This dovetails well with other more recent initiatives which seek to promote social inclusion. *The Social Exclusion Unit Report Mental Health and Social Exclusion*³ outlines the action needed to reduce stigma for people experiencing mental health problems. It signals a move away from traditionally based day services to more flexible forms of support which facilitate access to mainstream opportunities such as further education, employment and leisure opportunities. This has been further developed in the Day Services Commissioning Guidance: From Segregation to Inclusion⁴.

Day services cover a range of services with women-only day support being primarily provided by the voluntary sector and mental health day centres being provided by the NHS and local authorities. This document uses the term 'day services' to cover this broad range of provision and therefore covers all sectors which provide day time support to women.

Mainstreaming Gender and Women's Mental Health recognised that a range of services and support responsive to women's requirements have already been developed by women themselves within the voluntary sector. Women are likely to continue to lead provision of 'best practice' services. This implies that initiatives which emphasise partnership working across the statutory, voluntary and community sectors should be designed to support user-led provision. The challenge for commissioners is to review existing provision and to think creatively, together with local women and other stakeholders, about the best way of meeting local needs to deliver the flexibility, access and the appropriateness of services that women and their children require.

This guide is intended to support commissioners in implementing guidance on women-only community day services. It has been developed in consultation with the NIMHE National and Regional Leads for Gender and Women's Mental Health and informed by a national conference on commissioning women-only day services held in Birmingham in December 2004. The implementation of this guidance needs to take place alongside the guidance to refocus day services for adults of working age, both men and women⁵.

Further assistance, support and information regarding 'good practice' examples locally and across England can be sought from the NIMHE National and Regional Development Centre Leads for Gender and Women's Mental Health (contact details are available on www.csip.org.uk).

Purpose of this guide:

- As a practical guide for commissioners: PCTs, Local Implementation Teams and Local Authorities.
- To support local commissioners to review and develop women-only community day services which promote inclusion and access to mainstream opportunities for women with mental health problems.
- To provide further information and support to previously published Implementation Guidance: Mainstreaming Gender and Women's Mental Health.
- For local women and other stakeholders who want to get involved in the development of local provision for women.

Section 1

WHAT ARE WOMEN-ONLY COMMUNITY DAY SERVICES?

1.1 Definition

Women-only community day services include a variety of services providing community based support to women to meet a range of needs – emotional, psychological, social and practical – enabling them to improve their mental health and to access mainstream opportunities. Many women-only services are provided by the voluntary and community sector but the NHS and local authorities also provide a significant response to women's mental health in day centres frequently offering women-only sessions in a mixed-sex environment.

1.2 Role of the voluntary and community sector

Women-led organisations in the voluntary and community sector have traditionally provided a range of 'mental health women-only day services' which do not conform either to a conventional service model or to traditional mental health provision; neither do these organisations explicitly define themselves as mental health providers to women. When women are asked about the value of these various initiatives, they consistently confirm their importance in maintaining their well being in the broadest sense. These day services offer support to women with a broad range of needs from women who would not seek help from their GP or statutory mental health services to women diagnosed with serious mental ill health. Some provide more specialist support, for example to women offenders who are serving community sentences. Many regard them as a 'life line' in helping them to cope with their mental health difficulties, reduce their social isolation and provide parental support.

Often the very existence of such services relies on women identifying their own needs and organising their own responses to them. Women report feeling supported emotionally and psychologically in these settings because their diversity and their needs are appreciated in the context of their complex lives.

Such diverse responses include drop-in centres, help lines, support groups, physical activities, yoga and well women groups, crèche facilities, domestic violence projects, counselling (particularly for surviving abuse), projects for women from minority ethnic communities, information and educational projects and projects targeted at women identified with acute or serious mental health needs.

1.3 Service Specification

Mindful of the range of voluntary sector activities already flourishing and the value placed on them by women, the Implementation Guidance for *Mainstreaming Gender and Women's Mental Health*⁶ provides a service specification for women-only day services (see Appendix 1).

The following characteristics are highlighted:

- be staffed by women
- be flexible and responsive – to the range of women's needs and at times that are convenient for them
- be safe and confidential
- allow open access and referrals
- be supportive and welcoming
- have an holistic approach to health and well-being
- aim to promote self-esteem and empowerment
- use appropriately trained professional staff and volunteers, with mental health focused training a priority
- take account of the day-to-day family, social and economic realities of women's lives
- provide creche facilities and support for women who are parents and/or carers

- promote equality of access for all women giving due consideration to their culture, religion, age, disability, sexual orientation, where they live and their caring responsibilities
- maintain strong links with primary care, community mental health teams, other statutory agencies and voluntary sector organisations.

Whilst these characteristics are important, they need to be underpinned by an approach which maximises choice and opportunities for inclusion which may also include support in developing relationships with men for heterosexual women, particularly those surviving violence and abuse.

The services provided *may* include:

- drop-in facilities (i.e. open access)
- childcare support
- parenting support
- educational programmes
- therapeutic interventions and activities
- support for self-help and mutual support groups
- befriending schemes;
- crisis support
- help lines
- information facilities (newsletters, fact sheets etc).

1.4 Current context

In some primary care trusts (PCTs) many such activities are already provided for women outside of a standard health model. Women welcome such an approach for not having stigma associated with it, particularly if they have young children or are attempting to maintain paid employment. In addition some women have had unhelpful experiences of health provision, for example women from black and minority ethnic communities⁷, which have made

them reluctant to seek help from a formal source. Available resources for providing women-only day services may be accessed by the PCT from a number of community initiatives which focus on women. A PCT should therefore examine the potential for women-only provision across its health and community sectors. For example, recent initiatives which encourage social inclusion and community engagement are likely to encompass many aspects of women-only support.

1.5 Day service options

The multi-level approach required to develop women-only day services may mean that, for many PCTs, a day centre would not be appropriate. A number of different buildings may already operate at one or other time as a women-only resource. Equally key people, rather than key places, may make up women-only support. These individuals may facilitate access to community activities for women or provide crèche facilities; they may provide shopping or befriending services, especially important for elderly or disabled women.

The variety of functions and characteristics of community women-only day services can be interpreted in a number of different ways. The options for developing existing resources within any PCT will become clear through the commissioning process.

There is a balance to be struck between providing a safe and supportive environment and providing access to mainstream opportunities. All forms of daytime support should be seen as a route into social inclusion and mainstream opportunities. Refocusing mental health day services means moving away from a building-based approach to tailoring support to individual needs.⁸

Section 2

WOMEN'S MENTAL HEALTH: WHY SHOULD IT BE A PRIORITY?

2.1 Roots and context of women's distress

The women's mental health strategy consultation document, *Into the Mainstream*⁹ and the *Children's National Service Framework*¹⁰ both highlight why women need tailored care in the context of their complex lives. Not only are women at greater risk of mental ill health in their lifetimes, but they are also the greatest users of mental health services. Most women who use these services will have children and families and will act as carers for others at some point in their lives.

Whatever the underlying reasons for women's burden of mental health problems, the experiences of their social environment substantially contribute to their difficulties. Women in general are poorer and experience greater deprivation, have less social and political power and have less access to health, education and employment than men. Additional inequalities lead directly to an increased risk of poor mental health.¹¹

These include:

- Intimate partner violence and sexual abuse.^{12, 13}
- A high demand placed on women by virtue of their multiple roles which may involve part time/full work as sole breadwinner or surviving on benefits; being a single parent; caring for elderly and disabled relatives.
- Women also make up the majority of the teenage parent, sole parent and elderly populations.¹⁴

Practical Pointer

Consider what kinds of voluntary and statutory sector activities exist in your area:

- Are they accessed by women, whether or not they describe themselves as mental health support or day services or even women-only activities?
- Who uses them and do they cover the diversity of need in your community?

2.1.1 Which women are at risk in your area?

Older women

The number of pensioners living in poverty in the UK has steadily increased¹⁵. Older women are generally worse off financially than older men and more likely to be socially isolated.

Black and minority ethnic communities

Women from these communities are more likely to live in deprived areas, experience racism and have difficulties in accessing appropriate health care.

Asylum seekers and refugees

Women may have high levels of mental health morbidity reflecting past horrors, the stress of day-to-day survival as an outsider with little or no English, lack of family supports, lack of access to health care e.g. contraception and fear of detention and removal.

Women living in poverty

Deprivation is one of the most consistent predictors of a mental ill health burden¹⁶. Women consistently occupy both the poorest and most deprived position across all cultures.^{17,18}

Homeless women

For women, homelessness is often associated with domestic violence and many homeless women have children. Mental health needs are known to be high amongst this group and they are likely to experience difficulties, not only in accessing health care but also community resources.

Women surviving child sexual abuse

Research has consistently shown that between 20% – 30% of women have been sexually abused as children (and up to 10% of male children). It is estimated that at least 50% of women in specialist mental health services are recovering from child sexual abuse, alongside other forms of cruelty and neglect. Moreover some women sexually abused as children are more vulnerable to revictimisation and find themselves in violent or abusive situations and relationships subsequently.

Women experiencing domestic violence

It is estimated that 1 in 9 of the adult women population experience domestic violence (physical, sexual and/or emotional abuse) on an annual basis¹⁹, it accounts for 25% of all violent crime and two out of five murders of women in England and Wales are by partners/ex-partners. Much of this violence occurs repeatedly, 30% of domestic violence begins during pregnancy and after childbirth and existing violence often escalates at this time. Less than a third of women seek help.

Women offenders or women who are at risk of offending

Government clearly recognises that women offenders who do not pose a serious risk to the general public should receive community, rather than custodial, sentences particularly those with mental health problems; all the risk factors listed above may in different ways have impacted on their offending (see Section 3.1.4).

2.2 Expression and experience of women's distress

The roots and context of women's distress contribute to women suffering, for example, two to three times as much depression, anxiety phobic disorders, post-traumatic stress disorder (PTSD) and eating disorders as men; as well as more recurrent and more chronic disability from depression.²⁰ The World Health Organisation²¹ has identified depression as the second leading cause of global disability by 2020 and the leading cause of disability for women in developing nations. The economic and social costs of depressive illness are also recognised to be high^{22,23} and, although depressive disorder is under diagnosed and largely under treated or untreated, women make up the highest consumers of psychoactive drugs in general, and of benzodiazepines in particular.²⁴ **This may have specific relevance for PCT drug expenditure.**

Violence and abuse, in child and adulthood, are a significant factor in the development of mental (and physical) ill health and it's many manifestations – from self harm, suicide ideation/attempts, eating disorders and post-natal depression through to alcohol/drug dependency, depression, anxiety psychosis and PTSD. The WHO Report²⁵ highlighted the adverse health effects of sexual abuse. Up to 60% of women in the UK mental health service population have been sexually abused in their lifetimes.²⁶ This group of women have more chronic and diverse problems and use more health care resources.²⁷

Women also suffer from mental health problems related to their reproductive role as mothers and parents. The effects of mental health problems in mothers on their own, and their families' quality of life, are increasingly recognised. Between 10-15% of all new mothers develop post-natal

depression, and at least 3% suffer post-natal PTSD.^{28, 29} Although women are less likely than young men to commit suicide (possibly because they ‘hang on’ for their children’s sake), suicide is the commonest cause of death for women in the first post-natal year.³⁰

2.3 Women sensitive provision

Primary and specialist mental health provision often fails to recognise the importance of the social context of women’s lives (e.g. poverty, social isolation, past and present violence and abuse). This leads to women feeling pigeon-holed as vulnerable and ill, or as frail victims, rather than being recognised as extremely **resilient** in the face of appalling adversity.^{31, 32}

Women also report a lack of safety – physical, sexual and psychological – during their use of inpatient services.^{33, 34} Developing good quality mental health provision for women is likely to have far reaching consequences: not only will it impact positively on women’s mental health, but may strengthen their ability to fulfill multiple roles as mothers and workers and as members of the community, and ultimately may reduce the demand for, and cost of, services.

Useful resource:

Barnes et al (2002). Women-only and women-sensitive mental health services: an expert paper. Report for the Department of Health. Available on the NIMHE website. www.csip.org.uk

Practical Pointer

- Demographic data will be available for your PCT. Re-focussing women-only resources to take account of this information is likely to be cost effective.
- Start by making available detailed information about what activities there already are in your PCT which help women in high risk groups. These are likely to be provided through multiple agencies which will need to work in partnership to build an effective system of support.
- Arrange to have representatives of high risk women represented at key meetings to clarify their views on need within the PCT, and to help identify priorities for development and achievable targets.

Section 3

WHAT DOES THE POLICY SAY?

Current national policy provides a framework for addressing these inequalities and developing women-only day services by providing guidance, outlining additional investment e.g. direct payments (see Section 3.4: Increasing choice and control) and promoting workforce development e.g. new roles and new ways of working (see Section 3.6: Developing the workforce).

Recent policy initiatives provide a framework for developing women-only day services. These initiatives (outlined below) represent action to address inequalities; promote positive mental health; promote inclusion and access to mainstream opportunities for people experiencing mental health problems; increase independence and choices; invest in supporting community and voluntary sector groups; develop the workforce.

3.1 Tackling Inequalities

3.1.1 Delivering gender equality

The National Service Framework for Mental Health³⁵ first drew attention to the importance of developing gender sensitive services and to address experiences e.g. violence and abuse and expressions of mental distress e.g. self harm that are more prevalent in women.

The consultation document for the national women’s mental health strategy *Into the Mainstream*³⁶ was developed in recognition that the needs of women service users had been hitherto neglected. *Into the Mainstream* is an important strand of the Department of Health’s approach to tackling inequalities. The key message is that, in order to provide equity of service to all, specific gender differences in women and men, and their inter-relationship, need to be addressed: in childhood and adult life experiences; the day-to-day family, social and economic realities of their lives today; their expression and experience of mental distress; pathways into services; treatment needs and responses.

The subsequent Implementation Guidance outlines a series of aims, recommended actions and expected outcomes to develop a gendered context for mental health and social care and to ensure that, in future, commissioners and providers of mental health services consistently:

- Listen to what women say they want and need.
- Assess their needs taking full account of the causes and context of their mental distress in addition to addressing their symptoms.
- Acknowledge and address the high prevalence and impact of violence and abuse: childhood sexual abuse, domestic violence and sexual violence (outside the home).
- Maintain women’s safety – physical, sexual and psychological – particularly in inpatient settings.
- **Increase the number and range of women-only services including community day services.**
- Improve services for specific groups of women: those from black and minority ethnic communities, mothers, women offenders, women who self harm, have a diagnosis of personality disorder, have a dual

diagnosis with substance misuse, have perinatal mental ill-health and those who experience eating disorders, with violence and abuse as an underlying theme.

The Implementation Guidance also included a detailed **service specification for women-only community day services** and secure mental health services.

The Gender Public Sector Duty, that will take effect from April 2007, will legally charge all public sector bodies, including NHS organisations, to demonstrate equity of outcome for women and men in all aspects of policy, workforce issues and **service delivery**.

See: *Department of Health. (2003). Implementation Guidance: Mainstreaming Gender and Women's Mental Health.* London: Department of Health. <http://nimbe.csip.org.uk>

Department of Trade and Industry (2005). Public sector duty to promote gender equality. Consultation document. <http://www.dti.gov.uk/consultations/consultation-1540.html>

3.1.2 Supporting women to survive and recover from violence and abuse

This focus on gender equality includes an emphasis on supporting women to recover from violence and abuse. An Implementation Guide for *Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse*³⁷ sets out a two year programme of work to be undertaken by the DH/NIMHE Victims of Violence and Abuse Prevention Programme (VVAPP) in partnership with the Home Office. The aim of the programme is to tackle the root causes of mental and physical ill-health in child sexual abuse and domestic violence building on the Public Health White Paper. It outlines a strategic framework for the changes required to improve outcomes. Adopting a whole systems approach, it emphasises the importance of involving the independent sector, in particular the voluntary sector as major providers of services for women affected by child

sexual abuse, domestic violence and sexual violence 'outside the home'.

The focus on tackling violence and abuse is also reflected in the framework of Performance Indicators for Best Value which now includes a performance indicator in relation to Community Safety requiring Local Authorities to provide guides on local services that address domestic violence.

See: *NIMHE/Home Office/DH (2005): Tackling the Health and Mental Health Effects of Domestic and Sexual Violence and Abuse*

3.1.3 Delivering race equality

The Department of Health *Equality Framework: Priorities for Action* is the overarching framework for all of the Department's activities in relation to equality, including existing and future Race Equality Schemes. The *Race Equality Guide* published by the Commission for Race Equality³⁸ provides a framework for strategic health authorities (StHAs) to assess the performance of primary care trusts (PCTs) in making progress on delivering race equality and monitoring service developments.

Delivering Race Equality: A Framework for Action sets out what those planning, delivering and monitoring local primary care and specialist mental health services need to do to improve services for people, and their families and carers, from black and minority ethnic communities.

NIMHE's largest programme of work is on improving the mental health of black and minority ethnic communities (BME) with a focus on better information and research, appropriate services and community engagement. It is supported by Race Equality Leads in each of the CSIP regional development centres. Money has been allocated to PCTs to appoint 5000 community development workers who will support the development of services that reflect the needs of local BME communities.

See: Strategic Health Authority Race Equality Guide 2004 - A Framework for Performance 2004

<http://www.cre.gov.uk/gdpract/health.html>

See: *Delivering Race Equality: A Framework for Action*

<http://kc.nimhe.org.uk/upload/Delivering%20race%20equality.pdf>

3.1.4 Women offenders in the community

The Women's Mental Health Strategy was developed in close conjunction with the Home Office *Women's Offending Reduction Programme* which emphasises the need to maintain women offenders, who do not pose a serious risk to the general public, in the community with particular reference to women with mental health problems. Both documents cited below outline approaches across mental health services, the criminal justice system and other statutory and voluntary agencies (including women-only community day services) to effect this. There is currently an independent evaluation being undertaken to assess criminal justice and liaison schemes effectiveness in diverting women offenders from custody. In addition, the Home Office (funding of £9.15M confirmed) and the Department of Health (funding proposed) are working jointly as of 2005 to establish multi-agency initiatives in two areas to explore radical new approaches to help reduce women's offending and increase the number of women offenders maintained and supported in the community through community sentencing options.

See: *Women's Offending Reduction Programme* (HO 2004) and *Section 8.4 Women offenders with mental ill health of the Implementation Guidance: Mainstreaming Gender and Women's Mental Health*

<http://www.noms.homeoffice.gov.uk/downloads/WORP-action-plan.pdf>

<http://www.homeoffice.gov.uk/document/worp-annual-review-0405>

3.1.5 Women in prison

From April 2006, the NHS becomes fully responsible for commissioning health care for women in prison, including, mental health care. This means ensuring that women who are in prison have the same access, as other women, to appropriate mental health support and, conversely, that they continue to receive appropriate care on release including a care plan if required. As part of the National Offender Management Service (NOMS), the Health and Offender Partnerships Programme on community engagement, courts and the police will address the issue of access to services on release.

3.2 Promoting positive mental health

The White Paper, *Choosing Health: Making Healthy Choices Easier*, sets out the key principles for supporting the public to make healthier and more informed health choices. The Government will provide information and practical support to motivate people to improve their emotional well-being and improve access to services so that healthy choices are easier to make. It identifies child physical, emotional, sexual abuse and neglect and domestic violence as public health issues requiring a cross government strategy.

See: *Choosing health: making healthy choices easier*

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor

3.3 Promoting inclusion and access to mainstream opportunities

The *Social Exclusion Unit Report on Mental Health* highlights the significant investment in day services. £104 million was spent on day and employment services in 2002-2003 which averages out at approximately £460,000 per PCT.

However, not all of this is invested in the types of service that best promote social inclusion. The report emphasises the need for day services, for people with severe mental health problems, to promote social inclusion by:

- ensuring services are outward looking and inclusive;
- ensuring that people have access to the opportunities they value through involving people with mental health problems in their design and monitoring;
- linking to other services and support.

See: *Action on mental health: a guide to promoting social inclusion*. OPDM (2004). <http://www.social-exclusion.gov.uk/publications.asp?did=285>

3.4. Increasing choice and control

3.4.1 Direct Payments

Direct Payments were introduced in 1997 to increase the choice and control that people requiring social care have over the support they receive. They can offer greater flexibility and more choice for people than existing services including care that is more gender and culturally sensitive, and that has the potential to facilitate social inclusion. However the take-up of direct payments is slow and a number of barriers have been identified which include the lack of information about, and support with, the application process and a lack of awareness of their potential by existing services.

See: *Department of Health (2003). A guide to receiving Direct Payments from your local council — a route to independent living.*

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4097397&chk=y9l100

3.4.2 'Individual budgets'

The recently published Social Care Green Paper, *Independence, Well-being and Choice*, on the future of social care proposes the introduction of 'individual budgets' so that people needing social care and other support services, currently provided by local authorities, can directly purchase the social care they require instead of, or alongside, day service provision.

See: *Department of Health (2005).*

Independence, well-being and choice: our vision for the future of social care for adults in England.

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4106477&chk=PNyCVm

3.4.3 Meaningful choice

Our Choices in Mental Health sets out the framework for interpreting and delivering choice for people who use mental health services. During Autumn '05, local mental health communities undertook a Choice Themed Review as part of the Mental Health NSF Autumn Assessment process. The purpose being to quantify local good practice, identify what further needs to be done and to establish local priorities in taking choice forward. The outcome of the themed review will provide a national profile of the status of choice across mental health services.

The methodology includes providing a structured approach for considering the key opportunities of 'choice points' in the service user's pathway which have been defined as follows:

- Choice Point 1 – Promoting and supporting Life Choices
- Choice Point 2 – Accessing and engaging with services
- Choice Point 3 – Assessment
- Choice Point 4 – Care pathways

Each choice point is supported by positive practice examples which, together with other useful resources, can be accessed at www.mbchoice.org.uk.

3.5 Investment in supporting community and voluntary sector groups

There has been a drive to increase the diversity of provision and improve joint working and partnerships with the voluntary/community and private sectors for a number of years. The strategic agreement published in 2004 recognised the diversity of voluntary and community services and urged PCTs to see them as equal partners in service provision. Ultimately this means a shift in resources to this sector. In addition there are opportunities to strengthen community based resources and to secure funding from regeneration monies, for example for employment related initiatives.

See: DoH (2004): *National standards: local action* <http://dh.gov.uk/assetRoot/04/08/60/58/04086058.pdf>

Useful resource: Strengthening the links by Cameron, Edmans, Greatley and Morris (2004). King's Fund; www.kingsfund.org.uk/pdf/comrnwvl.pdf

3.6 Developing the workforce: new workers and new styles of working

New roles in primary care are being developed. They are intended to provide direct help to those experiencing mental health problems, and assist them to access the full range of help available within both health and social care, the voluntary and community sector and other opportunities available locally.

These include:

- Primary Care Graduate Mental Health Workers to provide brief interventions and manage common mental health problems in primary care, with particular emphasis on depression and anxiety (more prevalent in women).
- Gateway Workers to provide a link between primary care and specialist mental health services.
- Support, Time and Recovery or STaR workers in health, social care, housing or employment schemes.
- Staff to support carers.
- Community development workers for black and minority ethnic communities.

There are targets for the number of these workers to be appointed. Their introduction provides an opportunity to consider their role in relation to the support that they can offer women and their fit within a network of women-centred services.

See: *National Mental Health Workforce Strategy* <http://kc.nimbe.org.uk/upload/DOH%20MHI.pdf>

Practical Pointer

Current policy emphasises choice, self determination and strengthening community participation and inclusion in the development of day services for women. It adopts a whole systems approach which explicitly recognises the contribution of the voluntary and community sector, and advocates working in partnership with this expertise to develop the most appropriate services. This provides a real opportunity to refocus traditionally orientated day services and strengthen investment in the voluntary and community sector.

Consider:

- reviewing investment to groups and organisations in the voluntary and community sector;
- identifying opportunities to refocus day services so that the best return on investment is achieved;
- how direct payments are being implemented for women with mental health problems in your area;
- identifying opportunities for developing women-centred provision within other initiatives which the PCT is undertaking to improve health care, and within other sectors such as education and employment;
- the scope for women-focused support within new roles, particularly the introduction of Community Development Workers, Primary Care Graduate Mental Health Workers and STaR workers.

Section 4

COMMISSIONING

4.1 Commissioning Process

The commissioning process provides a framework for the following sections of this guide as illustrated in Figure 1.

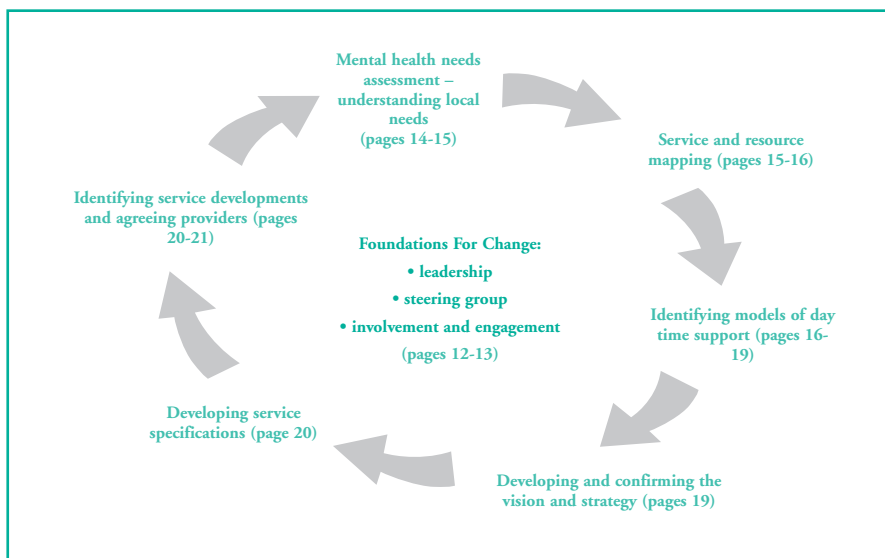


Figure 1: Commissioning women-only day services: overview of the process

Commissioning arrangements will vary over time and between places. Increasingly mental health services are being jointly commissioned by Local Authorities (LAs) and Primary Care Trusts (PCTs). The strategic direction for commissioning mental health services is usually developed by the Local Implementation Team (LIT) or Partnership Board.

Useful resources: Appendix 2 provides a Checklist for Best Practice in commissioning women only day services.

See also: Nat PaCT (2005): The Commissioner's Friend for Mental Health Services: A Resource Guide for Health and Social Care Commissioners. Also The Commissioner's Friend for PCTs

Both available from
<http://www.natpact.nhs.uk/cms/70.php>

4.2 Foundations for change

Before looking at the individual steps involved in commissioning women-only day services, it is useful to establish the foundations which will facilitate the process of review and change needed to commission the appropriate services.

Role:

- to connect organisations and individuals
- to bring together different interests
- to set and review the local agenda
- to drive change forward and to oversee the process of change.

Membership

The nature of the agenda for women-only day service provision is such that this group must involve people from all key organisations. These will include: domestic violence forums; health and social services; criminal justice agencies, the voluntary and community sector; women who have experience of these services and of mental distress; women who are 'informal' carers.

The outcome of the Steering Group should be the delivery of a process which enables women's views to be explored with representative women in a safe environment. At the same time it must involve those with the authority to commit resources to develop women's day services. Some participants may express feeling safer and freer in a single-sex steering group. However this may encourage marginalisation of the women's agenda and therefore needs careful thought.

Formal links

If the women's agenda is to become mainstreamed, the Steering Group must have authority and formal links within existing structures, particularly the LIT, PCT and the LA.

4.2.3 Involvement of women

A wide range of ways of involving women in developing women-only day services is needed. Women with a diverse range of mental health needs should be involved to influence and inform the development and improvement of women-only day services.

4.2.1 Leadership

Positive leadership is consistently identified as key to change and the implementation of policy. There is a genuine risk that women's mental health will continue to be seen as marginal unless an individual or group of individuals are identified to provide leadership for the process. Leadership secures commitment and establishes cooperation for the direction of change. Identifying those people, from different organisations, with the authority to effect change will help embed those changes in the local system.

4.2.2 Multi-agency Steering Group

A Steering Group can be an effective mechanism for ensuring a focus on women's mental health.

For this to be effective:

- The purpose of involvement needs to be clear.
- The ways in which women get involved will need to be negotiated.
- Effective engagement is required with a diverse range of women that may include those who are:
 - experiencing a range of mental health needs including a diagnosis of serious mental illness;
 - from black and minority ethnic communities;
 - mothers and/or carers;
 - recovering from or currently experiencing sexual and/or physical victimisation;
 - lesbian or bisexual;
 - at risk of offending or who have an offending history (that is very much linked to their social circumstances);
 - of different ages;
 - living with disabilities.

Accessing these groups directly through existing meetings and venues – such as those for parents and toddlers, community organisations for black and minority ethnic women and self help groups – will allow contact to be made with women on their own terms. This is the most effective and preferred method for ensuring that diversity is well represented. The voluntary and community sector and advocacy services will have particular expertise in involving particular groups and are important to link with.

Attention needs to be paid to the practical details which will support women to attend meetings including:

- Location and design of venues: they need to be safe, non-stigmatised, accessible and offer child care.
- Competence in equality issues, particularly gender and cultural sensitivity, for those running the meeting (training may be required).

- Arrangements to meet specific needs – particularly in relation to communication (interpreters, visual aids, hearing loops etc.).
- Reimbursement of expenses for travel and caring responsibilities.
- Style of the meeting with the use of a wide range of methods to ensure the full participation of those invited.
- Access to same sex members of staff particularly for personal support if necessary.

Useful resources: DH/CSIP (2006).

Reward and Recognition: The principles and practice of service user payment and reimbursement in health and social care.

Ferns, P. (2005). Letting Through The Light Training Pack- a holistic approach to black and minority mental health development. www.pavpub.com

4.2.4 Involvement of other key stakeholders

Involving a broad range of stakeholders will ensure that first, there is a more accurate picture of what needs to happen and, second, that there is an opportunity to promote collaboration and partnership working.

Potential stakeholders include:

- women's centres
- service user groups
- mental health service providers

- violence and abuse services
- adult education provision
- Jobcentre Plus
- primary care staff including health visitors and GPs
- counselling/therapy services
- self help and women's support groups
- groups for women from black and minority ethnic communities
- lesbian support groups
- services for homeless women
- Connexions and young women's projects.

Useful resource: A format for mapping stakeholder involvement is available in the *Commissioner's Friend*³⁹ available from <http://www.natpact.nhs.uk/cms/70.php>

4.2.5 Information

The following information should be available from the finance or information department in the PCT and Local Authority and public health department within the PCT:

- Clear financial information about what is currently being invested and where.
- Information about mental health needs and service use.

Practical Pointer

In developing women-only day services, attention needs to be paid to:

- Leadership and getting it on the PCT / LIT / LA agenda.
- Engaging a broad range of key stakeholders in the process including those with authority to execute change and those who are genuinely representative of local women.
- Embedding it within a whole system across different organisations to build a flexible and responsive network of support which meets a broad range of needs.
- Establishing a multi-agency agency group to drive and maintain/ monitor the process.
- Access information support to undertake analysis of mental health needs and existing service provision.

Section 5

MENTAL HEALTH NEEDS ASSESSMENT: UNDERSTANDING LOCAL NEEDS

5.1 Aim of a mental health needs assessment

The aim of a mental health needs assessment is twofold. Firstly, to gain an in-depth understanding of the mental health needs of local women and their diversity. Secondly, to place that need in the context of existing services and information about good practice and effective interventions.

Useful resource: NICE (2005) have produced a list of publications which are aimed at helping PCTS assess health inequalities and undertake health impact and health needs assessments. See: <http://www.publichealth.nice.org.uk/page.aspx?o=525871>

5.2 Understanding the diversity of need

Understanding the diversity of need in your area involves the following:

5.2.1 Engage and seek information from key informants including women who currently use services

The stakeholder mapping should enable you to identify the diverse range of organisations, community groups and sources of individuals who can provide information. These will include women living in the area, community development workers, those working in women-centred projects, service providers and commissioners. It is essential to hear directly from local women as to what their mental health needs are and their experience of accessing support.

Fruitful ways of gathering information include:

- Identify local women's events and networks

Get permission to gain written feedback from women, for example on postcards distributed at such events.

- Develop partnerships with existing women's groups and community groups

This is an effective way of gathering crucial information. It is suggested that these groups are asked to discuss and feedback on the following questions:

- What support is available for women experiencing mental distress in your area?
- What support is valued by women in your area?
- What makes these initiatives feel supportive for women?
- Are there any gaps?
- How would you like to see support for women with mental health needs developing in the future?

- Undertake focused interviews

Interview schedules such as the Camberwell Assessment of Need (CANSAS) provide a standardised reliable format for collecting information from women who have highly complex needs. A shortened form of the CANSAS has been developed for use in community samples which can be used routinely with minimal additional resources.⁴⁰ Alternatively a semi-structured interview schedule could be developed, to fit local circumstances, to identify needs, assess satisfaction with current provision, identify priorities in meeting current gaps in provision and detail the service style and quality required.

5.2.2 Develop a population profile

National data sets are available for your area from the Department of Health (DH) and the Office of National Statistics (ONS). They give detailed demographic information about the population, age distribution, and deprivation indices. The Local Council will have more detailed information on your area, for example unemployment rates and the profile of black and minority ethnic communities. The PCT will also have information on the socio-demographic profile and information about specific health issues for the local community, for example the rate of teenage pregnancies.

Useful resource: www.doh.gov.uk/publications_and_statistics/statistics

5.2.3 Develop a mental health profile of the wards within your area using the MINI scores

The Mental Illness Needs Index 2000 (MINI2K)⁴¹ has been designed to predict the distribution of mental health needs in a population, specifically the distribution of secondary care level mental health problems at ward level by PCT or Local Authority area. It is based on government deprivation monitoring statistics developed on behalf of the Department of the Environment, Transport and Regions (DETR). It applies these statistics to ward-based population census data.

Practical Pointer

A mental health needs assessment will enable you to answer the following questions:

- What range of mental health and mental health related needs do women living in your area have?
- Which groups of women are particularly vulnerable?
- How does this compare with the national picture?
- Which areas have the highest level of needs?

Useful resource: The MINI Index 2000 is available from the Durham website for public mental health: www.durac.uk/mentalhealth. This site also provides service mapping for adults of working age in England using the information collected on an annual basis from PCTs, NHS Trusts and LITS. This includes information about the provision of women only day services.

5.2.4 Review data about the likely size and severity of women's mental health problems in your area

The Adult Psychiatric Survey is the most quoted and viewed as the most authoritative source of information about mental health needs in Britain. It is a population-based survey of representative samples of individuals from 1993 and 2000. It covers a broad range of mental health problems and mental health service use of all types.

Useful resource: www.publications.doh.gov.uk/public/england.htm The North-East Public Health Observatory Report provides information about mental health and mental health service use in England⁴¹ and a useful review of data sources for mental health, mental illness and service usage. Available at www.nepho.org.uk

Section 6

SERVICE AND RESOURCE MAPPING

6.1 All current forms of day provision

The initiative for developing women-only provision needs to be taken jointly by the Primary Care Trust (PCT) and the Local Authority (LA), and it should include the review of all current forms of day provision, including acute day hospital provision. The latter often provides an alternative to acute inpatient care. However, a review of the evidence for acute day hospitals for people with severe mental disorders⁴³ concluded that whilst they may be an attractive option where demand for inpatient care is high, careful thought needs to be given to how they are integrated into modern mental health services. It is therefore vital that they are included in a review of day service provision.

6.2 Service mapping

Service mapping is an essential step in determining how services could be re-commissioned and what additional investment might be needed. Women access a broad range of supports and a whole systems approach requires that these are all considered in identifying how best to develop women-only day services

Appendix 3 provides a template for mapping local provision which includes:

- Informal community social support
Friendship groups, family ties and local community groups support women in coping with their lives and with the practicalities of day-to-day living such as child care.
- Community activity that supports social networks

Access to community activities such as drop-ins, baby massage groups, community sport or education classes are valued for not being mental health interventions. Many such activities are not designed for women-only, but may be predominantly used by women, and some will be specifically targeted at marginalised groups of women. Some women are concerned that mainstream environments will not be sensitive to their difficulties and additional support may be required to enable women to access these opportunities.

- Women-only provision

The majority of this will be provided by the voluntary and community sector and will be aimed at supporting women with specific health and social concerns including specific mental health problems, for example Women's Refuges and Women's Aid provide specific help for women experiencing domestic violence.

- Generic health services

Physical well being, reproductive and sexual health are integrally linked to women's emotional and mental health. Generic health workers within primary care, like GPs, health visitors and midwives, are important sources of information about all aspects of health.

- Primary care mental health services

Women are twice as likely, as men, to be treated in primary care for mental health problems, especially depression and anxiety. The enhanced capacity of primary care – through the introduction of Primary Care Graduate Mental Health Workers, the development of Primary Care Mental Health Teams and Gateway Workers – is well placed to provide access to appropriate interventions and to other forms of support.

- Specialist mental health services

There are only a small number of women-only day centres, the majority being provided or commissioned by the LA. Typically NHS and LA day services provide social support including peer support, access to social and educational opportunities, therapeutic help, routes into volunteering and employment, long

term support in a crisis and an alternative to acute in-patient care. These services often provide women-only sessions within a mixed-sex environment.

6.3 Resource mapping

As the proforma in Appendix 3 indicates, it is important to identify the current pattern of financial investment in day services for women. Placing this information alongside the number of referrals, caseload sizes and indicators of need (e.g. CPA level) can give an indication of service capacity, and allow a judgment as to whether this represents a reasonable return. It may be difficult to compare different services as they are likely to be responding to different levels of need and capture data in different formats. This issue can begin to be addressed through the development of consistent requirements for information as part of the process of monitoring and review.

The information gathered on local need, and the service and resource mapping, will allow the following questions to be answered:

- Where are the gaps in provision for your local population?
- Can priority be given to particular gaps?
- How might these be addressed within the framework of the current PCT agenda?
- How could stronger links and routes be developed between existing services and mainstream opportunities to benefit women with mental health needs?

Practical Pointer

A whole systems approach to commissioning day services for women is vital. A review of current service patterns needs to include Local Authority Day Centres, NHS Acute Day Hospitals, Women's Centres, generic health services and voluntary and community organisations in order to identify the strategic direction. In adopting this approach, it will be possible to identify both the gaps in current provision and the opportunities to address them.

- How could resources be invested differently to meet the range of needs?
- What are the main options for action for the PCT?
- What action needs to be taken, and by whom, in order to develop and sustain existing services?
- What time frame should the actions occupy?

6.4 Other outcomes of service and resource mapping

This mapping should also result in new opportunities being identified. For example:

- Identifying funding which develops and supports community initiatives and therefore crosses a number of agendas.
- Developing co-ordinated and accessible information for local women to enable them to access community activities.
- Encouraging women to access support from existing resources requires a means by which the existing workforce can be strengthened and developed to respond appropriately. For example, the provision of training and supervision for statutory health practitioners, such as health visitors and workers in community organisations, may be a valuable and cost effective way of extending day service provision for women within the PCT.

Section 7

IDENTIFYING MODELS OF DAY SERVICES

7.1 Context for women-only provision

In identifying the options for developing women-only day services, it is worth considering the context provided by the evidence on current provision and on effective interventions.

There is no systematic evidence available that focuses on the efficacy of one service model above another for women. However, in a review of the evidence commissioned by the Department of Health on women-sensitive provision, 178 projects were involved in identifying good practice and the principles which should underpin women-sensitive provision. The findings are summarised in Box 1.

Box 1: Principles for women-sensitive provision⁴⁴

Women-friendly services are those that:

- enable women to make choices about the staff and the care and treatment provided to them
- have staff who give women 'time to talk'
- provide women-only spaces within the physical environment of the service provided
- make women feel safe and secure, treat women with respect and ensure confidentiality
- understand women's distress in the context of their whole lives;
- address such difficulties as abuse, altered body image, reproductive and life stage changes, and those

7.2 Options for developing women-only day services

Options to be considered are:

7.2.1 Women's Centres in the voluntary sector

Description

They are nearly always provided by the voluntary sector and clearly meet the service specification outlined in the Implementation Guidance for *Mainstreaming Gender and Women's Health*.⁴⁵ There are 123 women's centres in the UK with 97 of these being in England. Not all of them operate on a full time basis but the majority are open Monday to Friday 9.00am-5.00pm.

Some of these centres have an outreach element with venues on housing estates close to particular communities to facilitate access. There are also women's centres taking active steps to reach out to women who have recently been discharged from acute inpatient care and/or are experiencing

which recognise that self-harm, or the abuse of food or drugs, have a meaning for the woman concerned

- recognise women's strengths and work to build on these strengths
- provide opportunities for women to have time for themselves away from home and provide opportunities to spend time with other women
- enable women to have a say about their own care and treatment and be involved in service planning and delivery
- are culturally sensitive, including to women who are refugees or asylum seekers
- have security and stability of funding to enable consistency of support.

serious mental ill health. Finally there may be activities, or centres, either targeted at specific communities or particular groups e.g. girls, older women, children of women who are victims of domestic violence.

Women's centres often provide a broad range of opportunities for women experiencing mental health problems to access mainstream opportunities.

These include education and training initiatives with support focused on the barriers which women can particularly encounter, such as low self confidence and difficulties securing appropriate childcare. In addition, they often provide help and advice in relation to health and social issues, sexual health and violence and abuse (experienced in childhood and/or adulthood) which are important but are often neglected for women experiencing serious mental health problems.

Issues to consider:

- Centralising resources in one building may increase the opportunity to offer a broader range of services for women. However this strategy needs to be considered in the context of the diversity of need in the local area and what other services currently exist.
- The provision of a women-centred service needs to be balanced with facilitating access to mainstream opportunities, particularly for women with severe mental health needs and women who are vulnerable to social exclusion.
- The voluntary sector can access funding from a variety of sources; however this is primarily for time-limited specific projects and therefore core funding should be considered.
- The stability of funding is pivotal to the sustainability and capacity building of voluntary sector provision. Core funding needs to be formalised with Service Level Agreements on a three year basis.

Useful resource: A National Directory of Women's Centres (2004) provides a full list of Women's Centres across the UK

and is available from Keighley Women's Centre, 182 Skipton Road, Keighley, West Yorkshire, BD21 2SY. Tel: 01535 681 316.

7.2.2 NHS and local authority day centres

Description

Women-only sessions in a mixed-sex environment are the most common form of women-only provision within NHS Day Hospitals or Local Authority Day Centres. Both of these provide for people with a diagnosis of serious mental illness and can provide part of a network of support as an alternative to acute in-patient care.

They provide a range of activities from therapeutic and social to improving access to educational and employment opportunities in a mixed-sex environment (clients and staff). Women-only sessions tend to be limited to one or two a week and are organised on a group basis. They may concentrate on specific topics such as sexual abuse but more typically will focus on social activities, confidence building or assertiveness raising. In addition, women may have access to a woman member of staff for individual support and therapeutic work.

Issues to consider:

- There is concern that such services may perpetuate the marginalisation of women and contribute to their exclusion rather than addressing it. Links with mainstream community organisations may be under developed. Increasingly day services are reorientating themselves to provide individually focused support which provide a 'bridge' to mainstream opportunities and strengthen participation in the local community.
- As the majority of women's time may be spent in a mixed-sex environment, this is unlikely to be gender sensitive and their needs may go unmet. There is the possibility that women may feel unsafe or experience discrimination or harassment.

Useful resources: : DH/CSIP (2006). From segregation to inclusion: Commissioning guidance on day services for people with mental health problems.

DH/CSIP (2006). Vocational services for people with severe mental health problems: Commissioning Guidance.

7.2.3 Personalised support

Description

There is an increasing emphasis on giving people choice and tailoring support to individual needs. Direct Payments are a practical means of achieving this. People who require social care can receive community care monies directly so that they can choose and pay for their own support to meet their needs. Local Authorities now have a duty to offer Direct Payments to people who are eligible (i.e. qualify for help from social services) and to make payments to those who want them. Direct Payments offer greater choice and flexibility for people over the support they receive, and the means of support is more likely to be gender sensitive and culturally appropriate. This, in turn, will increase opportunities for inclusion through supporting access to leisure opportunities, educational activities, friendship and pathways into employment.

Direct Payments in mental health have been used for:

- social support
- domestic support
- personal care
- practical support
- transport
- education
- art
- leisure
- respite
- childcare
- therapeutic support
- night-sits.

Direct payments are a choice and they can be used instead of, or alongside, existing services. Most packages are for help with 'everyday' tasks such as social,

practical and domestic support enabling people to participate more fully in activities and their local communities. Carers can also access direct payments and they therefore have the potential to support women, who are eligible, in their caring role.

Issues to consider

- The take-up of direct payments by people with mental health needs has been slow. There is a need for accessible information and support with the process of accessing and using a direct payment, as this can be an area of anxiety for people.⁴⁶ A direct payment advocacy and support service, which is sensitive to mental health issues, will need to be in place if the opportunity provided by direct payments is to be fully realised.
- The implementation of direct payments in mental health care requires action on a number of fronts including appropriate staff training, integration of the direct payment process with the care programme approach and the introduction of direct payments in a planned way with thought to how existing services can be reviewed, reconfigured and recommissioned.⁴⁷
- The systematic and planned introduction of direct payments across the board would mean that more women could define the type of support they receive.

Useful resources: Department of Health (2003). A guide to receiving Direct Payments from your local council – a route to independent living. [http://www.db.gov.uk/ Publications AndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONT](http://www.db.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONT)

Practical Pointer

Day services can be provided in different ways. In order to identify the best approach for your locality:

- Be clear about the needs and priorities that services should be addressing.
- Look at how the functions of day services can be provided across organisations.
- Let the principles of maximising choice, social inclusion and opportunities guide the design of women-only day support in your area.

ENT_ID=4097397&chk=y9ll00
Heslop, P. (2001). Direct Payments for Mental Health Users/Survivors. London: NCIL.
www.ncil.org.uk/dpays_mb_users.asp

DH/CSIP (2006). Direct payments for people with mental health problems: A guide to action.

7.2.4 Network of services

Description

The concept of a single centralised service is unlikely to meet a diverse range of needs and may not make the best use of local resources. An alternative model, where a network of services is developed with a central co-ordinating function, may offer greater diversity and flexibility. It could involve:

- Providing support to improve access to community activities by:
 - Using existing resources to build the capacity of the local community and locally based organisations in order to provide a range of women-only activities and support.
 - Empowering local "ringleaders" and identifying 'bridge builders' in the local areas.
- Developing a network to facilitate access to resources across different localities in order that:
 - Specific needs can be met, for example of women from black and minority ethnic communities.
 - There is seven day a week access.
 - Resources and information are shared across the network.
- Piloting approaches which develop the competence of women and provide support, for example, to respond to the demand for 1: 1 therapy which is unlikely to be met in the short term.

Section 8

DEVELOPING AND CONFIRMING THE VISION AND STRATEGY

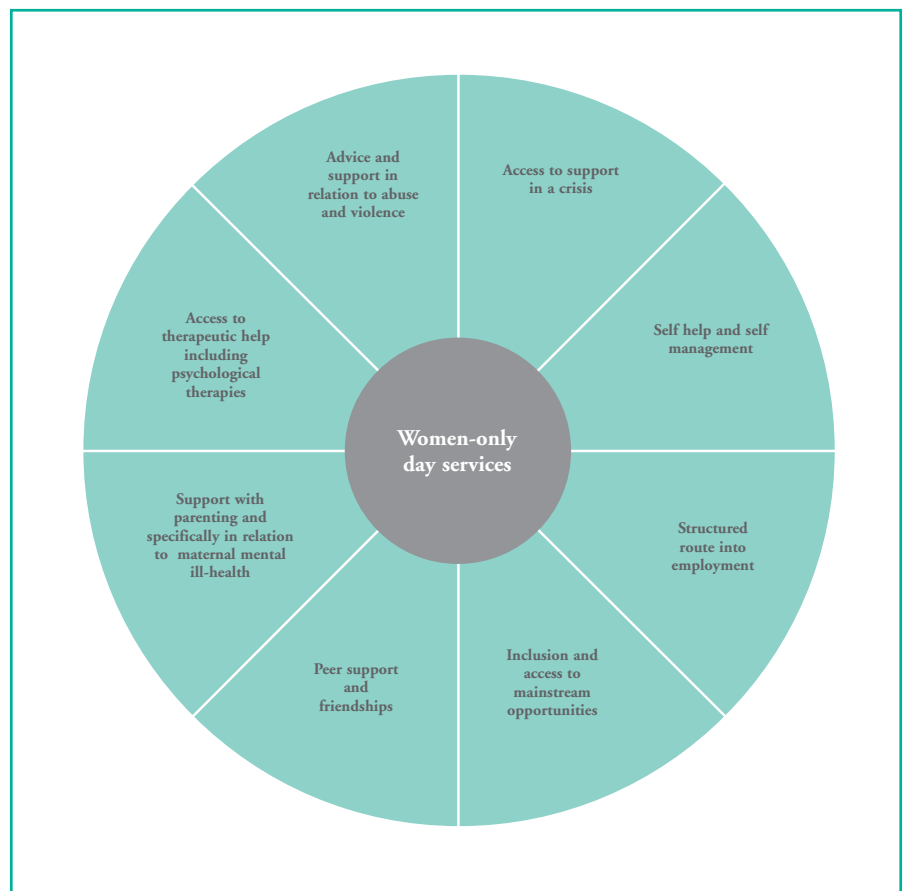
Articulating a vision – which sets out what local stakeholders are working towards over the next two to five years – establishes a reference point for the strategy. The strategy provides a framework within which the role of all organisations in responding to promoting and responding to mental health needs to be clear.

An overview of the functions of women only day service is provided in Figure 2. It is not suggested that any one service provides all of these rather that these should be available across the whole system of provision. Each area needs to decide, on the basis of the assessment undertaken and local consultation, which are a priority for development.

The strategy needs to include:

- An assessment of the relevant policy context.
- A summary of the mental health needs assessment.
- A vision of how these needs will be met including the service components, functions and interventions (as summarised in Figure 2 below).
- Detail of how the PCT and Local Authority, together with other stakeholders, plan to make a difference to the mental health of women in their locality over the next 12 months, 3 years and 5 years.
- Resources needed and resource shifts.
- Workforce and capacity requirements.
- Arrangements for implementation with agreed timescales and lead responsibilities.

Figure 2: Key functions for women-only day services



- Providing information, guided self-management and access to appropriate support at primary care level.
- Responding to the needs of specific groups of women through outreach from voluntary or statutory provision.
- Providing access to psychological therapies
- Providing access to specialist mental health services which meet standards identified by women.

Such a network of services would need to be supported by good information (about women's mental health and the network) and a strategy to ensure that the information is disseminated appropriately through local networks, community leaders and community based resources with which women have frequent contact (e.g. schools, primary care, sexual health clinics etc).

Issues to consider:

- Making resources available to develop the infrastructure required in particular:
 - Investment in coordination of the network.
 - Resources available to strengthen and develop community groups.
 - Training for community organisations in developing groups and in women's mental health issues.
- Developing the response of primary care to facilitate self management and access to appropriate support:
 - Linking with the development of primary care graduate mental health workers and gateway workers.
 - Developing the links between primary care and the voluntary sector.
- Ensuring that mental health services are improving the quality of care to women using their services:
 - Development of standards.
 - Clarifying the interface between primary care, specialist mental health services and community organisations.
 - Ensuring that the CPA facilitates access to broader opportunities.

Section 9

DEVELOPING SERVICE SPECIFICATIONS

9.1 Service specification

The service specification forms a basis for the service level agreement which is the mechanism for contracting with providers.

Service specifications for women-only day services should include:

- principles
- aims
- outcomes to be achieved
- service elements
- interventions to be provided
- skill mix required
- quality and service governance including arrangements for involving women; service users
- monitoring arrangements.

Useful Resource: Appendix 1: Service Specification from the Implementation Guidance

9.2 Service level agreement

The agreement with all providers, statutory and voluntary sector, should detail:

- objectives of the service to be provided and main responsibilities of the provider
- performance indicators
- quality and service governance
- scope of operational policies
- insurance and indemnity
- arrangements for monitoring
- financial arrangements
- disputes
- notice period.

Section 10

IDENTIFYING SERVICE DEVELOPMENTS/PROVIDERS

Having established the vision and strategic direction and developed service specifications, commissioners will have a range of options in terms of who provides what and for whom. These options are not mutually exclusive and include:

10.1 Commissioning the voluntary sector

The voluntary sector has acknowledged strengths which include:

- accessibility
- flexibility
- women's experience of the voluntary sector as being women focused and they feel listened to, empowered and understood
- responsiveness to diversity
- excellent 'value for money'.

The voluntary sector *requires statutory funding* because the nature of charitable funding is short term, primarily for new projects to meet the national or regional objectives of the charities concerned rather than any local objectives.

There are three key issues to consider:

10.1.1 Incorporating the voluntary sector into the 'mental health map'

It is essential that voluntary sector mental health provision is fully incorporated into the 'mental health map' and commissioned in the same way as other mental health services. There is a need to recognise the value of what this sector is providing and that it can represent 'best value'. However the sector needs strengthening and capacity increasing which implies:

- investment in the voluntary sector including a shift in resources from the statutory sector and new funding (see Section 10.4, Identifying new sources of investment)

- funding for infrastructure costs as well as costs related to client activity
- establishing contracts for a three year time period.

10.1.2 Sustainability of funding

Reliance on short term funding can diminish the contribution of the voluntary sector as activity is likely to be determined by available funding sources and timescales rather than by a more productive strategic approach. The time consuming nature of constant fund raising and the associated uncertainty can also affect staff morale. Ensuring sustainability of funding is therefore essential.

10.1.3 Eligibility and requirement for statutory funding

The voluntary sector is *eligible for statutory funding* and they meet significant gaps in statutory mental health provision or provide a different style of service in this case, for women. Moreover, historically, this sector has addressed those mental health needs of women which statutory mental health services have hitherto been reluctant to e.g. self-harming behaviour; survival of child sexual abuse; impact of domestic violence on women and their children; parental support to mothers experiencing mental health difficulties.

The less than conducive, funding context for the voluntary sector has often led to a paucity of resources for administrative support and to develop a solid management infrastructure to support the work they achieve. A fragile infrastructure inevitably has the potential for jeopardising the involvement of the sector in statutory commissioning.

Not surprisingly the nature of the funding means that voluntary sector organisations are often competing with each other for resources. Competition for resources can inadvertently result in a reluctance to share information, resources and ideas about meeting the gap in provision, which more enlightened organisations resist.

10.2 Strengthening and developing NHS and Local Authority provision

There will be a variety of ways in which existing provision can be strengthened including:

10.2.1 Reconfiguring existing provision

Reconfiguring existing day service provision affords an opportunity to invest in support that may more effectively meet the needs of women and men. Day centres provided either by the Local Authority or the NHS are usually supporting people with serious mental health needs. Reshaping existing provision requires:

- Looking at the individual needs of the people in the current service.
- Establishing what other needs there might be, for example through a one day census of people on existing caseloads.
- Identifying alternative ways of meeting these needs in discussion with existing service users, their families and carers, staff and other stakeholders.
- Identifying the functions that the current provision is meeting, which of these need to be reprovided and how.
- Being clear about what is currently invested.
- Developing a detailed transition plan which maps out how to move from the existing service to the new service. This transition plan will need to consider each person using the existing service, their families and carers and staff.

10.2.2 Strengthening the co-ordination, quality and capacity of existing services

- Networking the range of initiatives that exist for women locally.
- Identifying opportunities within generic services, such as primary care, for strengthening support.
- Training.
- Standards.
- Developing capacity of existing women focused services through training and supporting staff in addressing particular needs, for example, recovery from sexual abuse, support for mothers with mental health needs and their children.
- Refocusing the service to ensure that social inclusion and equity is a major objective.
- Ensure monitoring is in place, supported by time for reflection and team development in relation to the provision of services that deliver gender equality.

10.3 Piloting innovative approaches

If the approach to developing women-only day services is to be truly women centred, there needs to be scope for developing new approaches in response to the needs, views and concerns raised by women. It may be possible to pilot initiatives within existing resources (within the statutory and/or voluntary sector) or by securing a small amount of new investment. Equally the introduction of new categories of workers (see Section 3.6 New workers and new styles of working) provide a good opportunity to be innovative and address hitherto unmet needs.

Whatever route is chosen, thought should be given at the outset as to how the initiative will be mainstreamed.

10.4 Identifying new sources of investment

The development of women-only day services requires a recognition of the multi-faceted nature of women's mental health needs and their social context. This means that there is considerable scope to work with local partners to secure new investment to support service developments. The Local Strategic Partnership provides a route to potential sources which include:

- Regeneration initiatives: Neighbourhood Renewal Funding, New Deal for Communities.
- Initiatives targeted at parents eg Sure Start.
- Initiatives for black and minority ethnic communities.

Section 11

MONITORING AND REVIEWING

Regular review and ongoing monitoring of provision needs to be embedded in the service level agreement (SLA) with relevant providers to ensure that they 'stay on track' and continue to meet the original objectives. A framework for this can be provided through the development of performance indicators. Appendix 4 provides a self-assessment tool to review women only day service provision. It can be used in a variety of ways:

- To inform the development of women-only community based services.
- To inform the delivery of gender equality in broader service development.
- To evaluate local provision.
- To identify the focus for action to improve local provision.
- To provide a basis for developing indicators for community based support for other vulnerable groups.

The Good Practice Checklist for commissioning (see Appendix 2) can also be used as a self assessment tool for commissioners to review the profile of gender equality in the commissioning process.

Appendix 1

Service Specification for women-only community day services

Who is the service for?

These services have the potential to provide community support for women with a range of experiences and needs including those:

- who are mothers living or recovering from a serious mental illness
- suffering from post-natal depression
- who self-harm
- who are survivors of/recovering from violence and abuse in child and /or adulthood
- who need a women-only setting (e.g. for religious or cultural reasons, women who are lesbians, survivors of violence and abuse, older women)
- who are serving community sentences for offences of a non-serious nature and clearly linked to their social disadvantage
- who are suffering from depression and anxiety
- who are socially isolated and would benefit from the support of other women e.g. lone parents
- who would benefit from advice and support to maintain good mental health (links should be made to the development of local mental health promotion strategies).

The aim of combining the needs of these groups is to help remove the stigma experienced by many women accessing mainstream mental health services. There needs to be a link to other community based services to avoid such stigmatisation.

What should the service do?

The aim of the services should be to improve and promote mental health and well-being, to help prevent mental ill health or relapse by supporting women in their own homes and communities. A range of services, support and activities should be provided in a variety of settings, dictated by local need and informed by local consultation. The range of provision should include:

- educational programmes
- therapeutic interventions and activities (on an individual and group basis)
- self-help and support groups
- crisis support (within CPA for those currently in touch with mental health services; for others, signposting to other forms of out-of-hours support)
- information
- parenting support
- workshops and activities
- art and complementary therapies.

Service principles

Women-only community day services should:

- promote self esteem, empowerment and build on women's strengths
- be safe, confidential and non-stigmatising
- be supportive and welcoming
- have an holistic approach to health and well-being
- take account of women's parenting and other caring responsibilities e.g. the need for crèche or childcare facilities, access to carer support
- be accessible to all women by taking account of their race, culture, religion, age, disability, sexual orientation and where women live – also accessible with regard to location and safety of the environment;

- consider the provision of transport or access to transport for women who have difficulties getting from home to services e.g. as a result of physical disabilities, suffering from agoraphobia, living in a rural setting
- encourage access to mainstream community opportunities eg lifelong learning, leisure and cultural services
- voluntary/statutory agencies.

Planning and commissioning of women-only community day services

Within this process, PCTs and partners will need to:

- understand, uncover and tackle the 'hidden' needs of women (refer to *Women's Mental Health: Into the Mainstream, Section 7.1 Assessment of Need*⁴⁸)
- consult with local women and organisations, including black and minority ethnic groups, in their own languages if necessary
- build on existing positive practice and existing women-only day services (many provided by the voluntary sector)
- strengthen partnerships with voluntary sector organisations (including related provision like women's refuges) in planning and delivering services, and take a longer-term view on funding these services to ensure stability and continuity.

Staffing

Services should:

- be staffed by women to allow for the development of safe environments and to allow choice for women who prefer a women-only setting
- use appropriately trained staff and provide mental health focused induction and training programmes for volunteers and paid workers
- appoint staff and volunteers who have:
 - the ability to empathise and engage with women who use the services
 - an understanding of issues relating to gender and ethnicity;
 - health, social care or appropriate 'life experience' (including personal experience of mental health problems)
- provide supervision and support for professional staff and volunteers (including external supervision e.g. for women who are managing the service, therapists/counsellors).

Hours of operation

Services and support should be flexible and responsive to the range of women's needs and at times that are convenient to them.

Referrals

- open access;
- drop-in;
- referral from primary care or specialist mental health services.

An outreach facility should be considered to reach women for whom access is problematic e.g. because of a disability, isolated location.

Assessment of risk and policy on violence

Services should have clear policies and guidance in place on risk assessment and violence. Much existing women-only provision enters into a contract with women who use the service around risk (to self and others), confidentiality and acceptable behaviour.

Information to women who may be interested in using the service

This should include:

- description of the range of services available, times of opening, etc
- philosophy of the service i.e. that it is operated on an 'open access' basis 'by women for women'
- how to access other community based support/self-help networks.

Continual service improvement

Services should be led by the women using the service and be flexible and responsive to the developing and changing needs of the client groups. Primary care trusts, and other commissioners, should consider regular service audits to ensure that services are effectively meeting gaps in provision for women and providing a needs-led service. Audits should always include feedback from the women who use the service.

Extract from Implementation Guidance: Mainstreaming Gender and Women's Health, Section 6.1 Women-only Community Day Services (DH 2003).

Appendix 2

Commissioning Women-Only Day Services: Good Practice Checklist.

Process for developing women-only day support

1. Is there clear leadership for women's mental health at a senior level within the commissioning organisation?
2. Is there a multi-agency agency group which includes those with authority to execute change?
3. Are local women, with a range of mental health needs, well represented on the multi-agency steering group?
4. Is there a broad range of stakeholders involved in the process?
5. Is there access to information support to analyse need against existing provision to explore the potential for service re-provision?

Needs assessment

1. Is there an assessment of the range of mental health and mental health related needs of women living in the area?

2. Have the needs of women who are particularly vulnerable been identified?

3. Are the areas with the highest levels of need clearly identified?

4. Is there an assessment on how well the broad range of services are meeting needs and what women would like to see in terms of day time services including responses to:

- domestic violence
- child sexual abuse
- self harm
- depression and anxiety, including post-natal depression
- women living with or recovering from a serious mental ill health
- offending (of a non-serious nature) arising predominantly as a result of social deprivation
- women who need a women-only setting for religious or cultural reasons
- women who are socially isolated and other women who would benefit from advice and support to maintain their mental health well being

Service and resource mapping

1. Is there a map of the services currently available which includes service type, location and investment profile and service capacity related to need?

2. Have the opportunities – to refocus NHS and LA day services to enable women with acute or serious mental ill health to access mainstream opportunities been identified?

3. Have the opportunities for developing women-centred provision – within other initiatives which the PCT is undertaking to improve health care, and within other sectors such as education and employment – been identified?

4. Has the scope for women-focused support within new roles, particularly the introduction of Community Development Workers, Primary Care Graduate Mental Health Workers and STaR workers, been adequately explored?

Ensuring a comprehensive range of services which includes:

- information and advice
- access to educational programmes
- therapeutic interventions and activities (on an individual and group basis)

- self-help and support groups
- crisis support (within CPA for those currently in touch with mental health services; for others, signposting to other forms of out-of-hours support)
- self- management strategies
- parenting support
- art and complementary therapies

Identifying the commissioning options

1. Does the strategy clearly identify how the needs identified will be met?
2. Have the functions of day support, and the way in which they can be provided across organisations, been clearly identified?
3. Is it clear how stronger links and routes between services and mainstream opportunities could be developed to benefit women with mental health needs?
4. Have the requirements in terms of workforce development been clearly laid out?
5. Has consideration been given to increasing the take-up of direct payments?

6. Have the funding opportunities been fully explored?
7. Has the action which needs to be taken, and by whom, in order to develop and sustain existing services, been identified?

Commissioning the voluntary sector

1. Have the funding for infrastructure costs, as well as costs related to client activity, been clearly identified?
2. Are service level agreements with the identified providers for three years?
3. Is there a clear service specification for what is to be provided with arrangements for review and monitoring?

Modernising NHS and LA day services

1. Are current service users and their carers fully involved in the process?
2. Have the individual needs of the people in the current service been clearly identified?
3. Have ways of meeting these needs been fully explored?
4. Is there a clear picture of what is currently invested?

5. If developments have been identified, do they allow choice?
6. Is there detailed planning for the transition which maps out how to move from the existing service to the new service?
7. Does this cover all the people affected including service users, their families and carers and staff?

Monitoring and reviewing provision

1. Is there a process in place to monitor and review provision on a regular basis?
2. Does this process involve a systematic process for reviewing against national or locally agreed standards?
3. Does the process fully involve local women who have a range of mental health needs and who represent different communities?
4. Is there evidence of changes leading to improvements in quality as a result of monitoring arrangements?

Appendix 3

Proforma for mapping local provision

Type of service	1	2	3	4
Description including location / times of operation				
Function				
Function interventions				
No. of places				
Staffing (FTE)				
£ 000				

Appendix 4

Assessing Gender Equality in women only day services

Introduction

This self-assessment framework is intended to help you understand how well you are doing with commissioning, or providing, a service that delivers gender equality for women.

Section A is an overview of the values and principles that all services need to adhere in delivering gender equality, with particular reference to women.

Sections B considers the organisational context of all service provision and identifies indicators in relation to policies, workforce development and governance arrangements.

Section C focuses specifically on the

delivery of women-only community day services.

For each Section there is a list of specific statements. Review information about the service to help you judge whether each specific statement is fully met, partly met or unmet. At the end of each section there is a box for additional comments where you may wish to highlight good practice and/or identify priorities for action.

SECTION A: VALUES/PRINCIPLES WHICH UNDERPIN THE DELIVERY OF GENDER EQUALITY IN ALL SERVICES (with particular reference to women).

	Fully met	Partly met	UUnm Unmet
<p>The service promotes self esteem, empowerment and builds on women's strengths Examples:</p>			
<p>The service provides safety, is confidential and non-stigmatising Examples:</p>			
<p>The style of the service is supportive and welcoming for women including those from black and minority ethnic communities Examples:</p>			
<p>The service has a holistic approach to health and well-being. Examples:</p>			
<p>The service takes account of the social, economic and family context of women's lives including their parenting and other caring responsibilities. Examples:</p>			
<p>The service is accessible to all women. Examples:</p>			
<p>The services provides outreach or additional support to facilitate access. Example:</p>			
<p>The services promote and support access to mainstream opportunities. Example:</p>			

Comments

SECTION B: UNDERPINNING STRATEGIES REQUIRED TO DELIVER GENDER EQUALITY IN ALL SERVICES

POLICIES	Fully met	Partly met	UUnm Unmet
<p>The service being commissioned has policies which operationalise gender (and race) equality and include:</p> <ul style="list-style-type: none"> • Recruitment. • Employment and family friendly working practices. • Child protection. • Domestic violence. • Physical and sexual harassment, intimidation and violence experienced by service users within the service. • Risk assessment (to self and others). 			

WORKFORCE DEVELOPMENT	Fully met	Partly met	UUnm Unmet
<p>Training is delivered by those with identified expertise in gender (and race) equality.</p> <p>Women service users are involved in the design and delivery of training.</p> <p>Training on gender equality is targeted at staff and managers at every level within the organisation.</p> <p>Training for staff covers:</p> <ul style="list-style-type: none"> • The complex interplay of the economic, family and social context of women's lives. • The interplay between gender and other dimensions of inequality such as race, culture, ethnicity and age. <p><i>continue over page . . .</i></p>			

WORKFORCE DEVELOPMENT <i>continued . . .</i>	Fully met	Partly met	UUnm Unmet
<ul style="list-style-type: none"> • The potential impact on women of specific experiences, notably child sexual abuse, domestic violence, parenting and caring responsibilities. • Gender differences in the prevalence of risk and protective factors for mental ill health. • Gender differences in the experience and expressions of mental distress particularly those most prevalent in women e.g. self-injury, eating disorders, depression and the diagnosis of personality disorder, and pathways into services. • Gender differences in appropriate support, therapeutic needs and responses. • The relationship between gender and other inequalities and how they may affect individual service users and staff in their experience of services, their working lives and day-to-day living. • Tackling physical and sexual harassment, intimidation and violence, commonly endured by women service users and perpetrated by men service users. • The need for staff to consistently reflect on the ways in which they use their power, implicitly and explicitly, in their relationships with service users to ensure that it is in the best interests of the client group, <p>Supervision which focuses on gender (and race) equality, in particular, is regularly provided for all staff, including volunteers.</p>			

MONITORING AND REVIEW	Fully met	Partly met	UUnm Unmet
<p>The service monitors quality using standards which include gender (and race) equality.</p> <p>Women service users and carers from a broad range of backgrounds are involved in service planning, delivery and evaluation.</p> <p>Service governance arrangements for NHS Trusts and PCT provider Trusts, includes a gender and race analysis.</p>			

<p>Comments</p>

**SECTION C: SPECIFIC DELIVERY
OF WOMEN-ONLY COMMUNITY
DAY SERVICES**

INFORMATION	Fully met	Partly met	UUnm Unmet
<p>Information about the service is available in a variety of formats accessible to a broad range of women.</p> <p>Information about mental health issues is available in a variety of formats accessible to a broad range of women.</p> <p>Information about resources locally is available in a variety of formats accessible to a broad range of women.</p>			

ACCESS	Fully met	Partly met	UUnm Unmet
<p>Women may access the service in different ways including referral and 'open access'.</p> <p>The service provides outreach or additional support to facilitate access for women who might need it.</p> <p>The service is flexible and accessible at times that are convenient for local women.</p>			

STAFFING	Fully met	Partly met	UUnm Unmet
<p>Staff are women and are representative of the local communities.</p> <p>Staff are appropriately trained in social inequalities and mental health issues that have specific relevance to women.</p> <p>Staff have:</p> <ul style="list-style-type: none"> • The ability to empathise and engage with women who use the service • An understanding of the complex social, economic and family context of women's lives including their parental and other caring responsibilities • Health, social care or appropriate life experiences. <p>There is sufficient diversity to allow women to have a choice of key worker or therapist.</p>			

RANGE OF PROVISION	Fully met	Partly met	UUnm Unmet
<p>The range of provision includes:</p> <ul style="list-style-type: none"> • Information and advice • Access to educational programmes • Therapeutic interventions and activities (on an individual and group basis) • Self-help and support groups • Crisis support (within CPA for those currently in touch with mental health services; for others, signposting to other forms of out-of-hours support) • Self-management strategies • Parenting support • Art and complementary therapies. 			

The following components – Individual Care Plans and Inter-Agency working – of statutory service delivery have a clear link to Women-Only Community Day Services:

INDIVIDUAL CARE PLANS ⁴⁹ for Statutory Services	Fully met	Partly met	UUnm Unmet
<p>Individual assessment and care plans consider:</p> <ul style="list-style-type: none"> • parenting and caring responsibilities of women • their home, social and economic situation • generic health needs of women e.g. cervical / breast screening / contraception / fertility needs. • race and culture • experience of violence and abuse • access to mainstream opportunities including training and employment. <p>Women, both as service users and as carers, are involved in planning and delivery of their own care?</p>			

INTER-AGENCY WORKING	Fully met	Partly met	UUnm Unmet
<p>There is inter-agency working to ensure that the mental health needs of a broad range of women, identified in assessment and care planning, are met through a range of integrated provision including statutory services (e.g. day centres) and voluntary sector services (e.g. women's centres) services working with women with the following needs:</p> <ul style="list-style-type: none"> • support with parenting • domestic violence • child sexual abuse • depression and anxiety, including post-natal depression • eating disorders • self harm • a diagnosis of personality disorder, primarily borderline personality disorder • living with or recovering from serious mental ill health • substance misuse and mental ill health • learning disabilities and mental health problems • involvement with the criminal justice system. <p>The service is well co-ordinated between all staff and across agencies</p> <p>Examples:</p>			

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