ITEM 12A

Service Specification
for
Derby City Mental Health Day Services

Derby City Primary Care Trust & Derby City Council Adult Social Services Department

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Purpose of this document

This is an “Outcomes” based specification based on National Guidance.
This document is intended for use by local commissioners in Derby and Derbyshire in evaluating current service provision, in service reconfiguration, and in any tender for what traditionally have been called “day services”.
The specification is designed to give potential service providers’ maximum flexibility and innovation in how they deliver a service that will deliver these outcomes.

We have chosen the phrase “Social and cultural opportunities in Derby City” as a name reflecting our aspirations for the service and being more helpful than the term Day service.
The name of any particular service will be agreed between the provider, the service users, and commissioners.

Service Specification for: Derby City Mental Health Day Services

1 Background

This service is to be understood in the context of the social inclusion and emerging well-being strategy[1] of Derby City Council and Derby City Primary Care Trust[2]. The Commissioners have ambitions to deliver a range of Mental Health Services based on the recovery approach and social inclusion principles. National Guidance[3] has been issued to commissioners for the provision of "day services". For service users a community opportunity service is considered essential to them achieving and maintaining **independent living**. Additionally, service users identify the key roles of a service to maintain mental well being, and to assist in recovery and rehabilitation.

In Derby, service users have led an extensive consultation on what people would like to see from a day service. They have produced a service specification and we have drawn extensively from that work. **See Appendix A** for the full service user service specification details.

Use of the term 'Day Services' is in many ways misleading as this implies a day-time service, based in one building.

There are currently two funded services in Derby, one statutory by referral only, the other a non-referral service operated by the voluntary sector. These are respectively the Social Intervention Recovery and Rehabilitation Team (SIRRT) and Derbyshire Mind Day Service. User Focused Monitoring service undertook a review of these existing providers *only*, in 2005/06 **Appendix B**.

2 Commissioning Intentions

The Commissioners are looking for a provider with expertise and proven capability of working with people experiencing mental health difficulties and facing a range of issues related to social exclusion. We would like to see an organisation with a vision and entrepreneurial dynamic approach which will be able to bring in further funding and forge partnerships to extend opportunities.

3 Principles

The principles for commissioning day services are copied verbatim from the National Guidance below. "Delivering services in a manner that addresses social exclusion and promotes inclusion, requires the provider to have a pro-active approach to developing partnerships and seizing opportunities across the community. It is essential that the service grows beyond the confines of a "Mental Health Service Ghetto". The service should foster a sense of hope, and should aim to be operated by service users"[4].

'Key principles for refocusing day services'

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[1] Commissioning framework for health and well being DH 6 March 2007,Strong and Prosperous Communities 2006, Derbyshire Vision for MH Services 2007

[2] Described in the rest of this specification as the commissioners

[3] "From Segregation to Integration" Commissioning Guidance on Day Services. 2006 from www.socialinclusion.org

[4] This may mean a phased movement. There needs to be **empowerment and support** for service users to operate and run services

Current policy and guidance includes a number of common principles that commissioners should observe in the refocusing of day services:

3.1 ***Promote recovery*****:** enable people with mental health problems to maintain and/or rebuild meaningful, valued and satisfying lives in the face of ongoing mental health problems.

3.2 ***Focus on community participation*****:** support people to access existing opportunities in their local community rather than creating segregated activities, and to increase the capacity of communities to accommodate those with mental health problems.

3.3 ***Reduce social isolation*****:** provide people with opportunities to extend their social networks and form relationships not only with other people with mental health problems, but with people outside the mental health system.

3.4 ***Provide opportunities for people with mental health problems to provide each other with support and run their own services*****:** increase the extent to which services that are led and run [5] by people who have mental health problems themselves - people who have successfully rebuilt their lives with such difficulties are often in the best position to help others to do likewise.

3.5 ***Maximise choice and self-determination*****:** enable people with mental health problems to determine *what* is provided via user led services and enable individuals to make choices about the things they wish to achieve, the type of support they require to achieve them, and to facilitate inter-dependence.

3.6 ***Meet the needs of diverse groups*****:** address the diverse needs of different groups within the population, especially those who have historically been poorly served such that services are sensitive to age, gender, ethnicity, religion, sexual orientation and disability.

3.7 ***Ensure that services are accessible to people who are more seriously disabled by their mental health problems*****:** meet the needs of people with a range of problems including those with more severe and enduring difficulties who may require a relatively high level of support on an ongoing basis.

3.8 ***Involve users and carers*****:** maximise use of the expertise of those with personal experience of mental health problems in designing and developing services, including those who are not currently using existing day services because they find them inaccessible or, as currently constituted, fail to meet their needs.

3.9 ***Increase diversity of provision*****:** to fully recognise the ability of the voluntary and independent sector as providers in addition to traditional statutory services.

3.10 ***Improve cross sector working*****:** ensure integrated, participative working not only across statutory and voluntary providers of mental health and social care, but also across services outside the mental health system for example:

- faith groups
- minority ethnic community organisations
- libraries
- employers and employment organisations
- colleges

[5] A distinction has been drawn here between a 'user led' service - in which service users make decisions about what should be provided and how, but the actual service may be provided by non-users; and a 'user run' service – in which service users provide the service.

- the full range of providers of sports and leisure activities.

4 Key Functions of Day Services

There needs to be a comprehensive range of day service provision designed to promote recovery, rehabilitation, social inclusion and self-determination and to decrease social isolation. These should fulfil four key functions:

4.1 *Provide opportunities for social contact and support*

Research among those who use day services suggests that having somewhere to go during the day and the opportunity for social contact and peer support on a drop-in basis are the most highly valued elements of current day care 'packages'[6]. Statutory mental health services have moved to a model more focussed on short term interventions for those most severely mentally ill. This has left a deficit of support as service users move into rehabilitation and recovery.

4.2 *Support people to retain existing social roles, relationships and existing social/leisure activities that they value*

When people develop mental health problems, or experience an acute episode/hospitalisation, their social roles, relationships and activities are placed at risk[7]: too often they lose their job or place in education, many friendships are lost and social activities are never resumed. Retaining existing roles is both easier and less damaging than regaining them once they have been lost and is an important secondary prevention role within both primary and secondary mental health services. Not withstanding the alleviation of distress by pro-active interventions, it represents the most efficient use of resources.

4.3 *Support people to access new roles, relationships and mainstream social and leisure opportunities of their choosing*

Many people who currently use day services have already lost contact with many friends, former work colleagues and even family. They spend much of their time alone, with few activities to fill their time[8]. Day services should play a critical role in promoting valued social roles, relationships and activities within mainstream community facilities and organisations. This not only improves the quality of life for the individual and aids recovery but it serves to gradually increase the capacity of the community to accommodate people with mental health problems.

Knowing people with mental health problems - living, working and pursuing leisure activities alongside them - is key to reducing fear, ignorance and discrimination – the "stigma" that is still attached to mental illness.

4.4 *Provide opportunities for people with mental health problems to run their own services*

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[6] Caan, W, et al (1996) Auditing psychiatric day hospitals. The users' views in an inner city setting, *Journal of Mental Health*, 5, 173-182; Holloway, F. (1989) Psychiatric day care: The user's perspective, *International Journal of Social Psychiatry*, 35, 252-264; Malpas, G. and Weekes, J. (2002) *An investigation into drop-ins: Exploring the impact of peer support*, London: Mental Health Foundation (Strategies for Living Programme).

[7] Buchanon, J. (1995) Social support and schizophrenia: A review of the literature, Archives of Psychiatric Nursing, 2, 68-76; Holmes-Eber and Riger,(1990) Hospitalisation and the composition of patients' social networks, Schizophrenia Bulletin, 16, 157.

[8] See Social Exclusion Unit Report *Mental Health and Social Exclusion* (ODPM, 2004).

People who have themselves used mental health services can bring their expertise and experience to the provision of day services. Many service users particularly value help from others who are, or have been, in a similar situation: this can inspire hope, self-belief and confidence[9]. In addition, user run services can provide valuable ongoing social support.

5 Outcomes

The table below describes the outcomes identified within the Commissioning Guidance. It also suggests ways in which these outcomes could be demonstrated. This will form the basis of evaluation and subsequent monitoring of "the service."

It is recognised that some of these outcomes may be at this time be aspirational but careful monitoring of qualitative information should be able to demonstrate real progress or improvement in the circumstances of service users.

Key Outcome Areas	**Outcomes identified in Commissioning Guidance**	**Suggested ways for services to demonstrate outcomes**
5.1 Move towards individualised Recovery Plans	Assessments to include social roles and activities Care/Recovery Plans which also address the maintenance of existing social roles	Evidence of person centred approach (Mattingly and Bates)[10] in; • Individual assessments at the start of service involvement • Care / Recovery Plans that are revised at an agreed frequency or at the service users request • Crisis planning • service philosophy • staff training plans • use of Advance Directives • Number of people offered Direct Payments • Measuring Well-being • Improved physical health • Diet • Exercise • Smoking • Weight problems

[9] Young, S.L. and Ensing, D.S. (1999) Exploring recovery from the perspective of people with psychiatric disabilities, Psychiatric Rehabilitation Journal, 19, 55-62.

[10] **Mattingly, M and Bates, P (2002)** How are we doing on person- centred planning? Manchester: National Development Team

Key Outcome Areas	Outcomes identified in Commissioning Guidance	Suggested ways for services to demonstrate outcomes
5.2 Recovery Plans demonstrate an increase in the number of service users engaged in mainstream activities	The number, variety and composition of social networks outside mental health services Engagement in mainstream activities and roles Increased frequency of engagement in mainstream social and leisure activities	Baseline community mapping carried out identifying services as RED, AMBER or GREEN (Bates 2006)[11] and agreement reached regarding the appropriate profile to meet local need Yearly mapping reviews shows that agreed profile is achieved with an increase in number of people accessing Green services where appropriate
Year on year increase in people accessing leisure, education and employment (voluntary or paid)	Increased amount of time spent in mainstream settings A majority of activities/opportunities provided by the service are based in mainstream integrated settings Reduction of people on community team caseload not involved in meaningful occupation as defined by service users Increase in the number of people already in paid work who can maintain it with support Increase in the number of people supported in paid work Increase in the number of people	Recovery Plan audit show increase in individuals accessing GREEN services Partnership agreements with mainstream community organisations. Number of activities delivered in partnership with other organisations Using the Inclusion WEB[12] to demonstrate number of people accessing; • Leisure • Volunteering • Education • Faith/cultural groups • Arts and culture • Family and neighbourhood • Employment

[11] **Bates, P Gee, H Klingell, U Lippmann, W (2006**) Moving to Inclusion, Mental Health Today, 16 – 18.

[12] **The Web** is a Life Domain base device that can help people to map their lives in relation to the things they do and those they know. This web log links those interested in using this visual tool. http://uk.groups.yahoo.com/group/TheSocialInclusionWebGroup/

Key Outcome Areas	Outcomes identified in Commissioning Guidance	Suggested ways for services to demonstrate outcomes
	supported in mainstream education /training Increase in the number of people supported in voluntary work Targets set for people with established mental health problems skilled to work in local social firms. Targets set for people obtaining work (either part time or full time) in local social firms.	*Measurements to be agreed*
5.3 Year on year increase in service user led and run services, (with support provided as necessary)	People who use the services are involved in monitoring and evaluating the performance of the service Service users/ex-services users are at least equally represented on organisational boards Service users/ex service users are employed in mental health services Public services' employment policies reflect commitment to employ service users	Number of services commissioned which are service user (or ex-service user) led or run Number of service users skilled to lead and run services, ready to respond to opportunities as they arise. Number of service users (or ex-service users) skilled to be employed by service Number of service users (or ex-service users) on management committees /organisational boards *Measurement to be agreed*
5.4 Increased satisfaction with services	Improved quality of life Improved satisfaction with social life	Increase in the number of engagements with "new" service users User satisfaction measures Quality of Life measures User focused monitoring, user led evaluations –including reasons some service users are not engaging with

Key Outcome Areas	Outcomes identified in Commissioning Guidance	Suggested ways for services to demonstrate outcomes
		the service. User only meetings Surveys of user views to discover : • Why some service users do not engage with day services • If service users feel the degree of their mental health difficulties is recognised and services fully able to meet their varying needs • If service users feel they are respected and valued; and that they are fully engaged in decision making over their individual care and feel empowered within the organisation.
5.5 Increase in cultural, gender, age, disability, lesbian, gay and bi-sexual sensitive services		Year on year increase in • Younger people accessing the service • Older people assessing the service • BME communities accessing the services • Women accessing the services Satisfaction surveys specifically aimed at marginalised minority groups (including the LGBT community), and women Local needs assessment Equality impact assessments Service specifications which meet local needs and local inequity
5.6 Added value		The provider is expected to demonstrate the areas in which they are able to 'add value' to the service being provided under this contract.

6 Eligibility Criteria and Referrals

6.1 The service is for Adults (18+), who have a diagnosed mental illness or dual diagnosis and people who identify they need support in **improving their well-being**. Referral will be by an open referral system (with consent of person being referred).

6.2 *This* service does not provide a clinical or treatment service. It is not a social crisis resolution service. It *does* aim to **help people with independent living – to aid and empower people in rehabilitation and recovery from mental health problems.**

6.3 The eligibility criteria are intentionally broad to ensure an inclusive approach. Service user consultations evidence they do not want rigorous exclusion criteria. However, there should not be a waiting list for service users with enhanced needs, i.e. those with more severe mental health problems, where a consistent recovery approach and effective leadership is needed.

6.4 The service will accept self-referrals on the basis that people identify they have needs that can be met through the service. **Appendix C** sets out the adult mental health services care pathways in Derby.

6.5 The emphasis for all people accessing the service will be on identifying a Care or **Wellness Recovery Action Plan (WRAP)** to identifying what steps the person wishes to take to forward their rehabilitation and recovery, and what elements are appropriate within the service to assist with this (or to sign post and help to access help elsewhere where more appropriate).

6.6 It is expected that people's aspirations and needs will be identified in discussion with them at the outset and at regular interval points, or at anytime at the service user's behest. Tools such as the Web must be used by the provider as a way of identifying inclusion needs and progress. Monitoring and evaluation of the service will include data obtained on the achievement of outcomes based on this process. The regular review of needs and the focus on outcomes will enable a balance to be maintained between time limited support provided to some people and time unlimited support for others as their needs prescribe.

7 Individualised Support

7.1 The basis of the service is providing individualised support based on person centred planning or WRAP for people who access the service. Some individual work for people on CPA is already provided by the Community Support Workers (CSW's) integrated within the statutory Community Mental Health Teams (CMHT's).

7.2 People accessing the CMHT should be provided with a support time and recovery service from the CSW's.

7.3 It is essential that effective mechanisms are in place in partnership with the CMHT's to co-ordinate individual support services between day service provision and the time scarce resources of the CMHT's.

8 Spectrum of Services- Buildings

8.1 Whilst most activities have historically been buildings based, creating a "ghetto" identity, there has been a move welcomed nationally by mental health organisations, to activities being held in mainstream community provision such as libraries, colleges, sports centres, ethnically specific venues, Arts venues etc.

8.2 There will need to be a balance between buildings based and community based activity. "A day service does not necessarily require a dedicated building or centre. It

is the function of day services in maintaining and extending social networks and access to mainstream roles and activities that is critical". [13]

8.3 There should be a spectrum of services. In an ideal situation the service provision should aim to be (in the traffic light system devised by Peter Bates of the National Development Team) increasingly green[14]. However, there may be the need for some "red" areas where the safety of service users and /or others is required. Where there are buildings specifically dedicated, care must be taken to ensure a balance between building based provision and delivery offsite.

8.4 Any buildings should be considered a community resource; open to other community services supported or funded by the Council or PCT, for example adult continuing education, teams/employment services, arts groups, self –help groups etc. Other community organisations providing mainstream activities should also be welcomed, providing that their activities are ordinarily open to people with mental health difficulties, and that this adds value to the overall service available.

8.5 There are some people with mental health problems who wish to have a safe environment to socialise. The demand for an accessible, friendly, safe venue free from pressure should not be ignored. There should be a recognition that the service is open to people with varying degrees of mental health problems, and at different stages of recovery.

8.6 Service users in Derby have discussed and described their ideal form of building. **See Appendix A**

9 Out of Office Hours Provision

Consultation with people using the service says that it is something they value. The provider will be expected to offer services across a range of hours and days consistent with the aims of the service. Mental health distress is not confined to 9-5 Monday to Friday. Service users evidence their greatest needs often occur outside the hours of traditional statutory providers.

10 Development of the Service

10.1 It is not expected that the core funding for this service from Social Services and PCT budgets will rise, however further development of the service is anticipated through:

a) Pro-active development of volunteer support
b) Development of social enterprise
c) Pro-active promotion and the use of direct payments
d) Attraction of funds from other sources ie Job Centre Plus, European Social Fund etc
e) Joint Activity with other partners for example colleges, Learning Skills Council (LSC) etc

10.2 For service users **Social & Cultural Opportunities** are essential to achieving and maintaining independent living. We expect the service therefore to **develop strong partnerships with those organisations necessary for achieving this objective.**

10.3 Whilst the service is not a housing provision support service, there is an expectation that the service will work with the Supporting People Team at Derby City Council and

[13] "From Segregation to Integration" Commissioning Guidance on Day Services. 2006 from www.socialinclusion.org
Bates, P. et al op cit (2006,) http://www.socialinclusion.org.uk/publications/

supported housing providers. Sharing of resources with such providers is a further way in which the service may be delivered more effectively.

10.4 **One outcome that will be monitored is the number of partners for the project defined as *"organisations that provide additional money, staff time, buildings, or services."***

11 Diversity

11.1 In accordance with the guidance for commissioning day services for women, there should be the provision of discrete groups and opportunities for women. Existing service users also saw this as being important. The links between sexual abuse/domestic violence and poor mental health are clear. The service should provide support (or assist in accessing support) to women who have experienced such damaging experiences.

There must be evidence of good partnership working with organisations working in this field.

11.2 It is expected that the service will work proactively with Community Development Workers (CDW's) employed by the PCT, based at Derby Millennium Network, in developing appropriate partnerships and opportunities for minority ethnic groups. This should enable access to more ethnically appropriate supportive groups in Derby and elsewhere.

12 Staffing and Ethos

12.1 "Effective leadership of services is key to the successful implementation of change, particularly in fostering a sense of optimism and possibility in staff: A focus on possibilities and solutions to problems rather than deficits and dysfunctions".[15] The staffing profile of the service must reflect the aspirations of a recovery approach and that of an inclusive service. This will require an appropriate skill mix. It is expected that in addition to a core staff team funded through this contract, staff time should also be sought from other agencies and funding avenues. Volunteers should be a significant part of the service and it is expected that service users will be employed by the service.

12.2 In a consultation exercise led by Derbyshire Voice in Derby, service users have produced the following checklist of their expectations of staff:

Staff will:

- Believe in recovery
- Be caring and understand
- Have empathy
- Be respectful
- Be committed
- Have life experience
- Be helpful
- Understand trauma
- Be flexible
- Know Derby
- Respect diversity
- Have knowledge of social inclusion
- Be able to listen

[15] From Segregation to Integration" Commissioning Guidance on Day Services. 2006 from www.socialinclusion.org

- Be considerate
- Be able to signpost
- Show humility
- Manage their own stress
- Be enthusiastic
- Be motivational
- Inspire
- Prioritise people over paperwork
- Be open with information
- Take responsibility
- Be trustworthy
- Respect confidentiality

12.3 Staff should above all treat every service user as an individual and an equal. The Care Service Improvement Partnership (CSIP) is shortly to publish a social inclusion capabilities framework. We would expect that organisations will devise staff development plans to ensure the workforce can meet social inclusion capabilities. We expect training to be clearly linked to the Ten Essential Shared Capabilities. This will be one of the agreed monitoring points in the contact.

13 Transport

Service Users have identified the critical importance of enabling them to access public transport. This will require working with service users to have the confidence to use buses. Only in exceptional circumstances and for limited periods should service users be transported to this service by transport belonging to the service. This does not preclude the use of transport belonging to the service or outside agencies being used to aid service users to initially access offsite facilities.

14 Direct Payments[16]

14.1 The Council wishes to increase the uptake of Direct Payments. The use of Direct Payments is currently very low. The service provider will be expected to support the uptake of direct payments through:

- Information on direct payments
- Support to consider a direct payment
- Support with self-assessment
- Advocacy
- Working with the direct payments support service
- Ensuring that service users are able to purchase elements of the day service via direct payments
- Working with the City Council and the Mental Health Direct Payments group on joint activities.

14.2 **N.B. Over an agreed period of time core funding will change. We will be moving to an increasing balance of funding via Direct Payments and a reducing core in real terms or as a percentage of the whole service.**

15 Community Mental Health Teams (CMHTs)

[16] **Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) Guidance** England 2003 Department of Health

15.1 Derby has integrated Community Mental Health Teams CMHTs. These teams host the Community Support Work service - see individualised support Paragraph 7 above. Care coordination is the responsibility of these teams and they have the delegated responsibility for assessments under the Community Care Act. It will be important to work closely with the CMHT to promote effective care planning, risk management (including positive risk taking), and access to Direct Payments, and as seamless a recovery pathway as possible.

15.2 The role of Occupational Therapists within CMHTs is being developed across the City. It is important that close links are established with the community OTs who have particular skills to offer this service.

16 Primary Mental Health Care

16.1 The Provider will be expected to work with primary mental health care commissioners on how the service can be integrated with the local primary care service. For example:

- The use of a room in the building for access to a computer for web based self-help Cognitive Behaviour Therapy CBT for those who are unable to access it at home.
- Provision of groups on relaxation, sleep hygiene, how to manage stress and self-help group development activity with Primary Mental Health Care Workers.
- The development of Health Trainers whereby service users become trained volunteers to support other people accessing physical health care.
- Exercise on prescription

16.2 The Primary Care Mental Health model is still under development however it is the intention of the draft model to ensure over time increased access to psychological therapies. Many people with mental health problems experience social isolation and exclusion. A key role of the service is to enable service users to engage or re-engage with community opportunities, such as education, volunteering, employment and leisure facilities. In Derby we believe this service is well placed to develop such a service through partnership activity.

17 Vocational Support

Derby has been a pilot site for Pathways to Work. There are a number of job brokers, support services, and other schemes available to help people overcome the 'barriers' to work. Job Centre Plus and the Condition Management Team are seen as key partners in the development of the service. It is a **requirement** of this specification that the service works to maximise opportunities within the Pathways to Work programme and in particular that there are opportunities within the service for people to consider employment, voluntary work and permitted work. (Whilst this *is* a requirement, service user consultation doses not evidence this as a priority for them.)

18 Adult Education

The current service has developed links with the LSC and local education providers. This is an aspect of the service particularly praised by those service users consulted in Derby and they would like to see this developed further. It is expected that the

service will work with local colleges and adult education providers to expand the aspirations and opportunities for service users.

19 Monitoring and Evaluation

19.1 The Service will work to the agreed outcome related indicators. The Commissioners will set these in consultation with the provider and service users. An Advisory Group will be established for this purpose and its subsequent development. The identification of demonstrable progress is integral to the Monitoring and Evaluation process.

19.2 The Advisory Group will meet on a quarterly basis.

19.3 One of these meetings should be the Annual Review, held during September/October/November. A Mental Health Commissioning Team member will attend this meeting.

19.4 The third quarter Advisory Group meeting might decide to ask the Provider to carry over funds into the following financial year and offset the amount against usual funding or if additional funding has been agreed by the commissioners that the invoice is amended to reflect additional income.

19.5 The Advisory Group will be made up of representatives from:

- Senior Manager Provider Organisation
- Derbyshire Mental Health Trust General Manager
- Mental Health Commissioning Team
- Two or more people who use the service
- Any other organisation in partnership, providing staff, finance or resources to the service
- The Provider Project Manager will attend, act as secretary and provide reports to the Advisory Group

20 Over an agreed period of time core funding will change. We will be moving to an increasing balance of funding via Direct Payments and a reducing core in real terms or as a percentage of the whole service.

Bibliography and References

i) **Modernising Day Services-A Checklist For Providers Wanting To Bring About Change** Available in two versions, for commissioners and providers, **http://www.socialinclusion.org.uk/publications/Modernisationchecklistproviders.doc?zoom_highlight=checklist**

ii) **Where are you at? A benchmark for modernising mental health day services (CSIP NW) from http://www.socialinclusion.org.uk/publications/Benchmarkingtool.doc?zoom_highlight=where+are+you+at%3F**

iii) **Redesigning Mental Health Day Services - A Modernisation Toolkit for London**. You can download a PDF version of this document from the Mental Health Foundation website **www.mentalheath.org.uk**

iv) **Vocational services for people with severe mental health problems: Commissioning Guidance http://www.socialinclusion.org.uk/publications/DOH_Vocational_web.pdf**

v) **Vision statement for Mental Health services. 2007. Available from Lynn.Lunn@derbyshirecountypct.nhs.uk**

vi) **"From Segregation to Integration" Commissioning Guidance on Day Services. 2006. from www.socialinclusion.org**

vii) **The Social Exclusion Report (ODPM) 2004 from www.socialinclusion.org**

viii) **Extensive guidance on mental health social exclusion is to be found on www.socialinclusion.org**

DEFINITIONS

The Commissioners	Derby City Primary Care Trust (PCT) & Derby City Council.
The Provider	The Provider organisation that is responsible for delivering the service
The Service	Provision of **Social And Cultural Opportunities For People Recovering Their Mental Health In Derby City** as described in the Specification for the Service
Advisory Group	Management representatives of the Council, PCT, people using the service, Provider and other partner agencies
Care / Recovery Action Plan	Document describing an individual's assessed needs and aspirations linked to life domains how these will be met within the service.
Care Programme Approach (CPA)	The Care Programme Approach is the name given to the care planning and reviewing process employed within NHS provided Mental Health services. The Manager with responsibility for the CPA in Derbyshire is Wendy Slater. Contactable on Wendy.slater@derbysmhservices.nhs.uk
Community Mental Health Team (CMHT)	Community Mental Health Teams are multidisciplinary teams of staff jointly provided by the local authority and Derbyshire mental Health Trust. They are responsible for undertaking the Council's statutory responsibilities for assessment and care planning.
Community OTs	Within the CMHT there are Occupational Therapists who work with people in community settings
CSCI	Commission for Social Care Inspection The website address is www.csip.org.uk
CSIP	Care Services Improvement Partnership.
Derby Millennium Network	The Derby Millennium Network (DMN) is a Black-led initiative that aims to bring together and support Black & Culturally Diverse (BCD) Community groups in Derby and Derbyshire. Normanton Rd, Derby, DE23 6RH - 01332 206520

Derbyshire Voice	An independent company, which promotes and supports the views and opinions of receivers of mental health services. They aim to ensure that people have real, meaningful involvement in the way that mental health services are both provided and developed throughout the county. http://www.derbyshirevoice.co.uk/
Learning Skills Council (LSC)	The LSC is responsible for planning and funding high quality education and training for everyone in England other than those in universities. The LSC East Midlands works regionally and locally to make the East Midlands better skilled and more competitive. http://www.lsc.gov.uk/regions/EastMidlands/
Mental Health Commissioning Team	The jointly funded Derbyshire Mental Health Commissioning Team located at Derbyshire Country PCT, Parkhill, Hilton Road, Egginton, Derbyshire DE65 6GU. This team provides a lead mental health commissioning role for Derbyshire and Derby City PCT and Derbyshire County Council. There is a collaborative arrangement with Derby City Council
Derby PCT	Derby City Primary Care Trust
Person with mental health difficulties	Person of adult age diagnosed by GP, or receiving support in secondary mental health care services -
Primary Care staff	Staff working at GP practices or working for Derby PCT . For clarification contact Georgina Horobin at the Mental Health Commissioning Team as above.
Staff	Paid employees of the service provider, this would include volunteers or service users, when they have some responsibility for running/delivering of the service.
Provider Project Manager	The local manager employed by the successful organisation with responsibility for managing the local service
Service Specification	Document detailing the range of services to be provided within the contract for **Social And Cultural Opportunities For People Recovering Their Mental Health In Derby City**
Ten Essential Shared capabilities	The Ten Essential Shared Capabilities, developed in consultation with service users and carers together with practitioners, provide in one overarching statement, the essential capabilities required to

	achieve best practice for education and training of all staff who work in mental health services. The competencies document can be downloaded at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169
Social Firm	'A business trading for a social purpose. Any profits are principally re invested to achieve stated social and / or environmental objectives'. See www.socialenterprise.org.uk for further information.

APPENDIX A

Service User Consultation for Derby Day Services

Background

There were two providers of Day Services in Derby City in 2005, the Social Inclusion, Recovery and Rehabilitation Team (statutory); and Derbyshire Mind (voluntary sector).

The PCT ("The Commissioners") decided to review the provision of day services commencing in December 2004 following the publication of the "Social Exclusion Report" by the Office of the Deputy Prime Minister (2004) www.socialinclusion.org

An initial consultation event was held at "The Spot" in Derby on the 22nd Feb 2005. Of particular concern was that existing day services were not meeting the remit of the report, and that the majority of service users were not engaging with day services because either they did not meet the criteria of the referral only statutory service or they did not feel that the day services in general, as then constituted, met their needs and aspirations.

Statutory mental health services have focussed increasingly on the severely ill with time limited interventions through early interventions in psychosis teams, assertive outreach teams and crisis and home treatment teams. Some acute wards have been closed. As a result, there has arisen a vacuum of provision for people suffering from mental health problems, sometimes enduring, within which they can rehabilitate, recover and re-integrate into the mainstream community.

The general remit of the Social Exclusion Report is that people with mental health problems are stigmatised, suffer from social isolation and are excluded from the community. Traditional "treatment" models have been exercised within a mental health "ghetto" which suffocates empowerment and recovery and impedes re-integration into the "mainstream" – whether that is in relationships, leisure, education and training or work. It recognises that a move to "mainstreaming" of provision is the key to begin to break down the stigma attached to mental ill health.

Prior to the Consultation event of February 2005, Derbyshire Voice had advertised the event though their service user representatives to as many people as possible. These included acute wards, the day hospital in Derby, through the case load of the Community Mental Health Teams, through GP surgeries, the various support and self-help groups, via the members of Derbyshire Voice itself, through Residential Care Homes, and in community settings generally who had an interest in mental health, including homeless shelters. The event was also advertised through the existing two day service providers.

The event was very well attended. Over 90 people attended. Significantly 90% of those attending did not currently use day services. Through a series of syndicate groups their views formed the basis of this first consultation.

A "day service group" was formed which included six service user representatives and six representatives from the Commissioners, Social Services and the managers of the existing day services. This group met monthly and a newsletter was published to keep service users informed of the progress.

The second element of the service user consultation was the production of a very detailed questionnaire in tick box format which asked service users what *they* wanted provided. The questions were provoked by the responses to the 1st consultation. 1,500 of these 6 page questionnaires were produced and distributed to those identified above. Representatives of Derbyshire Voice went out to various locations to aid service users complete the questionnaires if help were needed. The questionnaires were analysed by the group in conjunction with the views expressed on the first consultation event.

The third part of the service user consultation (APPENDIX B) was performed by User Focussed Monitoring. These were face to face interviews but concentrated *only* on those service users who attended existing day services.

The exercise in service user consultation was unprecedented and held up as best practice. Notetably it had a 6/6 spilt on the steering group.

All the information was collated and presented to service users at a second public event. This was not a consultation event but to inform service users of the specification the group had decided to endorse.

The remainder of APPENDIX A details this specification

Proposal for the future of Mental Health Day Services in Derby City

“The service should be made to fit the people using the service rather than people having to fit into the service.”

Who is it for?

The service is for people who have a diagnosed mental illness or dual diagnosis and people who believe they need support with their mental health. People who attend do not have to have a psychiatrist and clinical diagnosis or be permanently off work.

People that use the services must be resident in Derby City, over 18 and under 65.

Referral to the service can be made by paid workers with an individual's permission or people can refer themselves directly to the service.

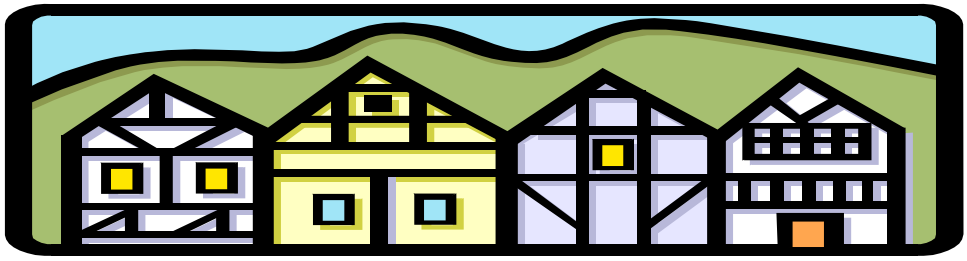
An assessment of each persons needs will be made before they receive services and an appropriate support package designed around them.

Inclusion in services will then be subject to a short probationary period with a review of services being received every four months or sooner on request or if needs change.

Where will it be?

The Derby day services will be facilitated from one centre/base but will be very strongly linked in with other services and the local community. It is hoped that as much will happen out of the building as inside it but it is from here that things will be coordinated.

The Building



Service users will be involved in the choice and planning of the building from the initial stages (not just asked what shade of green they would like the walls painting!)

The image and appearance are of importance. The building should blend in with the local area, be sympathetic to surrounding architecture and not appear like a traditional day centre.

The building should not be at all clinical. It should be modern, interesting and attractive.

There should be potential for the service to grow in future years – extra land or space should be available.

Obvious signage relating to mental illness should be avoided.

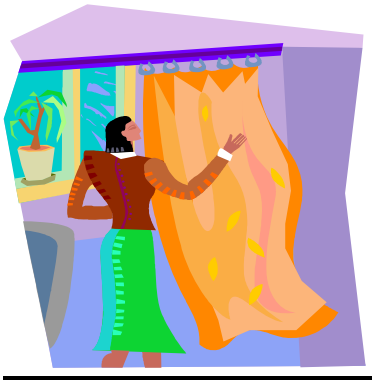
Location

Located in Derby City

Within minimal walking distance of the city centre

In a “safe” area

The environment



The building should invoke a strong sense of ownership and identity. Service users need to be involved in the interior design and purchasing of furniture and fittings.

There should be a maximisation of natural light. Artificial light should be subtle and relaxing. Portable SAD lighting should be available.

Ventilation should be of importance and natural air from windows that open prioritised.

The building should be kept fresh and clean but a clinical environment should be avoided.

The building should be fully compliant with Disability Discrimination Act regulations. No areas of the building should be inaccessible to users or exempt from these requirements.

Furniture should be fit for purpose but should not look like traditional “day centre” furniture.

Notice boards, NHS clocks, duty rotas, posters and leaflets should be replaced by paintings, art work and plants. Signage should be kept to a minimum with health and safety information being the exception.

External facilities

Adequate parking for service users, staff and visitors.
A bike shed
Seating
A barbeque area
A horticulture/gardening space
A semi covered area

Rooms

There should be enough rooms and spaces so that all activities can take place in

their own designated area.

Soundproofing is of extreme importance between rooms to ensure activities do not infringe on each other and so that confidentiality can be maintained.

The lay out and placing of rooms should be considered in conjunction with service users.

Areas that should be included are:

- A drop in/open access communal area which is the hub/centre of the building. This should be open at all times to all users of the service and activities must not take place here.
- A café/dining area with kitchen attached for the provision of hot meals.
- A training kitchen for use by service users working on life skills for use in conjunction with OT
- A non alcohol pub/juice bar/games room – for pool, darts, card playing, board games, music, socialising.
- A studio for physical activities such as dance, tai chi ,yoga, relaxation, aerobics
- Small rooms for consultations, depo administration, appointments, interviews.
- A crèche/family centre with a separate entry that can be used by service users and staff.
- An arts, design and crafts room
- A treatment room for reflexology, acupuncture, massage
- An information/resource room with a library and computer access.
- A smoking area situated on or near the outside of the building.
- A staff area with lockers, lounge furniture and an office. (This must be situated near the communal area.)
- Plenty of male and female toilets
- A changing area with provision of a shower and hairdryer.

Staffing

Service users should be involved in the process of staff selection from interviewing to appointment and induction.

Staff use of mental health services should be seen as a positive addition to the experience they bring to their job.

The staff team should be managed by an organisation that is non hierarchical and equity/equality in this team is of great importance.

A dynamic and robust support structure should be put in place for all workers to ensure performance is maintained, they are valued as individuals and that staff turnover is minimised.

All workers will:

Believe in recovery, be caring, understand, have empathy, be respectful, be committed, have life experience, be helpful, understand trauma, be flexible, know Derby, respect diversity, have knowledge of social inclusion, be able to listen, be considerate, be able to signpost, show humility, manage their own stress, be enthusiastic, be motivational, inspire, prioritise people over paperwork, be open with information, take responsibility, be trustworthy, respect confidentiality and above all treat every service user as an individual and an equal.

The staff team

Cleaners

Catering staff

A manager

An external coordinator – To promote opportunities outside of the day centre. With responsibility for coordinating staffing for people to use non day service services and facilities. To coordinate assessment process.

A centre coordinator – To organise activities within the centre and coordinate the staff to support these. To coordinate assessment process.

Support workers to support people both at the centre and in the community. To work as allocated link workers/key workers if service users wish to have one.

A qualified psychiatric nurse – to provide medical expertise, liase with clinicians and administer DEPO injections.

A benefits and welfare rights worker

Other workers

Although not part of the core staff team many other workers will come to the centre to provide services.

These may be workers who are already provided by statutory services or the voluntary sector e.g. advocates, psychologists, crisis workers, chaplains

Or subcontracted/sessional workers e.g. reflexologist, yoga teacher, art teacher

Groups

Groups will be run within the building. These will link on to groups that already exist or will be set up in the wider community. It is hoped that the confidence and knowledge of service users can be developed to the point where they access groups out of the centre when they are feeling well enough.

Groups will only be run by the staff team if they have particular expertise. Other professionals, self help groups and experienced service users will be used to facilitate in most circumstances.

Groups will be developed under direction of the people using the service.

Examples of groups that may be included;

Relaxation
Confidence building
Healthy living
Young people's mental health
Self harm
Abuse survivors
Personality disorder
Alcohol misuse
Anxiety management
Stop smoking
Depression

Lesbian and gay
Getting off prescription medication
Wellness and recovery

Getting back to work
Women's mental health
Campaigning
Lonely hearts

Activities

Activities will take place within the day centre building. Again these will be very closely linked with activities within the wider community so that service users can develop confidence to undertake activities independently or with worker support when they feel able.

Activities will be dictated by the service users rather than by staff choice or personal interest.

Activities may include;

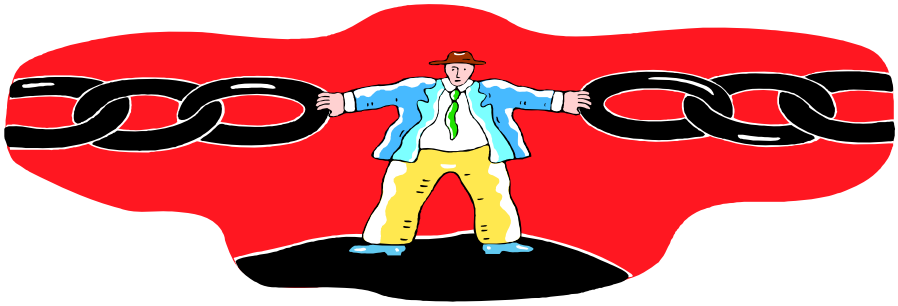
Yoga
Music appreciation
Walking
Acupuncture
Meditation
Swimming
Supported holidays
Aromatherapy
Cinema
Reflexology
Breathing
Massage
Dance
Voluntary work
Art
Cooking

Resources

It is of importance that the day service is adequately resourced in order to ensure that all groups and activities can take place.
The following is a list of items that would need to be included in the development.

A mini bus
A portable TV, video and DVD player
Cameras and a video camera
A music system
Kitchen and canteen equipment
Camping equipment
Yoga mats
Bar equipment and a hot water urn
Computers
Crèche equipment
Musical instruments
A library and up to date information resource
Craft and art materials
A barbeque
Plants
Pictures
Lighting and lamps
A therapy table
Garden tools
A shed
A greenhouse
A private payphone

Links with other services



Relationships will be established and maintained with numerous other agencies whose workers will provide specialist support to day service users.

Jobcentre
Dept Work and Pensions
Colleges
CMHT's
Crisis teams
Assertive outreach teams
A&E
Homeless services
Domestic violence groups
Rape crisis
Housing dept's
Housing agencies
Derby Friend
The women's centre
Multicultural centre
GP's
Primary care services

Review

There will be a review at regular intervals of the services provided from the daycentre. Service standards and quality assurance monitoring will involve service users at every stage and wherever appropriate be led by them.

Any subsequent action plans will be designed in conjunction with and monitored by service users.

Service provider

There will be a fair and open tendering process to find an appropriate service provider.

The selection will be led by the project group members who are not current or prospective service providers.

It is imperative that amongst other considerations service providers can evidence positive practice in the involvement of service users in the decision making process.

Documentation considered in the preparation of this proposal

Social exclusion report

Results from consultation day 22/02/05

User focused monitoring survey on Derby Day services

Best practice visits by the project team

NIMHE examples of day service considered best practice

Project team summary of findings

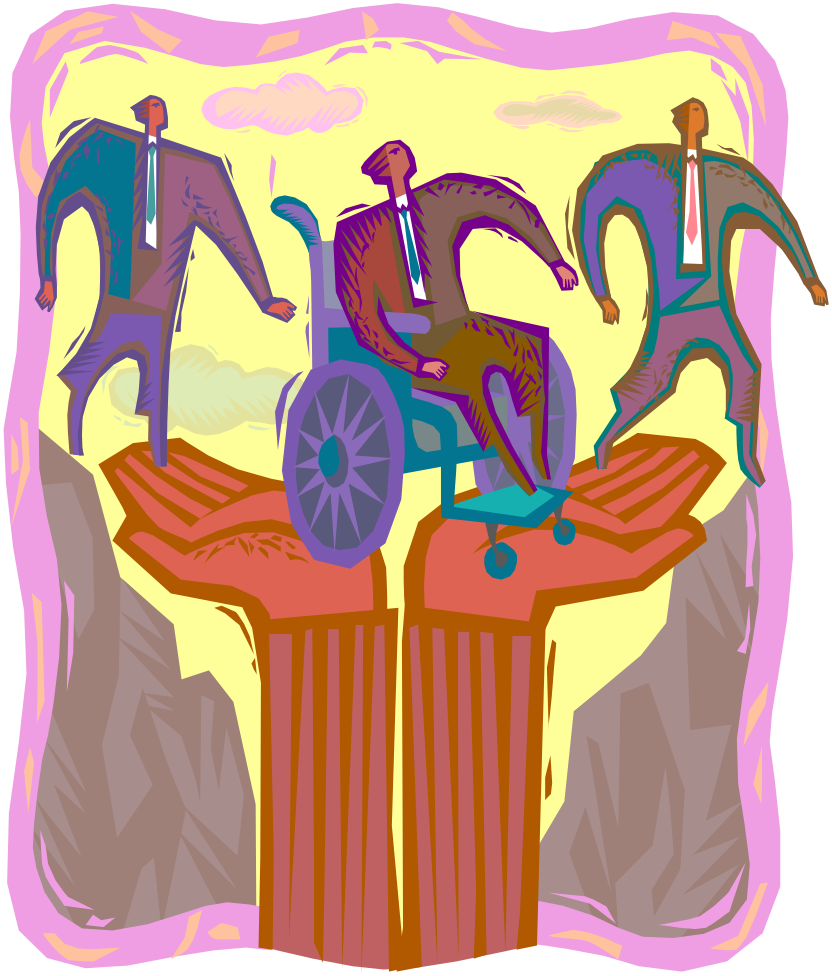
Derby city day services questionnaire results.

Proposal prepared by: Nancy Clements, Sharon Laing, Jonathan Norton, Carmen Ryder, Catherine Ingram September 2005

Appendix B

Day Service Qualitative Survey

User Focused Monitoring
Survey of People Who Use Day Services Across Derby



UFM
EIGHTH REPORT

JULY 2005

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Introduction

User Focused Monitoring projects usually originate from within the steering group or from the service user community. This survey was an external request. UFM was invited to support the multi agency project team that was investigating the service user needs and wants around day service provision within the city of Derby, and commission the Day Service Provision for 18-64 year olds.

UFM was asked to produce a plan and costing for carrying out a qualitative survey and submit to the project team for the beginning of March 2005. The go ahead for this was received before the end of April. Due to the time constraints of the Day Services Project Team we also had to complete our part within a deadline.

This qualitative questionnaire is the third part of a consultation process with service users. The other 2 parts were:

- A stakeholder day held at "The Spot" in Derby on the 22nd Feb 2005.

- A quantitative survey co-ordinated by Russell Mason for Clinical Governance of DMHST. 1500 questionnaires were distributed across the city at day centres, GP surgeries, Rehabs, Acute Wards and CMHT's.

As this was an additional project for UFM, and the wider project team would be producing a full report and recommendations, this UFM report does not have any action plan or recommendations but outlines what was done to support the project team.

Background

Day Services had for some time been under the spotlight from all the parties involved, Service Users and Carers, Mental Health Commissioners and the service providers whether voluntary sector or statutory. The model of Day Services in the city has not changed for some time. A mixture of services is provided either by the voluntary sector or the Derbyshire Mental Health Services NHS Trust. If people experiencing mental health issues are to remain in the community and recover, Day Services are one of the vital supports needed.

The **existing** components of Derby City **Day Services** comprise of:

- Resource Centre - day hospital for individuals either after discharge from the Psychiatric Unit or to prevent admission.
- SIRRT - Social Intervention Recovery and Rehab. Team
- Rosehill Centre - Derby MIND
- 63 Duffield Rd - Psychosocial and Psychodynamic Therapies
- Padley Centre
- Women's Centre

Project Process

A qualitative questionnaire and introductory letter were designed by the UFM team and then taken to the Day Services project team.

Questionnaire focused on whether people used day services, if not why not, if yes what they got from it and what could be better.

The letter asked the service user if they would be interested in being interviewed by UFM interviewers using the questionnaire. It explained that we are a user led team, supported by the Derbyshire Mental Health Trust and Mental Health Commissioners, to monitor services and feed back recommendations to improve them. The letter had a form and a self addressed envelope for them to return it if they were interested in helping us. The letter also highlighted that the questionnaire would be completely anonymous.

People either received the letter through the mail (90 service users from Brief Encounters project) or face to face at the day centres. Pre arranged days were organised with day centres for UFM interviewers to visit and talk to their clients.

Letters to take part in the survey sent out through the post were given four weeks for responses as to whether they would like to be interviewed.

Whether people were interviewed at the day centres or at home the co-ordinator then mailed the £10 reimbursement to the interviewee with a receipt form and SAE for them to acknowledge receipt.

1. Who was asked to be involved?

Service Users and patients (18-64 years) across Derby City. Invitation letters (approx. 250) either handed directly to individuals or through the post. Hopefully with a 20% success rate we would have 50 face-to-face interviews.

2. Where were people asked?

Letters sent to service managers asking if UFM interviewers could visit the centre. Responses were received from the centres listed below:

- 63 Duffield Rd - (Psycho-Dynamic therapy and Psycho-Social therapy)
- 74a Friar gate flats - (SIRRT)
- Rosehill Centre
- Resource Centre

Also invitation letters were sent direct to 90 individual service user homes (from Project 6 sample).

3. How were people involved?

Face-to-Face interviews using the qualitative questionnaire with UFM interviewers. These usually took around 30 minutes to do.

4. When were people involved?

- Questionnaire and Introductory letter designed by the end of Feb. 2005.
- Letter to service managers by end of Feb. 2005.
- Face to face interviewing March to May 2005.
- Feedback to Day Services project team July 2005.

Demographics and Qualitative Results

Q1a. Do you use any Day Service/Support Centre?

Yes = 46 No = 6

Which Day service?

Derby MIND	= 17
74a Friar Gate flats	= 17
63 Duffield Rd	= 6
Resource Centre	= 5
Pear tree	= 1
St Chads	= 1
Unknown	= 8

Q 6. How do you get to the Day Service/Centre?

Walk	= 22
Bus	= 10
Car	= 7
Taxi	= 7
Ambulance Car	= 2
Cycle or Motor Bike	= 1 each

Sex:

Male = 32 Female = 20

Age:

18 – 25	= 2
26 – 40	= 19
41 – 64	= 26
Over 65	= 2
Not stated	= 3

Ethnicity:

White	= 48
Mixed	= 2
Asian or Asian British	= 0
Black or Black British	= 2
Not Stated	= 0

Q1b. If no please give reason/comment.

- "Not sure of what is on offer. Places available do not meet my needs. The level of craziness is too much"

- Client finds it difficult to go out of the house due to panic attacks. Been told nothing suitable for someone like myself. Does not fit criteria.

- Referral to the Resource Centre for Anger Management, this made me more angry so I decided to do it myself.

- No contact, no information about existing day services.

- "Under my personal circumstances at the time of my discharge from 2 years as inpatient it was not thought to be appropriate. i.e. court case pending. This was a big leap from inpatient care back to home, which made me feel nervous and frightened"

The two main themes coming out of the above comments are choice and information. People needs and wants cannot be channelled into one or two types of day service. Also if people are not informed what, where and when day support is available then they will not use it.

Q2. What would need to be changed for you to use Day Services?

- "I was given a C.P.N. but other services including outpatient O.T. were not deemed to be in my best interest because of court case – needed to cope on my own for 12 months for case to succeed"

- "The way Doctors talk to you"

- "No idea whatsoever"

- Transport to be arranged to help her get there e.g. taxi or someone to accompany her on a bus.

- Website type things, centralised site.

- “More information”

Again information and access to day services need to be easily available and in a wide range of media for people to use. The specific services then need to be easily got to either by foot or by public transport.

Q3. What do you get at the Day service/Centre?

- Quizzes, Dominoes, games – meet people.

- “Fitness club, company, was doing computers but not since discharge from hospital.”

- “Have a meal 3 times a week”

- “Lunch that’s very limited”

- “Integrating with other people, or I feel isolated. Support that you get from staff that you don’t get at home”

- “I get help and support and would like that for always.”

- “I get company. I attend DM. The Padley Centre I only attend occasionally. Meals are better at DM.”

- “I attend SIRRT 3 times a week”

- “Breaks the day up, time passes, meal, people to talk with, games (darts, draughts, pool etc)”

- “Communication, talk, outings, games, darts, snooker, cards, good meals at reasonable price.”

- “Free meals, drinks, company, activities”

- “Art group”

- “Socialise join in with odd game.”

- “Help out, shop with the staff, company, meeting people, go to the garden centre at Normanton.”

- “Support only 10.30 till 2.30, more options?”

- "Starting today – keep fit at a gym (fitness classes)."
- "Men's group."
- "Peace of mind."

Company, activities and food seem to be the main needs met by the present day services.

Q4. How does the Day Service/Centre Help?

- **"I can be myself here. I don't have to pretend to be someone else. People accept you for who you are here at Derby MIND (DM)"**
- "I get more help at DM in every day sense for me, not as anxious physically or mentally. DM is open. Support workers help you, talk to you, help lessen anxiety"
- "Support, somewhere to touch base"
- "Day hosp. More constant something to do in the day"
- "Gives lots of help and support and that's good all-round"
- "Coming for 2 months. Staff very supportive. Already affecting my thinking."
- "Make friends – socialise"
- "On my own at moment so I get out to meet people."
- "It offers regular contact, a consistent kind of care. Makes a massive difference to how you are. Contact with other people."
- "Helps me mix again, re-enter the community."
- "Staff help with any difficulty I may have regarding mail, telephone calls. Have had help regarding my benefits and social payment."
- "Companionship – support from staff."
- "Great pleasure from Art group."
- "I do Art, Maths and English."
-

A number of the themes are again highlighted such as company and activities, but some new themes are put forward - acceptance, support and consistency in the community are very important.

Q5. Is there anything more you would like from Day Services?

- "Opportunity to phone Debbi Seed or see David Smith"
- **"Everything stops at 2.30pm" "Weekends are difficult"**
- "Places that aren't therapy based, as opposed to things like help lines. More contact for people who struggle to be on their own."
- "Bigger premises, so that more groups can be offered under one roof."
- "More outings."
- "Contact with other aspects of my care. To have a more holistic care."
- "Bus trips out, holidays"
- "More comfortable seating (because of my physical disabilities)."
- "Facility within the services to support me looking for maybe voluntary or some paid work."
- "More of everything."
- "I'm not allowed to bring 18+ video's, I want to be treated more like an adult. I need a bit more freedom at Derby MIND."
- "Activities Co-ordinator lost his post and no money for activities."
- "Psycho-dynamics give a good service here"
- "Gardening Class"

Time of opening or closing of the service, a choice of therapies, activities and a non-institutional environment with comfortable interior and premises are high on the list of wants to improve current services.

Q7. Is there anything you DO NOT like about the Day Services/Centre?

- "Sometimes staff are not aware when someone's having a problem. Left to sit and stew and the problem has to be pointed out by other members"
- "Noise from other groups"
- "Practical things (clean cups) would anyone else have to put up with things just because I am mentally ill. Do we have to put up with it?"
- "No really happy with the service."
- "No, not really."
- "Decoration, the room we sit in is out of the 1970's. Rooms are stuffy, smell like a jumble sale. Parking is horrific. If you can't park and people see you walk into SIRRT it makes you feel uncomfortable, not good when you're feeling fragile."
- "Sometimes can be a little difficult when new people come."
- "I wish the pool playing area was separate to main area."
- "Wednesday afternoon boring, dull group"
- "Staff are sometimes too busy to listen to me or help. Premises are compact and bijou. Its dingy, damp and fusty."
- "I felt let down and disappointed - building my hopes up for a trip that got cancelled."
- "Does not like the Padley Centre. Cannot get. Feels threatened."
- "Wish we could have money in MHS. Trips, groups, music, poetry at MIND."
- "I would like more one to one therapy"
- "There is cultural Anglo Saxon characteristics it's sometimes cliché and stand offish."
- "Food (lack of choice for healthy eating) security (taxi driver entering day room), exercise (no gym facilities)."
- "Can't watch over 18 video's or DVD's"
- "It's annoying when it has to close because of staff sickness or shortages."
- "I don't like the area that Derby MIND is in at the moment."
- "Derby MIND is a bit too small."
- "Sometimes they treat you like children"

A lot of the dislikes are either staffing or environmental issues, too few or un-engaging staff with noisy and cramped rooms.

Q8. Is there any reason you are not using Day Services now?

- "I am using the day service and always want to."
- There is no contact, no information getting to patients
- "Find it hard to get out and interact with people."
- "The way Doctors talk to you"
- "I need help with building up self esteem and that is not being helped."

Lack of information and un-supporting staff are the main reasons people stop using the day service.

Q9. Is there anything else you want to say or ask?

- "There should be more done for mental health people coming into the centre. There are lots of people sitting on their own in bedsits with MH problems. There are not enough people who know about voluntary sector groups in this case DM."
- "There should be regular visits to the wards from staff at DM. More leaflets from DM. In hospital people don't take much notice of leaflets. They need more one to one talks. Meet people. Staff/members to go along with staff. Examples of benefits of voluntary group, which will make it real for them. Bring it home to them"
- "All day services would benefit from ethos of 63 Duffield Rd, (valued, listened to)"
- "No everything's OK!"
- "Generally found day services to be really good. Would like to be able to go to the Resource Centre." "Long wait to get into Resource Centre, after hospitalisation." "Service needs more funding, so there is more available."
- "If there can be something structured around substance/alcohol in my case."
- "Staff do try to treat everyone equally, music and windows opened, can be difficult as people want different things."

- "Took 3½ years to get here, after a Psycho-therapist opened me up. Passed from agency to agency, signed posted from one to another. Lost friends and difficult for family"

- "Trips to seaside are good, everybody involved. Brilliant idea."

- "I find the day services poor."

- "I would like to be involved in wider activities."

- "Staff turnover has diluted the professionalism of the staff in general. Staff criticising each other in front of each other."

- "Believe funding needs to be positively discriminated for MH sufferers to engage in meaningful activities. This really helps a person to get well."

- "Why do the charitable organisations i.e. DM receive very little funding in comparison to social services and NHS run organisations. When in my opinion the work that charities (MIND etc) do is far more hands on and effective work."

- "I am looking for work, I have been out of work too long, and I would like some help to get back to work."

- "They don't have day services for different age groups. No day services seem to have a Depression group any where in Derby."

Two extra themes are highlighted with this last question. They are both around inclusivity of different age needs and support/treatment needs.

Summary

A feedback event was held at Oakland's, 103 Duffield Rd, Derby for the UFM interviewers and Day Services project Team. Around 15 people attended the meeting where the attached demographics, graphs and comments were presented.

The demographics only gave grounds for more questions - predominantly male, white middle-aged population? Is this the need or a picture of the usage? It does say that the majority of people walk or use public transport to assess day services. The 2 major services (Rosehill Club and SIRRT) had nearly two thirds of the usage. Questions were raised as to what the total usage of the Individual Day Services was and then compare this with the number of questionnaires completed from each one.

The few comments to questions 1 and 2 did not give any strong answers as to why people had not been using the available day service. It either did not meet their needs, was not appropriate or the information was either not available or had been insufficient. Another couple of points were raised as to how people's care plans inform or direct them to day services and could there be stepping stones with levels of care?

Finally, from the remaining questions 3 to 9 the overwhelming picture was that Day Services need to go towards meeting the needs of people in the 2 main areas of nourishment.

- The mind as regards therapy, activity and company
- The body as regards food

These areas are either neglected or excluded by society when individuals experience mental health issues. Many other issues were commented on from education, employment, finance and benefit advice.

The overall comment from the UFM interviewers is that service users needed this support to be locally and widely available (geographically and time wise) across the city.

Appendix

UFM TEAM (alphabetical order)

Stella Brass

Julie Brownsword - a service user for ten years, believes that it is important for service providers to be aware of the feelings and views of service users regarding the services they deliver.

Dr Catherine Clulow - Dr Clulow started working for the Trust in November 1995, having done her psychiatry training in Liverpool, and then working for 9 years in Substance Misuse in the Mersey Region. Her role in Derby has been somewhat varied and she has landed up as a part-time Associate Specialist in General Adult Psychiatry in Amber Valley. She hasn't managed to find time to fit in any special interests, but one day would like to look at the impact of diet, weight and exercise on mental health.

Peter Davie - I am 53, and originally come from Leicester. I moved to Derby in 1987 for my work. A small hi-tec company employed me as an electronics designer. I had previously been diagnosed as having Bipolar Affective Disorder (BAD) or Hypomania as it was then called, which I prefer.

From 1992 to 2000 I scratched around doing a variety of things, some to do with music. By then I had had a further Hypo manic episode, accompanied by yet another time in hospital. I had also met another Service User who was actively involved with what were then embryonic Service User led initiatives, which I became involved with. I found that some of the skills from my previous life transferred well to this. Over a period of time I became disenchanted with some aspects of Service User politics.

Eventually I found UFM. As well as working with this, I have recently done some training to enable me to put my experience as a Service User to some use, and look forward in the near future to taking part as Service User consultant in the new Social Services degree course.

Gill Earl - Gill has been involved in the project from the start and was one of the first people to train as an interviewer. She feels the project is very worthwhile and is getting constructive results. Gill has taken an active part in service user involvement at various levels for the past 4 years and feels privileged to be able to represent the views of other service users.

Sean Edson - Sean is a service user who has gone through the Mental Health System and is successfully beating his mental health problem. He has been involved with the Springboard Project from the beginning and is actively involved with improving Mental Health Services in South East Derbyshire.

Lynn Gibson

Dr Chris Gillespie - A Clinical Psychologist with a commitment to user involvement and staff support/development. He trained in Edinburgh with research and clinical interests in people with severe mental health problems. He has been supporting the UFM Project since its launch early in 2000.

Clare Hallsworth - Clare has been a service user for the last 2 years. During that time she became involved with the UFM team and has found it very interesting, challenging and rewarding work. She also finds it is a privilege to be able to go out into the community and meet other service users.

Zelma Hutchinson

Frances Jackson - Service User from Amber Valley.

Stella Knott - I have been a service user for 7 years. I enjoy listening to people, and being an interviewer enables me to contribute towards improving mental health services in the future.

Cairen Millican - Cairen has worked with the UFM team since Jan 2004 as team administrator, supporting the UFM Co-ordinator on a part time basis. Since working for UFM Cairen has gained greater knowledge and a better understanding of mental health issues and enjoys being part of an important process helping to improve services for current and future service users.

Sue Price

Catherine Robinson -Catherine has been involved in a variety of service user projects for the past 18 months in addition to working part-time in another capacity. She has been a mental health service user for many years and is keen to see more service user involvement in developments.

Deborah Rose - Deborah is a service user who has been working with UFM for the past year. Her involvement in UFM means that she is contributing to improving the Mental Health services for existing and future users. Deborah finds her role as an interviewer very rewarding work and is proud to be a member of the team.

Graham Saxton- Graham has been employed as the Co-ordinator of the project for the past 3 years. He has played a major role in service user involvement for the past 6 years at various levels in Statutory and Voluntary. He has over the past year also taken on a role as a Service User Consultant within the Trust.

Derryck Shearer - Derryck has been involved with UFM for over one year now, arising from government strategy with regard to patients becoming pro-active in affecting the services they receive. As a result of this, he has attended day seminars and now sits on a forum to set up the working practises of SUIDM (Service User Involvement, Development and Management) Committee**.**

Muriel Townly - I have been an interviewer for about 4½ years. This is the first active work I undertook with the service user movement. It has given me autonomy to go out and interview other service users; they in turn like to be interviewed by those who too have suffered mental stress. However, I do get frustrated when the powers that be do not follow through with our recommendations.

Michael Walsh - Michael has been involved with UFM from the outset three years ago. He has been very proud to be involved in all the projects up to now and hopes to be as involved in the future. Michael would also like to say that being involved with UFM projects has helped him to cope with his own illnesses and problems. He would also like to add that he has met fellow service users, all of which he has been able to get along with and has made many more new friends.

DAY SERVICES QUALITATIVE SURVEY
APRIL 2005

FACE TO FACE INTERVIEW BY UFM INTERVIEWERS

Part of consultation procedure, which involved a stakeholder day and Quantitative Postal Questionnaire

Question 1.	Do you use any Day Service/Support Centre? **Yes** / **No** **If there is one in particular you use – please state** If **No** please give reason/comment below If **Yes** please go to question **3** **/** If Yes but now **No** go to question 8
Reason/ Comment.	
Question 2.	What would need to be changed for you to use Day services?
Comment.	
Question 3.	What do you get at the Day service/Centre?
Comment.	
Question 4.	How does the Day Service/Centre help?
Comment.	
Question 5.	Is there anything more you would like from Day Services?
Comment.	
Question 6.	How do you get to the Day Service/Centre?
Comment.	
Question 7.	Is there anything you do not like about the Day Service/Centre?
Comment.	

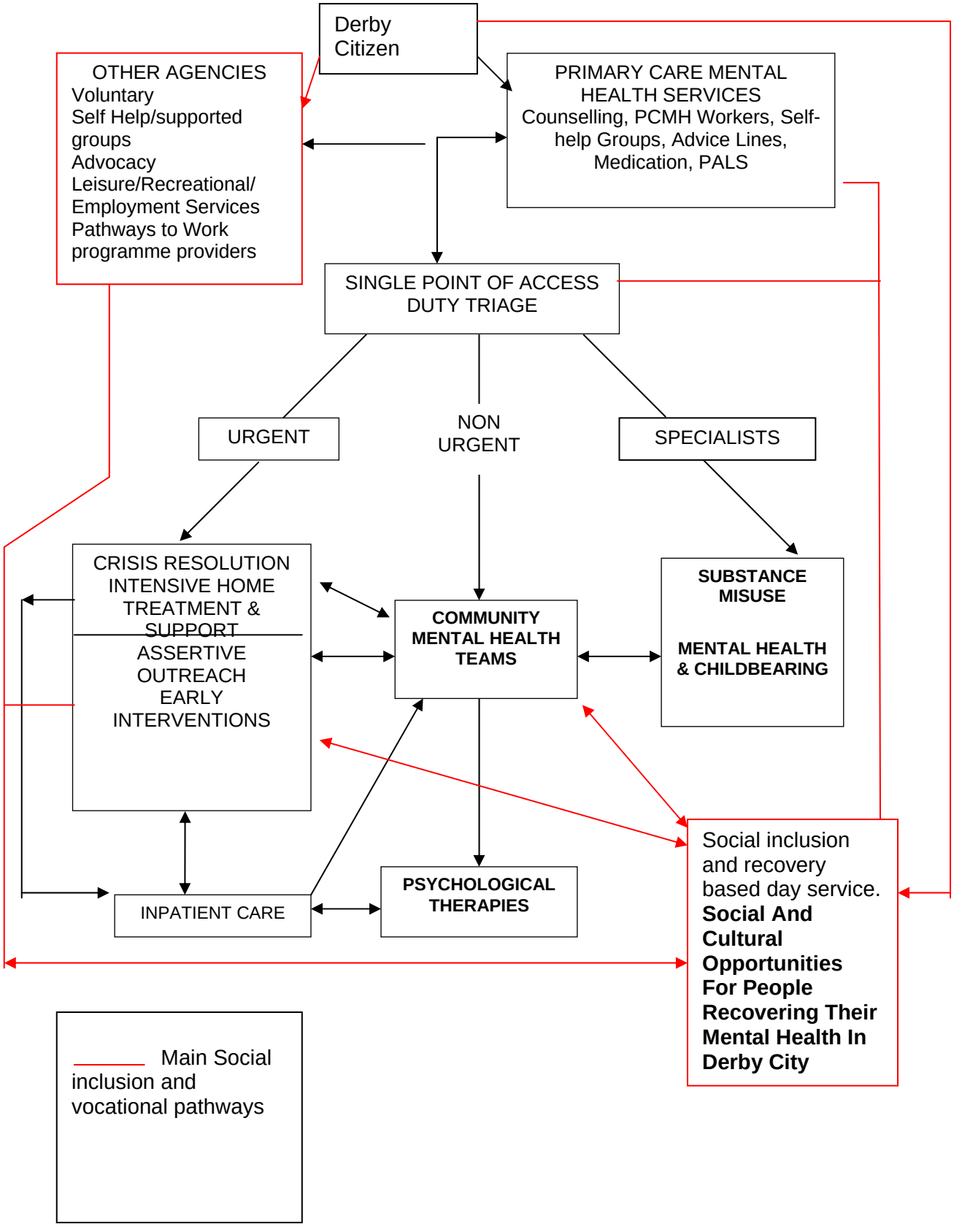
Question 8.	Are there any reasons why you are not using Day Services now?
Comment.	
Question 9.	Is there anything else you want to say or ask?
Comment	

Demographics*		
Male…….. **Female……**	**Age: 18-25…….** **26-40…….** **41-64…….**	**Ethnicity** **…….**

* **For Information Purposes Only**

Appendix C

Figure 1 - Adult Services Mental Health Care Pathways



ESTIMATING INCIDENCE AND PREVALENCE OF MENTAL HEALTH PROBLEMS IN ADULTS

Estimates of resident population (mid 2004) by LA

	All ages	<16	16-74	75+
Derby UA	233,700	47,480	168,120	18,100
Males	115,600	24,500	84,000	7,000
Females	118,200	23,060	83,840	11,200

Source: Office for National Statistics

Estimates of resident population (mid 2004) by PCT area

	All ages	<16	16-74	75+
Central Derby	64,200	15,540	44,860	4,000
Males	31,900	7,880	22,420	1,500
Females	32,400	7,660	22,340	2,400

	All ages	<16	16-74	75+
Greater Derby	169,500	32,240	123,260	14,100
Males	83,700	7,880	61,660	5,400
Females	85,800	7,660	61,600	8,700

Registrations as at April 2000*

Recent estimates of the numbers of registered patients in each PCT are shown below.

*includes small numbers of patients assigned to PCTs but not registered with a practice

2. Survey of Psychiatric Morbidity Among Adults Living in Private Households

The *Survey of Psychiatric Morbidity Among Adults Living in Private Households* is generally regarded as providing the best available data about the rates of mental health problems, their treatment and impact on sufferers. The surveys have been carried out on two occasions, in 1993 [1] and 2000 [2], and include large samples (9,450 and 8,580 respectively).

The 2000 survey describes the prevalence of a range of mental disorders, including personality disorder, in the general household population. It also considers the changing prevalence of some of these disorders since the 1993 survey. It describes how people with particular disorders differ from those without any disorder on a range of factors: their background and personal characteristics, including employment and accommodation, physical health, current treatment and service use.
The survey used assessment tools to detect the prevalence of relatively minor disorders (neurotic psychopathology) and major disorders (psychotic psychopathology).

Geographical analysis of the Survey data is reported for the NHS Regional Office areas in place during 2000. Data relating to the Trent Region give the nearest equivalent to the current East Midlands Region, and are presented below to allow comparison with national data. Although the former Trent Region and the current East Midlands Region have many areas in common (Derbyshire, Nottinghamshire, Leicestershire, Lincolnshire), the former Trent Region also included South Yorkshire urban areas (Barnsley, Doncaster, Rotherham and Sheffield).

2.1 Common Mental Health Problems

Using the Clinical Interview Schedule (CIS-R), the Survey defined fourteen neurotic symptoms and their severity was assessed. Scores for each symptom were summed and those scoring over a defined threshold were classified as having significant psychiatric morbidity. Based on the presence, frequency, severity and duration of various symptoms and utilising a set hierarchy, relevant subjects were then assigned to six neurotic diagnostic categories which could be related to the ICD 10 classification of disorders.

The table below shows the prevalence of each of the 6 neurotic diagnostic categories for Great Britain and Central and Derby City PCTs.

Table 3. Estimated number of Derby adults aged 16-74 years with neurotic disorders, by PCT area (OPCS, 2000)

PCT	Diagnostic category						
	Mixed anxiety & depress-ive disorder	General-ised anxiety disorder	Depress-ive episode	All phobias	Obsessive compuls-ive disorder	Panic disorder	Any neurotic disorder
Prevalence	8.8%	4.4%	2.6%	1.8%	1.1%	0.7%	16.4%
Central Derby (44,860)	3,948	1,974	1,166	807	493	314	7,357
Greater Derby (123,260)	10,847	5,423	3,205	2,219	1,356	863	20,215

Notes:
1. The number in brackets indicates the total population within the PCT aged 16-74 years.
2. The above estimates are based on unweighted extrapolation of national prevalence rates and there might be considerable variation from the true number of adults with neurotic disorders within each PCT.
3. Sources: OPCS Survey of Psychiatric Morbidity Among Adults Living in Private Households, 2000. Population mid-2004 estimate National Statistics Compendium of Clinical and Health Indicators (Health and Social Care Information Centre: www.nchod.nhs.uk)

Table 4. Estimated number of Derby adults aged 16-74 years with neurotic disorders, by Local Authority area (OPCS, 2000)

	Diagnostic category						
	Mixed anxiety & depress-ive disorder	General-ised anxiety disorder	Depress-ive episode	All phobias	Obsessive compuls-ive disorder	Panic disorder	Any neurotic disorder
Prevalence	8.8%	4.4%	2.6%	1.8%	1.1%	0.7%	16.4%
Derby UA (168,120)	14,795	7,397	4,371	3,026	1,849	1,177	27,572

Notes:
1. The number in brackets indicates the total population within the UA/LA aged 16-74 years.
2. The above estimates are based on unweighted extrapolation of national prevalence rates and there might be considerable variation from the true number of adults with neurotic disorders within each LA/UA.
3. Sources: OPCS Survey of Psychiatric Morbidity Among Adults Living in Private Households, 2000. Population mid-2004 estimate Office for National Statistics.

2.2 Severe Mental Health Problems

The *Survey of Psychiatric Morbidity Among Adults Living in Private Households* defined subjects as suffering from psychotic psychopathology through a two stage process: identifying the possibility of psychosis through detecting psychotic experiences in the standard interview; and for those with a possibility, an interview with a psychiatrist to confirm a diagnosis of probable psychotic disorder.

The prevalence rate for probable psychotic disorder in the year prior to interview was 0.5%. There was ten-fold variation in the prevalence of probable psychotic disorder, from 0.1% in the South-West Region to 1.0% in Trent.

Table 5. Prevalence of probable psychotic disorder among adults aged 16-74 (OPCS, 2000)

	Great Britain			Trent		
	Female (%)	Male (%)	All adults (%)	Female (%)	Male (%)	All adults (%)
Probable psychotic disorder	0.5	0.6	0.5	1.1	0.9	1.0
Base n	*4728*	*3852*	*8580*	*418*	*333*	*751*

Source: OPCS Survey of Psychiatric Morbidity Among Adults Living in Private Households, 2000
Trent refers to the NHS Regional Office in place during 2000 and includes Derbyshire, Nottinghamshire, Leicestershire, Lincolnshire, and South Yorkshire

The evidence about the epidemiology of severe mental illness in Great Britain has been recently reviewed by Lewis et al [3]. They concluded that between 0.48% and 1.13% of people have schizophrenia. Manic-depressive disorders and psychotic depression are found in about one fifth of this number. Other psychoses, mostly associated with substance misuse, are much rarer. These findings are broadly in line with the estimated given in the table above.

The variation in probable psychosis by age appears to show a concentration of cases among those aged between 30 and 54 years of age. The highest rates among women were observed in the 40-44 year age group (1.2%) and for men in the group aged 30 to 34 (1.3%).

Factors associated with increased risk of probable psychotic disorder were:

- separated or divorced
- low educational qualifications
- Social Class IV or V
- economic inactivity
- living in rented accommodation
- living in urban area
- living as single person family unit or as a lone parent

The following tables apply the probable psychotic disorder prevalence rates from the survey to the Derby population to give the number of people within each area expected to have such a diagnosis. Tables are presented for both PCT and Local Authority populations. Great Britain rates have been applied in preference to Trent rates, due to uncertainty regarding the impact of different geographical boundaries.

Note that the data should be used as an estimate only. They are based on national rates and take no account of factors prevailing in particular populations that affect the numbers with psychotic disorders (as listed above). The true number of people with probable psychotic disorder within each PCT/LA will be higher or lower than that stated depending on the socio-economic and demographic profile of the area. For example, urban areas including neighbourhoods with high deprivation are likely to have higher numbers of people than given in the table whereas the numbers in more affluent areas are likely to be lower.

Table 6. Estimated number of Derby adults aged 16-74 years with probable psychotic disorder, by PCT area (OPCS, 2000)

PCT	Number with probable psychotic disorder
Central Derby (44,860)	224
Greater Derby (123,260)	616

Notes:
1. The number in brackets indicates the total population within the PCT aged 16-74 years.
2. The above estimates are based on unweighted extrapolation of national prevalence rates and there might be considerable variation from the true number of adults with probable psychotic disorder within each PCT.
3. Sources: OPCS Survey of Psychiatric Morbidity Among Adults Living in Private Households, 2000. Population mid-2004 estimate National Statistics Compendium of Clinical and Health Indicators (Health and Social Care Information Centre: www.nchod.nhs.uk)

Table 7. Estimated number of Derby adults aged 16-74 years with probable psychotic disorder, by Local Authority area (OPCS, 2000)

Local Authority	Number with probable psychotic disorder
Derby UA (168,120)	841

Notes:
1. The number in brackets indicates the total population within the UA/LA aged 16-74 years.
2. The above estimates are based on unweighted extrapolation of national prevalence rates and there might be considerable variation from the true number of adults with probable psychotic disorder within each LA/UA.
3. Sources: OPCS Survey of Psychiatric Morbidity Among Adults Living in Private Households, 2000. Population mid-2004 estimate Office for National Statistics.

4. Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC)

EMPIRIC [7] was the first major national study designed to provide detailed data about mental health problems in ethnic minority members of the population. It was conducted alongside the *Survey of Psychiatric Morbidity Among Adults Living in Private Households (2000)* [2] and included individuals aged 16 to 74 identified from the Health Survey for England as belonging to one of five specific ethnic groups: Black-Caribbean, Indian, Pakistani, Bangladeshi and Irish. It investigated common and severe mental disorders, use of services, social support and the personal meaning of symptoms and their context.

In order to give context to the EMPIRIC findings, the following tables give 2001 Census data for Derby regarding the proportion of people within selected ethnic groups, by PCT and LA. Of particular note is the relatively high ethnic minority population within the Central Derby PCT/Derby Unitary Authority population.

Table 10: Percentage of people in ethnic groups by PCT area (Census, 2001)

PCT	Base Pop-ulation	White %	Irish %	Black Carib-bean %	Bang-ladeshi %	Indian %	Pakis-tani %	Other ethnic group
Central Derby	59,923	67.2	1.7	3.1	0.3	9.7	12.4	5.6
Greater Derby	116,47	93.1	1.3	0.8	0.0	1.7	0.8	2.4

Source: National Statistics Census 2001. The other ethnic group category includes mixed race, Chinese, Black African and other groups not otherwise specified.

Table 11: Percentage of people in ethnic groups by Local Authority area (Census, 2001)

Local Authority	Base Pop-ulation	White %	Irish %	Black Carib-bean %	Bang-ladeshi %	Indian %	Pakis-tani %	Other ethnic group
Derby UA	221,70	86.1	1.4	1.4	0.1	3.8	4.0	3.3

Source: National Statistics Census 2001. The other ethnic group category includes mixed race, Chinese, Black African and other groups not otherwise specified.

4.1 Common Mental Health Problems

EMPIRIC findings were complex but generally suggested that there was little difference in the prevalence rates of common mental illnesses between the minority ethnic groups and the white population. Specific group differences showed that Irish men and Pakistani women had higher rates, while Bangladeshi women had lower rates. However, evidence from the somatic symptoms of distress and lack of positive responses to wider psychological questions suggested that rates of common mental illnesses in Bangladeshi men and South Asian (particularly Indian and Pakistani) women may have been underestimated. While social factors commonly associated with mental ill health were widely prevalent, particularly in the Bangladeshi group, the link between these and illness seemed weaker than in the general population surveys.

Table 12. Prevalence of neurotic disorders by ethnic group (EMPIRIC,2000)

	White %	Irish %	Black Caribbean %	Bangladeshi %	Indian %	Pakistani %
Mixed anxiety & depressive disorder	10.9	11.6	12.0	9.0	11.9	12.3
Generalised anxiety disorder	1.4	3.0	1.3	0.6	1.2	1.4
Depressive episode	2.9	2.8	2.4	1.9	3.8	4.5
All phobias	1.8	2.1	1.5	0.7	0.8	2.1
Obsessive compulsive disorder	0.9	1.0	1.0	1.0	1.2	1.7
Panic disorder	0.5	1.7	1.3	1.3	2.1	1.2
Any neurotic disorder	**10.9**	**11.6**	**12.0**	**9.0**	**11.9**	**12.3**
Base n	*837*	*733*	*694*	*650*	*643*	*724*

Source: OPCS Survey of Ethnic Minority Psychiatric Illness Rates in the Community, 2000

4.2 Severe Mental Health Problems

EMPIRIC found significant variations in the prevalence of probable psychotic disorder. Overall, Irish people showed similar rates to the white population, though with a greater concentration in younger people. Caribbean people showed a two-fold excess, with no gender difference. Indian people showed a slight excess, and higher rates were found in women. Pakistanis had a 60% higher, and Bangladeshis a 25% lower rate, both with no apparent gender difference.

Table 13. Estimated annual prevalence of probable psychosis by ethnic group (EMPIRIC, 2000)

	White %	Irish %	Black Caribbean %	Bangladeshi %	Indian %	Pakistani %
Annual prevalence of psychosis	0.8	1.0	1.6	0.6	1.1	1.3
Base n	*837*	*733*	*694*	*650*	*643*	*724*

Source: OPCS Survey of Ethnic Minority Psychiatric Illness Rates in the Community, 2000

This variation in the prevalence of probable psychosis should be considered alongside the variation in the proportion of ethnic minority populations, as shown in Table 11 above. For example, within Central Derby PCT 67.2% of the population are white while 3.1% are Black Caribbean, 9.7% Indian and 12.4% Pakistani. Applying the EMPIRIC prevalence data to this population suggests that in one year there might be approximately 100 cases of probable psychosis within the Pakistani community, over 60 within the Indian community and over 30 within the Black Caribbean community.

This variation has a two-fold effect: firstly, the increased prevalence of probable psychosis among these ethnic minority groups means that the overall number of cases will be higher than in a predominately white area. Secondly, any special needs of these clusters of ethnic minority will have to be borne in mind particularly in terms of ensuring access to services.