

NORTH
MANCHESTER
HEALTH
AUTHORITY

DEPARTMENT
OF
PSYCHIATRY

GETTING TO KNOW YOU PROJECT

CONSULTATION DOCUMENT

25TH JULY 1984

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- * The idea for the process was in part taken from "Getting to Know You - One Approach to Service Assessment and Planning for Individuals with Disabilities"
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SUMMARY

The process by which the proposals at the end of this document were reached, was a long, careful and highly inovative one, involving staff from all levels inside the hospital, and representatives from services and voluntary bodies outside. It was based on a detailed survey and analysis of the lives of the people living in some of the wards of the hospital, together with looking at existing resources. This material was used in a rational and sensitive way, with constant checkbacks, to devise a service that would met the needs of the patients.

The service will be aimed towards resettling clients into their own homes in a community and helping them to construct to the largest degree possible, an ordinary life in that community. This includes intensive, individual work in helping them to make friends, to find daytime occupation, to look after themselves, and to find leisure activities. All of these activities should be in ordinary settings with ordinary people, wherever possible. The service should be flexible and responsive and should be available whenever and wherever it is needed. Independence, choice, self-determination and respect of the client's rights should be the cornerstones of this service.

It is proposed that two multi-disciplinary teams should be set up.

One would be called the **hospital rehabilitation and resettlement** team whose job would be mainly inside the hospital working with staff and about 25 selected patients towards eventual resettlement. They would attempt to suggest beneficial methods of practice and work closely with management to alter routines and procedures of the hospital in accordance with the neds of the patients. In addition, they would make contact with outside agencies including the community resettlement team, housing associations, industry, housing corporations, etc., to negotiate agreements where necessary.

The other team would be called the **community resettlement team**. Their job would be to work intensively with one or two communities in North Manchester helping to integrate patients who are being resettled into those communities. This will mean identifying and working with local emenities (e.g. clubs for elderly people), local housing offices, education centres, local shops. etc.

There must be a close liaison and working relationship between the two teams, as well as with the other staff working inside and outside the hospital with patients who are being resettled.

Volunteers, befrienders and paid carers are an essential part of the process of resettlement. In accordance with this volunteers organisers should be a part of both teams.

It is hoped that the hospital resettlement team will be financed through district savings. The community resettlement team could be financed through a bridging loan from the Regional Health Authority. The District Health Authority would take up the funding over a period of years through savings, made by the closure of one ward.

FOREWORD

REHABILITATION AND RESETTLEMENT DEPARTMENT OF PSYCHIATRY NORTH MANCHESTER HEALTH AUTHORITY

Prior to 1974, there was hardly any organised rehabilitation and resettlement for the chronically mentally ill in the North Manchester Health District. The 1974 re-organisation of the National Health Service had beneficial effects and created opportunities for developments in this deprived service area. The first and most important change was the introduction of a Community Psychiatric Nursing Service, initially two nurses. During that year Dr. J. Seper, an Associate Specialist in Psychiatry, started systematic reviews of patients in the long-stay wards.

In 1975, when I was appointed to a Consultant post, I realised that there was hardly any in-put by the Consultant Psychiatrists in the long-stay wards. I initiated weekly ward rounds in every long-stay ward I had and, since then, over the succeeding 9 years, every long-stay ward is visited by the Consultants at least once a week.

In 1976, the potential of Crescent Mount was realised. This house used to be the residence of the Master of the old Springfield Hospital. Since the middle of the 60's it had been used for patients awaiting discharge to satisfactory accommodation. However, due to poor administrative arrangements, a number of patients had been left stagnating, discharge somehow was delayed, and did not seem to happen all that often. As there was a desperate need to provide a realistic home-like situation where patients could be taught basic living skills such as cooking, budgeting etc. It was agreed that it should come under the responsibility of one Consultant (myself). Since then, Crescent Mount has been the focal point of intensive rehabilitation, where all disciplines meet in order to provide a careful assessment plan, followed by rehabilitating patients to a standard so that they can return to the Community.

Of course, a proportion of patients, we have discovered, are not in a position to return to the Community and therefore, had to be transferred back to the ward.,

In 1976, there was another development and this was the opening of a private hostel on Crumpsall Lane, Southfields, which a few years later was supplemented by a further annexe, Seper House, where patients can live more independently.

In 1976, Mr. Scott, then Divisional Nursing Officer, decided that one of his Nursing Officers should have responsibility for the rehabilitation area. This was a strategic and well-thought out decision, the Nursing Officer of that area was able to initiate the development of group homes and establish a number of links between hostel and local Community resources.

Over the last 9 years, there have been periods of development and periods of stagnation. I have no doubt that what has contributed to development has been dependent on the presence of staff keen to be involved in rehabilitation, and these staff come from all disciplines. However, because of demands from other areas of this department, and because of vacancies that arise due to staff leaving, it has not been possible to sustain a

consistent momentum. It is worth giving you two examples, firstly, during the period of 1976-1979 there was a severe shortage of in-put from clinical psychology and this has been repeated since June 1983. Secondly, vacancies in the Occupational Therapy Department have lessened the impact of our efforts and the most recent example was the period July 1982/April 1983.

It is essential for a sound rehabilitation and resettlement service to have a strong team from all disciplines, which will not be distracted by other commitments and least affected by vacancies which may arise from time to time. It is also important to mention that despite all the difficulties and shortages that have afflicted psychiatric services in this District, we have been able to establish most of the essential components for a progressive rehabilitation and resettlement service. I would like to list these components below:-

Consultant Psychiatrists Since 1974, the input has increased from 3 whole-time equivalents to 8 whole-time equivalents. All 8 consultants are interested in rehabilitation and resettlement and it is felt that no one person should ever undertake this task.

Junior Medical Staff: There has been an increase in the previously poorly staffed department. We identified the need for a Senior House Officer to be solely employed in the rehabilitation area but, because of the freeze in posts of this grade some 2 years ago, the high medical needs of patients in the area could be met by Clinical Assistants. There is available funding for this post which, at present is utilised for the Industrial Therapy Instructor.

Occupational Therapy: Ward based Occupational Therapy plays a vital part in the assessment process and assists patients with developing living skills and leisure activities. Their absence severely impedes the rehabilitation and resettlement process. We need at least 2 Occupational Therapists for this area.

Physiotherapists: We have identified a number of patients with serious mobility problems because of chronic chest disease and other musculoskeletal problems. Without a doubt, the physiotherapists presence is essential to assist in the overall effort. I suggest we need at least one post.

Dr. Seper Day Unit (Ward 30): This Day Unit was the first one to be established on the Springfield site in the early 70's. Due to the efforts of the late Dr. Seper, considerable expertise has been accumulated and the purpose of this Day Unit is to cater specifically for the problems of the chronically mentally ill who are maintained in the Community. This is a very important facility for any District Psychiatric Rehabilitation Service. Through long-stay monies, which this District received before the 1982 re-organisation, a receptionist and S.E.N. were appointed.

Crescent Mount: This 10-bedded unit, in an ordinary house dwelling, has been a very important resource, helping patients to develop skills unaccustomed to themselves in a home environment.

Industrial Therapy Unit: It initially started as a sheltered work-shop in the old Springfield place in the early 70's. Last year it was transferred to a modern building and this had an important effect on the moral of the staff and patients there. The Manager, who has worked in industry prior to his appointment here, has initiated important changes and established

healthy links with the local industry. Further impetus has been added since appointing the Industrial Therapy technician some 8 months ago., Despite unhealthy unemployment record it is encouraging to see that some of our patients have managed to regain employment in the last 12 months after many jobless years.

Other Facilities: There are a number of facilities which have helped patients over the years, areas in which they were able to develop more skills or find useful diversions and some of these are, woodwork, linen bank, gardens, and the pets corner.

Harpurhey Day Centre: This Day Centre was established by the Social Services Department in the late 70's. It has been an important facility where patients have been able to move to, thus becoming more integrated with the Community and less dependent on the hospital service.

Dr. Alex Theodossiadis
Chairman - Division of Psychiatry
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26.6.84.

PART I

THE PROCESS

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INTRODUCTION

As part of the new approach to the treatment of mental illness and the longer term aim of moving people out of traditional type hospitals into the community, a lot of thought is being given to the planning of new services for the mentally ill. Getting To Know You was devised as one way of helping to plan these services by placing greater emphasis on a closer understanding of peoples' actual needs.

The idea was first discussed in the summer of 1982, work was started in the early part of 1983 and continued through to the middle of 1984. The first part of the process was concerned with a detailed look at the past, present and future lives of a group of people being treated at North Manchester General Hospital for psychiatric illness. The aim was to carry out individual assessments on a one-to-one basis by examining the whole of a person's life which included, but was not restricted to, that part relating to their problem.

The named rehabilitation wards (25, 26, 27 and Crescent Mount) were chosen as being the area of the hospital most suitable for starting the project, partly because of their manageable size but also as a result of a request from the District Management Team. Also patients were selected from a range of other long stay wards. Patients were allocated to give a fairly good sample according to age, sex, length of stay and background on the basis of a 'census'* carried out on all the patients in the rehabilitation wards by Dr. Neill Simpson (Senior Registrar in Psychiatry). The project also involved about 30 members of staff who were directly concerned with the care of patients on the wards as well as a proportion of staff members holding vital positions in the hospital with respect either to making decisions or implementing them. (See appendix VIII)

As part of the process of gathering information visits were made to the wards at different times of the day, meals were eaten together, relatives visited and a picture gradually built up of the person's day-to-day existence and background. The staff on the relevant wards were also consulted and as much information as possible was obtained on how the hospital functions including the leisure facilities available and the work done by voluntary organisations.

This information was used as the basis of several planning/discussion sessions held over a period of approximately six months between August 1983 and February 1984. They were attended by all the staff involved in the project as well as others with a legitimate interest or point of view e.g. MIND, Social Services etc. At these meetings an attempt was made to form a coherent picture of what life in the rehabilitation wards is like now and what is required in the future. From this information a detailed description of the range of services needed to provide for the human needs of the people at present living in these wards has been drawn up and forms the main body of this report. In order to keep this section as brief as possible the information concerning the lives of the people, their past history and present existence is given in Appendices 1-3

* The statistics are too lengthy to quote here. Some of the information is given under the heading 'Some Facts Concerning Patients'. See appendix III.

A description of the existing hospital provision with details of staffing, outpatients, group homes etc., and the provision of other facilities including voluntary and self-help is listed in Appendix IV

A SHORT SUMMARY OF OUR FINDINGS

1 LIFE STYLE OF PATIENTS

In describing the life style of patients in the rehabilitation wards the overall impression is of a caring attitude on behalf of staff and an attempt to make the lives of their patients as happy and as interesting as possible by all concerned. There have been many improvements over the past few years, particularly in the material things like personalised clothing, better leisure facilities, provision of mini buses etc. There are still some areas where improvements would make a big difference to the quality of life for many patients. For example:-

(a) Facilities for making Snacks, Tea, etc.

The food served in the wards is fairly uninteresting and there is little choice. To add some variety it would be much appreciated by patients if they could prepare snacks, make tea or coffee etc. Cookers already exist on the wards and with a little encouragement this should be possible. A minimum requirement would be a readily available supply of milk.

(b) Conditions on the Wards

The main criticisms by patients about conditions on the wards are of lack of privacy, lack of individual possessions, drab surroundings, high noise level and overcrowded conditions.

(c) Therapies on Wards and Patient Behaviour

The survey on patient behaviour seems to indicate that the provision of more ward-based occupational therapy would be beneficial to many patients who seem to have time on their hands.

(d) Leisure Activities

This is probably one area where there is still scope for improvement although much has been done recently to expand facilities. The use of more leisure facilities outside the hospital could be an important first step in the process of introducing patients back into the community.

2 FACTS CONCERNING PATIENTS

Some of these facts are quite encouraging. For instance, most of the patients are in good health (265 out of 280 are in a good physical state) and a high proportion are in a fair or good mental state (220 out of 280). On the other hand, almost half have no housing, and just over three quarters have no daytime occupation. One third have had no

contact with their relatives in the last year. This means that a lot of help will be required in assisting people to form new friendships and to settle down outside the hospital. Also, a lot of effort will be needed to find accommodation via local authorities, housing associations etc.

3 EXISTING PROVISION

This is probably the area where most will have to be done before any large outflow of patients can be assimilated into the community. The number of places available in group homes and hostels is relatively small. Over the past eight years 150 patients have left the hospital and have been found accommodation. A higher figure over a much shorter period of time is envisaged and will put a great strain on available resources unless expansion is planned well in advance.

CONCLUSION

The overriding conclusion we reached was that many of the needs of the people we looked at could not be met within the hospital, particularly the needs to make friends outside and participate in the community. This was despite the best efforts of the staff involved. Making friends is very difficult if you have no place to take friends back to and few recent experiences to talk about except those that have taken place within the hospital. Learning to behave normally is made harder if you spend most of your time with people who behave strangely. Participating in community life is almost impossible if you don't live in that community. With this in mind, the next sections do not concentrate on how to make life inside the hospital better, but on how to resettle people into their own homes in a community.

HOW WE MADE THE JUMP FROM LOOKING AT THE LIVES OF THE PEOPLE TO A SERVICE THAT WOULD MEET THE NEEDS WE HAD IDENTIFIED

By the end of the summer of 1983, about 20 people had each spent time getting acquainted with a person and her/his situation. In many cases the participants had arrived at an account of the main needs of the patient concerned. The task that faced the project was one of using this rich source of information about (a fairly representative sample of) individuals to generate recommendations about the service itself. In other words, we had to convert individual-based knowledge into a strategy for changing a system so that it was more responsive to the needs of those individuals.

People who had gathered information attended three day-long meetings where a facilitator, neutral with regard to participants, led two parallel groups through the following agenda:-

1. THE PEOPLE AND THEIR LIVES

Here we worked through the information about the people:-

WHAT ARE THEY LIKE?

- * who are they/what are they like as people/how old, how long in hospital?

WHAT HAS LIFE BEEN LIKE?

- * how did they come to be here?
- * what happened before they came here?
- * what has happened here?

WHAT IS THEIR SOCIAL NETWORK?

- * contact with friends, relatives, family, neighbours, others.

WHAT MAKES IT DIFFICULT FOR THEM TO LEAD AN ORDINARY LIFE?

- * problems with service system
- * what complications do their disabling conditions create for them, for others?

WHAT DOES THE FUTURE HOLD?

- * what aspirations do they have?
- * what plans are there for them (theirs, others)?
- * what is the likely consequence for them if nothing changes?
- * what might help to make a more desirable future for them?

2. WHAT DO THESE PEOPLE NEED?

Here we looked at the information organised as above and extracted "themes", or important similarities and differences, about these people. Some of the themes concerned the situations of the people and some concerned their personal characteristics. The majority of these themes were indicative of some kind of disadvantage, and we therefore found it a fairly straightforward task to translate them into statements of need.

e.g.

Difficulty communicating	>>>>	Help with communication. Other people to understand you
An empty, poor life. Depressing	>>>>	Increased financial resources. Opportunities for a fuller life. Interests.

3. WHAT WOULD HAVE TO HAPPEN TO MEET THESE NEEDS?

From the general statements of needs, the groups next task was to invent means for meeting them.

A useful method here was to answer the following three questions:-

- A) How do ordinary members of society fulfill these needs?
- B) What makes it difficult for these people to do so, as a result of,
 - a) their characteristics, and/or
 - b) characteristics of their immediate and cultural context
- C) What can we propose that will meet these needs in ways that are as close as possible to A) but that take into account the very real challenges of B)?

By working through the list of needs in this fashion, the characteristics of an adequate service began to emerge. These were summarised as a set of "design principles" for service, and the knowledge of staff members about individuals was then used to check back with reality and elaborate what these proposals would mean in a concrete case.

At this point the two groups were combined. Their conclusions, while not identical, were similar, and any differences were complementary rather than contradictory.

4. MANAGING TRANSITION

The final task was to relate these ideas to the existing service. Here we began to consider practical steps that could be taken:-

- e.g.
- 1. extend choice within the hospital
 - 2. set up a resettlement team
 - 3. develop the role of volunteers as befrienders, etc.

These proposals form the basis for the remainder of the document.

PART II

THE PROPOSED SERVICE

The next sections attempt to summarise the work we did in designing a service which meets the ordinary needs of the individuals who live in the hospital. The first part concentrates more on the practice and the second part on the organisational structure which would be needed to put it into effect. The third part presents several illustrative examples, which would follow on from the design principles.

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SECTION ONE

DIGNITY AND RIGHTS

We identified 3 principles that are essential to the maintenance of dignity and rights of each individual.

PRINCIPLE 1 :

The Service Should be Flexible and Tailored to Each Individual.

In practice this means that a great deal of time and effort must be spent talking with and learning about the individual.

A key worker from any of the professions would be selected. This person would do an in-depth, broad assessment of the individuals' needs, similar to the process of "Getting To Know You". This assessment would include talking with and observing the individual in a variety of settings; talking with all the important people in the individual's life; reading the case-notes. In short, building a picture of the person's history, present life, strengths, preferences, appearance, behaviours, desires, physical needs and possible future life, together with the difficulties that lie in the path of the individual leading an ordinary life. Thus a picture of the person's needs will be built up, which must be continuously up-dated as needs change.

A plan of action should then be drawn up, plotting the stages towards an ordinary life. Those involved in the care of the individual, both staff and volunteers decide how their skills and knowledge best contribute to the process of enabling the individual to live a more ordinary life. Each person agrees to do certain tasks. The resettlement worker has the responsibility of monitoring these - i.e. seeing that the tasks are done and followed through. There should be regular review meetings, including all relevant people, where more tasks are allocated. These meetings should be set up in a sensitive manner and encourage equal participation of all members.

All parts of this process should involve direct consultation with the individual in a variety of ways. He or she should be actively encouraged to take part in the meetings and the key worker should be ready to explain things and to listen to him/her. In general any action should build on the individual's strengths. Emphasis should be placed on identifying and listening to the client's hopes and wishes.

PRINCIPLE 2 :

The service should support and enable each individual to make real choices

Choice and self-determination are the bricks on which this entire document is built.

Firstly, there must be the opportunity to make choices. There must be a range of options, right through from "Do you want to have sugar in your tea?" to "What sort of accommodation do you want to live in?". There must be the clear recognition by all staff that the individual should be allowed and encouraged to make choices. This will take a great deal of effort and

energy on their part. A lot of time must be spent listening to individual's preferences. Clients should be made aware of choices and given all the relevant information to help them make that choice.

Secondly, there must be the practical and emotional support to the individuals to help and encourage them to make choices and determine and plan their own future. This may mean guided practice in how to choose effectively. Some of the clients should not be expected to make very complex decisions immediately e.g. choosing where to live. There must be a gradual build up, working from smaller easier decisions. This process may take a great deal of time and effort, depending on the individual. It may mean helping the person to experience a range of alternatives. On one level this might involve encouraging someone to try both options on a menu and letting her/him decide which she/he prefers, on another level, trying out different leisure options, like swimming, dancing, cards.

One type of support may be to allow the individuals to make a 'poor' choice and helping them learn from that experience.

Emotional support may be entail helping clients become aware of their capabilities, and of their past and present achievements and to talk through difficult choices with them. (There should be a staff training programme to learn these skills).

Thirdly, there should be the organisational support for encouraging choice and self-determination. In many cases few options exist. This necessitates the planning and setting up of new facilities and resources wherever possible. For instance, at present there is no way of providing overnight support for clients in their own homes.

There should be administrative back-up to enable choice-making on wards and outside the hospital, e.g. increasing the range of options at meal-times, getting rid of obstacles to choice making. Sometimes, at present, staff have to break rules to allow clients to have more choice.

More generally, the clients must feel that it is worthwhile for them to make choices and determine their own future. They have to have hope of a better future and that there will be support and recognition for their decisions. By making decisions which actually make a difference, they are given a sense of power and control over their own lives.

PRINCIPLE 3 :

A service should protect and promote the rights of each individual

We should consciously not deprive people of their ordinary human rights. Sometimes the need to 'conform' and the structural limitations of certain ways of organising, can restrict opportunity to exercise those rights, e.g. it is a lot simpler if all clients wear the same clothes, eat the same food, and have little privacy. Rights should only be taken away if this meets a major need of the client.

When people are deprived of rights we should have to justify it (not by filling in another form) to:-

- a) the client
- b) an impartial befriender, advocate or relative
- c) a key worker
- d) mental health commission.

dependent on the right which is being taken away.

One of the ways to ensure that people's individual and collective rights are preserved is to enable the setting up of user groups and to encourage feedback and positive suggestions for change in the services that are provided. This should be done in ways which avoid tokenism and which result in clients having an effective say. The ward is "home" for a large number of patients; it seems reasonable to encourage them to have more control over their living environments.

FRIENDS, RELATIONSHIPS AND LEISURE

Friendships are very valuable to us in our society. We gain much of our self-respect and confidence from them. We rely on them for emotional and practical support, and in turn support them. Feedback, assurance and criticism from our friends keep us within the acceptable limits of our society. Many activities especially leisure activities are impossible without friends, or far less enjoyable. People without friends are looked upon as strange and are often outcasts. Friends are often the passageway to more friends, as well as to new interests.

Leisure activities are the major route through which we make and maintain relationships. Our hobbies and interests are ways in which we express ourselves to others and ourselves. They are a source of status, a way of learning new skills and one of the ways in which we participate in community life.

The people we got to know generally had very few friends. Moreover they had few meaningful relationships with other patients or staff. We felt that perhaps their greatest need was for the opportunity of having a range and depth of relationships with other people, especially for empathic, sensitive and caring friends. Many of the people also had a fairly limited range of leisure activities many of which were done only with mentally ill people. There are two principles that came out of this analysis.

Any service that is proposed must ensure that clients are given the opportunity, support and encouragements to make meaningful relationships.

Any service that is proposed should provide the opportunity, support and encouragement for clients to participate in ordinary leisure activities.

The amount and type of help required will vary greatly according to the wishes and needs of the clients.

HOW DO PEOPLE MAKE RELATIONSHIPS

People make relationships in many different settings and in many ways. Some of these are:-

- * early in life through school or college
- * having neighbours and a neighbourhood
- * having the flexibility to come and go and to invite people (institutions are very restrictive in this respect)
- * through relatives and friends
- * through work
- * through leisure activities:-
 - . shared interests and hobbies
 - . going to pubs and clubs
 - . through belief-related activities like church groups and political groups
 - . through watching and participating in sports
 - . through sex
 - . adult education classes
- * many others

From looking in detail at the lives of the people inside the hospital and at the way people make friends we drew up two essential guidelines for any service to meet the above principles.

- 1) Clients must have the opportunity to make friends in the ways outlined above e.g. through leisure activities in the community
- 2) Clients should have the right to therapies, practical help and support to increase their chances of making friends or developing relationships, whether through leisure activities, work or in other ways.

The two guidelines and the methods of working they suggest are not serial but parallel processes. Each is dependent on the other.

THE TWO ESSENTIAL GUIDELINES EXPANDED.

(a) GUIDELINE 1.

The hospital, at present, offers few opportunities to make friends with ordinary people. Those activities it has, are usually segregated, involving a large number of clients which drastically reduces the chances of forming friendships. People living in the hospital should also have far more opportunities to make ordinary friends in ordinary places. When they

leave the hospital this is what they will have to do anyway. If possible, friends should be made near to where a client eventually wants to live.

Real opportunity means that there must be actual support and encouragement to participate in activities in the community as detailed in Guideline 2. At present there are many hurdles which make it difficult for people inside the hospital to take part, fear of rejection, lack of motivation and confidence, and dislike of making relationships (learned through many failures). Opportunity, in the way meant in this guideline, must include helping the person to have positive experiences of participating in leisure activities and of making relationships.

(b) GUIDELINE 2.

Guideline 2 is best illustrated by using leisure as an example"-

A Leisure Enabling Service would,

1. Learn about the person's life past and present in a detailed way, identifying the kind of leisure activities the person is interested in now, was in the past, and might be in the future. The person's choice of leisure activities will change of course as the person becomes more aware of alternatives, more confident of success and has positive experiences of different activities in different settings. This understanding of the person will also point to the kind of practical and emotional support the person will need to accomplish these leisure activities and make friends in integrated settings.

2. Encourage the person to make choices for himself. This would include giving information about different activities available in a particular area or enabling the person to find out for himself. It would also help the person to experience positively different alternatives and work slowly to reduce the fear of failure and the fear of being 'picked out'.

The ability to choose should be encouraged beginning with easy decisions (e.g. whether to have sugar in your tea).

3. Offer practical and emotional support wherever and whenever it is necessary, including:-

- a) someone to go with
- b) help with social acceptability
- c) help with money/transport! Many leisure activities can be expensive.

In addition to ensuring that clients receive their full entitlement we might need to create a leisure fund by which some of the person's activities could be subsidised. Transport should wherever possible be ordinary types of transport, walking, cycling, private car or public transport. We need to avoid 'picking out' the person as mentally ill and encourage his independence. One role of staff or a befriender might be to use public transport with the client helping him to acquire the necessary skills. If public transport is not an option for physical or mental reasons then the 'Dial-a-Ride' community car scheme is one possibility.

Many of the people we got to know looked and behaved unusually, sometimes unacceptably. They were not easy to get to know, though everyone agreed that each of the people we looked at was interesting, worth knowing and had nice parts. For example, one of the people described who sounded very

likeable turned out to be disliked widely by both staff and patients. From the assessors description one might never have guessed this.

As well as making and maintaining friends and relationships through leisure there are several other points that need to be mentioned.

There needs to be practical and emotional support to families and existing friends to develop and maintain these relationships.

Other ways of maintaining and making relationships should be encouraged and supported, through work, making phone calls, writing letters etc.

Befriending may be the only available option for many of these people, and a volunteer or paid worker who sets out to make friends with a client.

References to Change Inside the Hospital

The clients are not going to find it easy to make friends outside. They need as many things in their favour as possible. They might need help with clothing, facial appearance, speech, social skills, movement. They might need help to learn to make friends and to understand how to behave. To take clothing as an example:-

- they should be helped to choose their own clothes and
- encouraged to wear more attractive clothes
- this should be an ongoing process, learning from past failures
- it should involve other people who are important to them to give feedback on their appearance (not just staff).
- also we must not go along with their odd appearance

Any help given should be on their terms. More than just offering help with appearance, we need to provide a reason for them to look better; in this case it could be participating in a particular leisure activity.

Any help given should be flexible and build on the person's interests e.g. there are many ways of helping a person to improve their posture, a physiotherapist is one, going to dance classes might be another.

The help should be given on the person's terms rather than in our way. This is important not only because the clients should have the ordinary human right of self-determination, but also because one of the major aims of the service is to encourage independence and the ability to choose. The help should be ongoing and available where it is needed.

SOMEONE TO GO WITH

Many leisure activities are difficult or impossible to participate in without someone to go with, or someone you know. Going to a football match on your own could put you off for ever. Many of the people we got to know had very few, if any, friends. One of the most important things that we could help with is to find someone to go with the person. This person could be a friend, relative, staff member, neighbour or befriender. (See section on befrienders). This person could go with the client, introduce

him to other people, offer practical and emotional support and advice. He could act as an enabler for the client to make other friends and to participate in the activity and learn how to behave in the community.

Alternatively, depending on the nature of the activity, someone who is already involved could be enlisted as a foster friend. For instance, if the leisure activity was going to football matches then someone from the fan club could be recruited. However, great care has to be taken when approaching particular settings, as the advantages of enlisting the help of people there has to be balanced against the disadvantage of identifying the person as being 'mentally ill'.

In some cases people may need to re-learn how to enjoy being with other people. This can only happen through encouraging and supporting them to have positive experiences of relating to other people.

There needs to be acceptance and understanding of failure on our part and on the client's part, but always the willingness on our part to try again in perhaps a different way. This should be based on past experience and analysis of success and failures.

LIVING AT HOME

What does home mean to most of us:

- 1) A place you can call your own
- 2) A place to gain privacy when wanted and where we have freedom of deciding what we do and when we will do it.
- 3) Somewhere to store our personal belongings.
- 4) A sense of self-worth: an identity.

If we do not have a home we come across difficulties when asked for our address for forms etc. We have nowhere to take friends or relatives and we have less control over what happens in the place where we live i.e. meal times, decorations, furnishings, etc.

Any proposed service should provide the opportunity, encouragement and support for clients to live in ordinary housing

The essential guidelines for this part of the service should include:-

- 1) Choice: Clients should be able to choose from different options, with the necessary encouragement, support and information to make a realistic choice.
- 2) There should be no test to pass to get out of Hospital. If the client wishes to leave and he is at liberty to under law, then the necessary support should be available in the community, whenever it is needed.

Types of Homes:-

- * One's own house or flat (whether council, private or housing association).
- * Communal living - this should be non-institutional.
- * Living with your family.
- * Living with a foster family.
- * House with staff living in.
- * Sheltered Housing: This involves having self-contained flats in one building with a communal lounge where residents can take part in activities with other flat occupants.

Ongoing support should be available however the person chooses to live.

The accommodation could come through Housing Associations, the Local Authority or Private Owners. There should be an agreement made between the National Health Service and the Local Authority and Housing Associations to make available houses or flats for people who are being resettled. On a more specific level finding a home would involve a great amount of detailed work with the client. (See Appendix V).

It is important for a person who has lived in hospital and perhaps had a position of status or felt they belonged there to have an identity in the community, and it is in this area where support and encouragement is required. Each person is an individual and should be treated accordingly to help them develop a sense of self worth.

WORK AND EDUCATION

PRINCIPLE :

The service must ensure that clients are given the opportunity and support to participate in meaningful occupation.

PAID WORK

Most people need some kind of work or occupation and those suffering the effects of mental illness are no exception. A job can provide money, friends, status and a more general sense of worth. Most of the people featured in the "Getting To Know You" process were without any kind of valued or rewarding occupation. A rehabilitation service should therefore attempt to enable a range of meaningful, non-isolated, interesting activities or occupations. It should also attempt to inform and motivate the client to enable them to make realistic choices.

The essential guidelines of such a service should be:-

- 1) Choice Clients should be able to choose from meaningful and realistic options. Their needs and desires should be fully taken into account at every stage.
- 2) Support to the client where it is needed, through training, and encouragement. This should be flexible and accessible.
- 3) Integration with ordinary life and people in non-segregated settings.
- 4) Adequate Income There should be valued work available paid at the proper rate, sufficient to support the client and any dependents.

For more details see Appendix VI.

UN-PAID WORK

In many cases paid employment is likely to be difficult or even impossible to obtain. Jobs are difficult to find for 'normal' members of society, those labelled 'mentally ill' are faced with an additional handicap. Voluntary, un-paid work may be the only realistic option for many. Whilst such work provides no financial rewards, it can provide other aspects of 'having a job' - friends, status, a routine etc. In addition it can provide a very real sense of doing something useful for the community, of being a helper rather than one who is being helped.

Design guidelines of a service for voluntary/unpaid Work

To establish a voluntary work finding service similar guidelines should apply to those for finding paid work i.e. it should offer choice, support and an integrated setting. In addition, volunteers should not be used to do jobs normally done by paid employees. For details see Appendix VI.

COMMUNITY EDUCATION

Community Education is a special example as it does not fall completely into the categories of either work or leisure. It can provide training, occupation, enjoyment and chances to make new friends. Numeracy, literacy, basic skills, cooking, sewing classes as well as many hobby skills are available in most Adult Education Centres. There is also a commitment by Manchester Education Authority to integration of disabled people into ordinary classes. These resources should be used whenever possible rather than segregated resources. The clients need the opportunity, support and encouragement to use the classes, including meeting co-students, talking to teachers, and helping with input into course content.

WORK BEHIND THE SCENES

There is a great deal of back-up and supportive work that has to be done for the service to meet the needs of the clients in the way outlined in the sections on work, living at home, and friends and leisure. This section attempts to identify the main strands of this essential work, but the details must be worked out as the service is put into operation.

- A) CHANGES INSIDE THE HOSPITAL: In line with the needs of the clients as identified through 'Getting To Know' the clients, there will need to be many changes in ward routine, hospital organisation towards a more outward looking institution, including getting to know local resources, going out more with individual clients, looking to resources outside to meet client's needs.
- B) THE SERVICE AND THE COMMUNITY: The emphasis in this document has been on enabling clients to use ordinary community resources, housing, adult education centres, clubs. There are several levels of this enabling:-
 - 1) Information: Information needs to be gathered about housing, workplaces, shopping areas, community centres and this should be available to anyone who requires it. Much of this information could be gathered from staff already working at the hospital.
 - 2) Liaison with These Resources: A working relationship needs to be built up with people in control of these resources, e.g.
 - a) Reaching agreement with local housing associations over the renting of houses to people who are being resettled.
 - b) Working with local firms to encourage them to take on ex-psychiatric patients as detailed in the section on work.

- c) Negotiating with local church groups and other leisure facilities to increase their confidence and ability in working with clients.
- d) Working with voluntary groups such as MIND and Care Groups who might provide voluntary help. These groups would need training and support.

3) Community Involvement: We need to work directly with representative bodies in the community, (e.g. Allied Workers Groups), involving them in the process of resettling people into their communities. These bodies can be a great source of assistance by pressurising for more facilities, encouraging others in the community to be more tolerant, promoting the rights of ex-psychiatric patients etc.

C) CHANGING ATTITUDES TO MENTALLY ILL PEOPLE

Realistically, a lot of people living in the hospital will never live totally independently of the service. Many of them will never lose entirely the odd habits and appearance gained over their lifetimes, as they have become personal characteristics. This means that people outside will have to accept the harmless habits, mannerisms and looks of some chronically mentally ill people:-

- a) The main source of change will be through contact. We can help to ease the way by enabling that contact to be successful, which is the central theme of much of this section.
- b) As well as contact, education will be needed; giving talks, preparing exhibitions and leaflets. Many people are afraid of mentally ill people or strange people from lack of understanding and knowledge. There are other organisations who would be willing to help in this process such as MIND.'

DESIGN PRINCIPLES FOR A SERVICE

1. The service should be flexible and available, friendly and efficient but not bureaucratic.
2. The service should give the people the opportunities and support to live real lives. It should encourage contact with the community and give people the support to change and develop.
3. For each individual there should be identification and assessment of her special needs. This should be a broadly based assessment including relevant settings. There should be a key worker to take responsibility for continuously up-dating the assessment. There should be consumer participation at all stages.
4. The service should provide,
 - 1) Ordinary housing with a variety of support
 - 2) Proper employment service (including alternatives to paid work)
 - 3) Proper leisure enabling service
5. The service should support and enable real choices that are made by consumers. There should be safeguards on those occasions when rights need to be withdrawn to meet a major need.
6. The service should develop links, contacts and give support to community organisations who help with ordinary and specialist ways of developing friendships.

RESETTLEMENT IN THE COMMUNITY**1. WHO SHOULD BE RESETTLED**

The process of resettlement must be carefully carried out. It will start with work inside the hospital. This work is already being done by people working in and out of the hospital. What these proposals aim to do is firstly to speed up the process and secondly to make it possible to resettle some of the more disabled people who will need more intensive one-to-one support both in the preparation for resettlement and in the community itself. The Resettlement Team will identify patients who wish* to move out. Groupings of people should be encouraged. If people have links with a particular patch, or strong wishes to return there they should be grouped with others who wish to be resettled in the same patch or who do not mind where they are resettled, but are friends.

Choice should be an essential part of this process. This needs careful development by gradually giving patients more alternatives and helping develop skills.

The choosing of the first group of between 20 and 30 people to be resettled (those for whom this particular care-in-the-community bid is being made) will be a difficult and complex task. We suggest the following guidelines should be followed, or at least attempted seriously:-

- a) Clients wishes* should be paramount
- b) Staff on the wards and those with close knowledge of individuals should be consulted to identify those people who will be the first to be resettled.
- c) Staff should be encouraged to be as positive as possible and people who are less able and more mentally disabled should be chosen as well as the more able individuals.
- d) The people will have to be Manchester residents, unless suitable reciprocal agreements can be reached with other authorities.

* "wish" in this context needs defining in terms of informed choice. If present residents are asked "do you want to move out?", many at this time may say "no" because they have no experience outside the hospital and have become so dependant. Focussed work will need to be done in the hospital to help people make that decision. That work will entail:-

- . giving people more information about alternatives.
- . helping people to have experience outside the hospital.
- . helping people develop their skills and confidences
- . so that they can cope with alternatives to hospital
- . without fear

If after this kind of development work an individual says "no" to the question then that will be a more informed choice.

This choosing of individuals is needed before a Care-in-the-Community bid is made, since it applies only to the resettlement of named patients. In a survey carried out on 16th February, 1984 (by Richard Walne - Administration) there were 180 patients from Social Services Area 1 and 86 from Area 2 and 40 from Salford in residence in the mental illness wards. Out of a total in-patient population of 360 in residence in mental illness wards at North Manchester General Hospital.

2. WHERE MIGHT PEOPLE BE RESETTLED

There are strong arguments for the resettlement first of groups of patients into one patch of the North District. This would enable the setting up of all the necessary staff support systems in this initial patch.

In order to qualify for Care-in-the-Community money, savings have to be made in the hospital in three years' time, and the money transferred to pay for the staff and resources required in the patch. We should therefore aim to close a ward in three years and concentrate on resettling those patients in a patch.

The identification of PATCH No. 1 should ideally include a number of considerations:-

- Are there between 20 and 30 patients who choose to move into this patch or who do not feel strongly about where they go?
- Are there positive aspects of this patch which make it desirable residentially?
- Are there council houses in this patch available and is there or could there be an agreement with the Housing Department to give priority to these patients.
- Are there any houses owned by Housing Associations, or plans to build in this patch, and is there an agreement or could there be with any such Housing Association to give priority to these patients?
- Are there friendly Community Groups, Neighbourhood Care Groups, etc?
- Are there desirable facilities, e.g. shops, libraries, pubs, cinemas, recreation facilities, adult education facilities, clubs, etc. within the patch?
- Do staff working within the hospital already have connections and contacts within the patch?
- Is the patch defined as a community by local people?
- Is the patch defined as a community by local workers?

3. WHO MIGHT HELP THE RESETTLEMENT PROCESS

A **Community Resettlement Team** would be essential. The Hospital Resettlement Team is described below. Whereas the majority of its work would be done inside the hospital, some of the work done by resettlement workers will involve contact with community. Correspondingly whilst most of the work of the Community Resettlement Team would be outside the hospital some will involve contact with the hospital.

e.g.1) Whereas a hospital resettlement worker might identify contact and make arrangements with housing associations, a community resettlement team worker might contact the relevant local officer in the Housing Department.

e.g.2) Whereas a hospital resettlement worker would contact the Education Department to discuss future community developments in adult education for patients to be resettled, a member of the Community Resettlement Team would talk to local teachers about specific developments or specific people's needs.

From the examples used it is clear that an essential worker for this would be a **Community Liaison Worker** who would identify resources ranging from education to leisure to employment on the one hand, and supportive groups, tenants groups, neighbourhood care groups on the other.

Detailed individual work with the Housing Department and Housing Associations identifying ordinary houses or flats should be done by the Hospital Resettlement Team, and in such a way which encourages patients' choice and participation.

This post would be filled as the Resettlement Team is developed and should work in parallel with it.

The resettlement patch would "house" the Community Resettlement Team and the premises might be used for some of the functions of the team, although many of those would be done outside the patch in ordinary everyday settings.

The team might include:-

- a social worker
- a psychologist
- a nurse therapist
- an occupational therapist
- a community psychiatric nurse
- a day activities, leisure and employment officer
- a volunteers organiser (see below)

The team would be new appointments, but they may be made from present hospital workers, (If this is so those posts must be replaced.) They would continue the skills-building, the therapies and the support already started in the hospital, but in the resettlement patch, and would aim to increase the participation of resettled individuals in the life of the community. They would also aim to increase the tolerance and capacity of the community to offer support to resettled individuals. Part of this will be work with parents, relatives and friends, family therapy, and support work.

A **Volunteers Organiser** should be part of the patch team. The work would entail recruiting, training and supporting volunteers who live in this patch. They may work as befrienders. They will be volunteers already in volunteer networks such as neighbourhood care groups.

Some patients will need emotional and practical support perhaps for the foreseeable future. Some people will only need occasional support. Some people will need less support as they gain in skills and confidence, others will need more as they grow older. Some will need more support at some times and at other times feel relatively independent. A flexible support system, devised by the team described above, would need the skills and hands-on work of **carers** similar to those employed by the Social Services Department to enable mentally handicapped people to live and participate in the community. They would provide the kind of support a caring relative would provide and would be available on a 24-hour basis. (Until a detailed needs assessment is performed it will be difficult to predict the exact number of carers required to support 30 individuals). Carers at times will have roles rather like a paid befriender taking patients out into the community into ordinary settings and being a friendly supporter.

This work may well start when the patient is still officially a resident of the hospital when the carer would work under the guidance of the 'patch team' when the patient is resettled.

Since this team will be an innovation to the District (as will the Hospital Resettlement Team) much of its work will evolve in practice.

It is hoped that detailed work on the lines of that carried out in the Openshaw Project will be done with community groups and individuals during the time the Hospital Resettlement Team starts work with individuals in the hospital. (For costings of this team see appendix VII.)

Befrienders and Volunteers

The method of working suggested by this document suggests means involving many more non-professional helpers in the care of clients, e.g. teachers, clergy, neighbours. These people will need advice, encouragement and support from professional staff. In some cases this will mean formal training as with befrienders. In other cases, such as a co-worker, it might mean someone to offer support and be available in case of difficulties.

Befriending is a specialised form of volunteering requiring far more dedication. In some cases befrienders will have to be paid depending on the difficulty and skills required of working with particular clients.

A) What Befrienders Do:

Generally speaking befrienders do the tasks that a friend would do, only in a more conscious way.

- a) Someone to go with: a befriender would go with the client to leisure activities, help him to make friends and to join in, to learn the requisite social skills, and act as someone to listen.
- b) Someone to work with: a befriender might go to work with the client, help him to learn the work task, introduce him to his colleagues, etc.
- c) A neighbour: a befriender might initially visit the client in hospital and help him to move outside, talk about the neighbourhood, show him where the shops are, listen to problems.

The nature and extent of these tasks must be carefully laid out between the befriender, the client and the hospital authorities. This is to avoid the traps of over-commitment, too much responsibility and being unable to cope on the part of the befriender and over-dependence on the part of the client.

An overall agreement should be reached with Unions about the nature of tasks that unpaid befrienders and paid befrienders should do.

B) Training and Support

This is vital to the success of any befriending project. Perhaps volunteers could be trained in batches, helping them to see their own strengths and weaknesses and the kind of voluntary work they would best be suited to.

Ongoing support and training will also be vital as befrienders and volunteers take on tasks. This should involve both individual and group support.

C) Matching

Matching of volunteers with clients will be difficult and there are no easy solutions. However, it must be done using an intimate knowledge of both client and befriender. It will also depend on the nature of the tasks to be undertaken e.g. if the befriender's role is to help the client integrate into leisure activities, the befriender should have some interest in the client's choices of activities.

D) Recruitment

Generally volunteers and befrienders should be recruited from the area where the client is to be resettled.

Recruitment could be from local organisations such as church groups, community associations, British Legion clubs, etc. Alternatively, existing voluntary helping groups such as the Neighbourhood Care Groups, MIND, St. Vincent De Paul, etc. might be encouraged by support and training to take on a greater role with respect to chronically mentally ill people.

Hospital Volunteers Organiser

It is clear from the above description that there is a large amount of work to be done. Parts of it could be done by the resettlement team and the staff already working from the hospital, as some of it already is, but there is a need for a co-ordinator to take on responsibility for recruitment, organising training programmes, arranging support for befrienders and matching clients and befrienders.

THE HOSPITAL REHABILITATION AND RESETTLEMENT TEAM

Resettlement from Springfield Hospital has been a continuing process over a number of years. Much of what follows is implicit in existing practice. The purpose of this section is to establish and make explicit some of these roles. It is now felt that a number of added supports are necessary to facilitate this process alongside plans being made for hospital bed reduction. In line with this, a Resettlement Team is envisaged, to be drawn from existing staff. To ensure that their added workload does not result in a decreased quality of care for patients remaining in the hospital, new staff will have to be appointed to replace them.

The Hospital Rehabilitation and Resettlement Team is a vital part of the process and will act as co-ordinator to ensure that people originating from a specific patch are given sufficient help and support to return there. Hospital resettlement workers would liaise with the Community Resettlement Team; they will both link with the appropriate community to develop those networks and resources necessary to facilitate the individuals re-integration in the community.

The composition of the Team is seen as :-

- existing staff e.g. nurses, psychologists, psychiatrists, occupational therapists, volunteers organiser etc.

These are the professionals who have the skills and credibility to explain and demonstrate to other staff the methods and procedures of resettling people according to their individual needs, which include assessment, support of key workers and community knowledge.

FUNCTIONS OF THE TEAM

- identifying individuals in hospital who are to be resettled
- identifying and supporting a key worker who will work intensively with this individual
- liaising with hospital management structures and community groups/networks to ensure continuity of resettlement
- encouraging changes in hospital procedure which will enable key workers and individuals to move through the resettlement process smoothly.
- discussing with all possible staff groups and trade unions the methods and procedures used in resettlement taking into account the day-to-day problems of the staff when seeking solutions.
- the team will thus need to know the Resettlement workers and will liaise with the Community Resettlement Team. This will facilitate an understanding of the community networks and facilities available in a given area as well those which may need development in order to meet the needs of the hospital residents.

The team must have identifiable links with decision making bodies to enable its smooth functioning.

Two phases of resettlement were identified:-

1. Grouping these residents together (into a ward or section) who either wish to move or who originate from an identified geographical area. These residents would then be worked with to develop those skills which may help them when resettled. This task would be that of the keyworkers' who would be concurrently becoming familiar with the area into which they are moving.
2. After a period of years, resettlement should occur with the team overseeing and co-ordinating the move and the linking with the community and the Community Resettlement Team.

KEY WORKERS' ROLE

- . A Key worker would be a "hands-on" worker, most probably a nurse, who spends most time with the resident. S/he would be given sufficient time free from other duties (cover being arranged) to get to know the resident very well and develop something like a multi-disciplinary assessment of needs, strengths and required action, the majority of which the key worker would implement.
- . The key workers would spend some time in the community into which the clients would be resettled so that continuity and appropriateness of programmes etc. would be maintained. This would include liaising with the Community Resettlement Team.
- . The relevant community nurse/social worker would also be involved in the process in and out of the hospital to facilitate the co-ordination. They would also link with Community Resettlement Team.

Any Social Worker or C.P.N. at a certain stage of resettlement may become the key worker. This depends on the individual and the team.

SUPPORT GROUP

The Resettlement Team will need support at a number of levels and it is suggested that a support group exist to cater to the needs of the team.

- . to give the team quick and reliable access to policy and decision makers
- . to be a source of expertise in a number of areas that the team may consult
- . to act as a focus for problem solving and to encourage creativity (it is recognised that the Resettlement Team's role demands many skills and many facets of work, that that this may appear onerous at times).
- . to support individual members if necessary
- . to ease the load of responsibility - each support group member will have access to a range of knowledge bases/practices etc., which the team will not be expected to have
- . to aid training and team development

PREVENTION

It is important that these teams, in the hospital and in the community, should aim at developing specific strategies for prevention.

We have noted that a number of patients in need of rehabilitation are not necessarily found in the long-stay wards; they can also be found in the acute wards and in the day hospital and, from time to time, in general medical wards. In the community there is an unknown number of severely mentally ill patients who have either never been seen by specialists or may have had contact at odd times.

It is only when the supporting relatives become too old or ill to look after these people that the problem surfaces and, whenever we come across such patients, who have become institutionalised in their own homes, they present the same problems as those we have seen amongst patients in the long-stay wards..

CONSULTANT TEAM

It is vitally important that the rehabilitation and resettlement team, once formed, initially relates to one clinical team, that of Dr. A. Theodossiadis, who has identified a specific number of patients who have potential for discharge into the community. Once the rehabilitation team has become fully integrated with the life and the workings of this unit, it would be reasonable to start relating to the other clinical teams.

SECTION THREE (the examples)

These examples are entirely fictitious and are used as a device to illustrate the suggested method of working.

EXAMPLE 1

WORK

Bill left hospital three days after his 56th birthday. In total he had been a patient there for over 20 years. He was found a small council flat in a quiet residential neighbourhood. The Social Workers from the hospital visited him daily for the first few weeks - helping him to sort out benefit claims and paying bills. The worker who explored with him the possible ways of getting a job. In his youth Bill had been a skilled car mechanic, but within a year of going into hospital he had lost most of his knowledge and confidence.

With unemployment high, the worker explained to Bill that he had little chance of finding paid work. He applied for a number of part-time jobs, all but one of which didn't even reply. So the Resettlement Worker discussed with Bill and his Social Worker other possible areas, such as voluntary work. They contacted a local, very active voluntary group, and explained Bill's situation and needs. The Care Group suggested a volunteer called Alan, who had been with them for a number of months. Alan met Bill and afterwards talked to the Community Psychiatric Nurse who had been visiting Bill since he had left hospital. She discussed with Alan ways in which he could help Bill to meet other people and encourage him to take care of himself - especially in his appearance - which after years in hospital he'd lost interest in.

Alan started by visiting Bill once a week for a month or so, then started asking him to help him do D.I.Y. jobs for other people in the community. The first job Bill can remember doing was for an elderly woman who lived a few streets away. It took him and Alan an hour or so to put up an indoor clothes line in the bathroom. Bill felt very shy and nervous, but also very pleased, and before they left went back upstairs to have another look at their work. Alan introduced Bill to lots of people for whom they did jobs locally and gradually encouraged him to take care in his appearance. Bill, Alan, the C.P.N. and the Resettlement Worker would meet every few months and discuss how Bill was getting on. The Resettlement Worker remained in close contact with the Care Group, and is soon to introduce another client to them, after the success of Bill's experience. The Care Group is already expressing worries of overloading its volunteers with people with many needs, and of volunteers subsequently dropping out.

After a time Bill was happy to do household and gardening jobs for people on his own, and gradually got to know more and more local people. He has also recently started doing minor car repairs in the area.

EXAMPLE 2.

LEISURE AND FRIENDSHIP

Carol had been living in the hospital for five years. With the help of the staff there she had moved out into her own flat, but she was still coming to the day hospital and attending the hospital socials in the evening. She was doing very few other activities outside, except shopping occasionally. It was decided between her and her resettlement team to integrate her further into other activities in the neighbourhood of Crumpsall where she lived.

Her key worker (a CPN) worked with her over a couple of months, going out with her twice a week, visiting and learning about facilities in that area, including the library, the adult education centre, the community centre and the swimming pool. The key worker also used these trips to encourage Carol to dress more tidily and help her to use public transport and handle her money. The resettlement worker provided a contact in the area for the key worker and Carol with someone who knew about local resources, (in this case one of the local vicars).

The key worker encouraged Carol to come to some decisions about what kind of activities she wanted to do, by looking at her interests, strengths, preferences and the problems she had in living day to day.

Carol decided to attend an education class on cookery as the meals she cooked infrequently were fairly uninteresting. Also she wanted to go to the local church every Sunday. In both cases she was too afraid to go on her own, as she thought she would be picked out as being strange, and wouldn't know what to say or do. In Carol's case this was a fairly realistic appraisal of what might have happened as she wasn't very careful about clothing. She also talked to herself sometimes and twitched and shook. Her speech though comprehensible was slow and stilted.

Carol had no friends, except a few other people attending the day service, and no-one to go with. The resettlement worker took the task of identifying and contacting people at the local church group and adult education centre. It was thought that the advantages of identifying Carol as being a former psychiatric patient outweighed the disadvantages. He built on the relationship already made with the teacher of the basic cookery class, asking her to help Carol to settle into the class and explain the situation to the other students. They were very agreeable to help which led to a problem of over attention for Carol.

It took a month of encouragement and a visit from the teacher before Carol felt confident enough to go, and there have been several upsets since, where Carol felt she was being laughed at. However, she now goes fairly regularly and her home diet has improved greatly. An Occupational Therapist who is part of Carol's resettlement team has been visiting Carol occasionally for extra tuition in cooking if Carol is getting left behind or having difficulty in the class.

The local church was approached through one of the nursing auxiliaries from the hospital whose church it was. She, together with the vicar introduced Carol to the church and helped her to practise how to worship and what to do during the ceremony. This was not successful as Carol used to mutter during the prayers. There were several complaints from the other worshippers and Carol felt embarrassed and ostracised. She left after

going four times and so far isn't prepared to go again. The key worker is helping her, under the guidance of the hospital staff, to become more aware and able to control her muttering.

The key worker is also trying to aid Carol to join in other leisure activities.

EXAMPLE 3.

LIVING AT HOME.

Florence lived in the hospital for 15 years. She was not suffering from any mental illness except chronic insitutionalisation. After an initial period of getting to know Florence an agreement was reached between the Resettlement Worker, the Key Worker (A Nurse on Florence's ward), and the others involved in Florence's care, to aim towards resettling her in her own home, preferably in Crumpsall, where her ageing parents lived. Her parents could not look after her, but it was a place which Florence knew and in which people from the hospital had a lot of contacts. Florence, at this stage, had no easily discernible views on whether she wanted to stay in the hospital or not. She generally tried to give the answer that the person she was talking to wanted to hear.

Each of the people in Florence's Resettlement Team agreed the tasks which they would be part of. The Key Worker's job was gradually to encourage Florence to start making decisions for herself again, beginning with simple decisions and gradually building up. This meant a lot of work with other staff in the ward to encourage Florence to start making decisions, as she all too easily let herself be told what to do. The Key Worker also started to take Florence out more, to the shops she would be using when she left, and to the other resources in Crumpsall; like the Library, Adult Education Centre, Community Centre, etc., helping Florence to learn more about the outside world again. This was very difficult to begin with as Florence was very afraid of going out, since she had forgotten many of the skills of ordinary living. this fear was overcome mainly through the trust that had built up slowly between the Key Worker and Florence. The Key Worker also helped her to re-acquire some of her lost skills, such as using money and public transport, with the guidance of the Psychologist and the Occupational Therapist.

The Resettlement Worker was meanwhile negotiating with the local Housing Association to secure a house for Florence. He was also trying to lay the basis for a permanent agreement with the Housing Association. As well as this he was working with the Social Worker and Community Psychiatric Nurse to identify likely sources of assistance for Florence when she was living at home. This included talking with the local Care Group and Church Group, as well as the more orthodox services, such as Meals-on-Wheels and Home Helps. The Church Group were very ahppy to help with furnishing the house and doing minor repairs, and the Care Group were willing to pop in once a week to have a chat. It had been agreed that the Volunteer' Organiser should look for a befriender for Florence, preferably somebody from the Crumpsall area who could provide a link with and source of information about that area. She could help with acclimatising Florence to living outside once again.

The Social Worker had agreed to work with Florence's family to help them come to terms with the fact that Florence would be leaving the hospital after so many years. Initially, they were afraid that too much burden would be put on them, and this led to their insistence that Florence was too ill to leave. Once they realised that this was not the case, they were very supportive to Florence, who by this stage, was beginning to look forward to leaving.

The house was now ready and furnished with the help of (the Church Group) and a resettlement grant, and the gradual process of introducing Florence into her house could begin. The Key Worker and the Community Psychiatric Nurse accompanied Florence one morning a week to begin with, encouraging and supporting her in cooking her own meals, buying food, and in learning simple cleaning tasks. (the guidance and help of the Occupational therapist was important at this stage.) There were many benefit and money problems at this stage to be sorted out. Gradually Florence spent a longer time at the house, sometimes sleeping there, on her own. She then of her own accord, decided that she didn't want to go back to the hospital. She now has regular visits, twice a week, from the Home Help, who does some of the housework, and from the Meals-on-Wheels Service. The Key Worker and befriender are still working with her to help her make new friends and to find some useful occupation during the day. She would like a paid job, but as with many other people living in Crumpsall, this is unlikely.

All through this time Florence's Resettlement Team met regularly to think up solutions to the obstacles and difficulties that were all too often present, from hospital procedure, the Local Authority and between themselves. Tasks had to be re-allocated as Florence's needs and wishes changed, more so as she became capable of making her own decisions.

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APPENDIX I.

THE LIVES OF THE PEOPLE

a) Past History

It was found that most of the people concerned had led fairly normal lives prior to their admission to hospital. They had for the most part been brought up in the Northern part of Manchester, had been to state schools and were of average intelligence. Many had married and brought up children or had lived in a normal family environment. In most cases some crisis had occurred in their lives which had coincided with the onset of mental illness. This varied from a severe disabling accident to marriage breakdown, leading to alcoholism and included the effect of losing a job and also a succession of family bereavements causing hopelessness and despair.

b) Life Now

(i) Daily Timetable

The practical details of a typical day in the lives of the patients as described by them are given below:-

The time for getting up is from 6 a.m. to 8 a.m. approximately half of the patients getting themselves up and the rest requiring some help.

Breakfast is served from 7.30 a.m. to 8 a.m. and consists of porridge or cereal, followed by bacon and egg or sausage and tomato etc.

Lunch is from 12 noon to 12.30 p.m. and is usually three courses - soup, main dish and sweet.

Tea is from 4.30 to 5 p.m. and is mostly a hot dish.

Meals are served by nurses at tables seating three to four people. There is only occasional choice and although there are facilities for making snacks on the wards in the present organisational set-up, this is not possible. For example, in theory it should be possible to make tea as most of the wards have cookers, but supplies of milk are kept locked up in a cupboard and so tea is not made.

There is no fixed bedtime. Most patients have returned to the wards by 10.30 p.m., but there are no strict rules on this.

Sleeping arrangements vary slightly according to the ward. Most people sleep in individual, curtained-off type cubicles containing a bed, wardrobe, drawers etc., and separated by wooden partitions, of which there can be approximately between 6 and 12 in one ward.

Others sleep in dormitories of maybe 6 or 8 beds, each bed being curtained off. There is little privacy and limited locker space. The lockers vary, but are mostly too small. They are also supposed to lock but because many of the keys have been lost in the past, they are now kept in a cupboard. In discussion with patients concerning the conditions on the wards many comments were made on the lack of individual possessions, the lack of privacy, the drab surrounds, the high noise level, and the overcrowded conditions.

(ii) Clothing

There has recently been a big improvement in the standard and choice of clothing supplied to patients. Previously many patients appeared very drab and lacked any individuality in their dress. Since August, 1982 a new system of 'personalised' clothing has been introduced. This was started on one ward originally and is gradually being implemented throughout the hospital. There are many different styles available and a complete wardrobe of day clothes, outer clothing, e.g. a raincoat or topcoat, shoes, underwear etc., is issued to each patient. The clothing is given an individual number so that there is little chance of losing it in the laundry and it is delivered back to the ward after washing. Unfortunately, even with all these precautions a large amount of new clothing has already gone missing. This is now being rectified.

(iii) Money

D.H.S.S. Benefits for most patients are paid by GIRO directly into the hospital bank. Some patients get their GIRO sent to the ward directly by post. Patients receive a minimum of £3.50 per week, and if they do any kind of paid work, such as gardening, they are paid extra in accordance with the D.H.S.S. guidelines on therapeutic earnings. For example, the pay for doing 4.1/2 days gardening plus D.H.S.S. Benefit would be approximately £7 per week. Any money which accumulates in the bank can be drawn out in small amounts (maximum £5). There are no restrictions on how the money is spent.

(iv) Shopping

There is a small shop located near the wards which sells chocolate and sweets, biscuits, canned drinks, etc. There is also a fairly good selection of clothing and some items of food are available. Tea and coffee can be bought at the tea bar. Outside the hospital there are good shopping facilities within a few miles.

(v) Individual Activities

Many of the patients attend classes in occupational, social, industrial or art therapy held outside the wards. There are some ward-based therapies on wards 2,6,10,32,34. On ward 10 this consists of a two hour period of occupational therapy and a cookery class one day a week. The Social Therapy Department offers two main areas of service - the therapeutic farm and gardening

For many people the day is spent sitting about on the wards, walking in the hospital grounds or watching television. Some run errands and act as messengers. For these people there is no organised structure to the day and a priority of the unit is to provide more ward-based occupational therapy.

The lending library is open most days. It is generally used as a reading room, although books can be borrowed. A trolley service is provided for supplying books to patients on the wards. Adult Education classes are held at the Abraham Moss Centre on four afternoons a week in literacy and cookery. Some classes are held jointly with Prestwich Hospital, and some outsiders also attend. A literacy class is held in the library for assessment of new patients.

(vi) Leisure Activities - Evening and Week-end

Facilities exist for leisure activities inside and outside the hospital. In the hospital these include watching television, reading, listening to music and attending discos and social evenings. There are no therapies at the week-end but in the week the Social Therapy Department opens until 9 p.m. on Monday, Wednesday and Friday, and arranges social and recreational events. These include a weekly video film show and two social evenings each month organised by the Patients Association. There is a regular monthly dance and approximately three visits a month are made to clubs in the community. The League of Friends also run a tea bar every Sunday from 2 p.m. until 4 p.m. There are football and cricket matches in the hospital involving in-patients and day patients - 15 fixtures per season, home and away. Swimming sessions are also organised, some with instruction.

Outside the hospital patients can go to the cinema, visit friends, go to night school classes, have meals out and, probably most popular of all, have a night out at the local pub. There are also many organised outside activities which include regular trips to holiday resorts during the summer and visits to museums, theatres and the pantomime in the winter. For such excursions there are two mini-buses available throughout the year for use by all wards and departments. They are driven by staff specially authorised to drive hospital transport (approximately 30 staff) who are spaced out between units, each ward arranging outings for their patients according to staffing levels. The buses are mostly used within a 50 mile radius of the hospital (averaging 9,000 miles per year), but they also accompany patients on holiday. A number of holidays are arranged each year at hotels in Blackpool, Morecambe, Weston-super-Mare etc., and some very successful holidays have been spent in recent years at Butlin's Holiday Camps.

APPENDIX II.

SOME OBSERVATIONS ON PATIENT BEHAVIOUR

In an empirical study* carried out in January 1983, observations were made of patients from two of the rehabilitation wards. The study consisted of taking random observation samples of the behaviours engaged in by the patients. Observations were carried out between 9 a.m. and 9 p.m. on Monday to Sunday for one week. A total of 122 samples was collected. The majority of the time during which patients were observed they were engaged in solitary behaviours (78.1%). These were the times when they were observed to be doing things which did not involve interaction with other people, things like reading, involvement with their therapeutic activities (provided by Occupational Therapy for example), eating and watching television. Over half of the time spent in solitary behaviour (51.1%) patients were considered to be behaving in an egocentric manner. This was defined as blank staring, aimless wandering, talking to self and sleeping at inappropriate times.

Considering that patients were observed in interaction for 21.9% of the time this would appear to indicate that there are few opportunities for them to learn new, appropriate skills. Therefore it would seem that the therapeutic potential of the wards and therapy departments for these patients is being under utilised.

* FOX. W.P.

Staff and Patient Behaviour Profiles on Long-Stay/Rehabilitation Psychiatric Wards. Paper presented at the Annual Conference of the British Psychological Society, London, 1983.

APPENDIX III.

SOME FACTS CONCERNING PATIENTS

Derived from data collected by Dr. Neill Simpson (Senior Registrar in Psychiatry)

The total number of patients was 280 of which 150 were men and 130 women

They were on Wards,

	Total (280)	Men (150)	Women (130)
1. HAVE NO FIRST DEGREE RELATIVES (i.e. Parents, spouse, children)	49	28	21
2. HAVE HAD NO CONTACT WITH RELATIVES IN LAST YEAR	94	61	33
3. HAVE HAD NO CONTACT WITH RELATIVES IN LAST THREE MONTHS	109	67	42
4. HAVE NO HOUSING (excluding ESMI wards*)	134	77	57
5. HAVE NO DAYTIME OCCUPATION	220	114	106
6. ARE IN GOOD MENTAL STATE	98	64	34
7. ARE IN FAIR MENTAL STATE	122	64	58
8. ARE IN POOR MENTAL STATE	60	22	38
9. ARE IN GOOD PHYSICAL STATE	169	93	76
10. ARE IN FAIR PHYSICAL STATE	96	49	47
11. ARE IN POOR PHYSICAL STATE	15	8	7

* Elderly Severely Mentally Ill People

Note:-..Short-stay women have no relatives and medium-stay men and women have no relatives.

APPENDIX IV.

EXSISTING PROVISION

This can be divided into two parts. Firstly, a hospital dominated psychiatric service with approximately 380 beds and several day departments and secondly, a range of resources outside the hospital including Social Services establishments and other projects run by various voluntary groups.

In the hospital approximately 46% of the patients have been there for more than two years including both psychiatric and psycho-geriatric patients. There are also five Day Departments offering a range of rehabilitation services. Of these one caters for chronically mentally ill people (60 places) and one for people with drinking problems (20 places). Another provides an Industrial Therapy service (70 places) and there is also a Specialist Day Department for psycho-geriatric patients (25 places). There are a further 50 places in the Macartney Day Centre for more acute illness.

Working outside the hospital there are Community Psychiatric Nurses, each of whom works with a hospital based team supporting patients/clients in the community. Psychiatrists also do home visiting.

Manchester Social Services Department provides for mentally ill people on a city-wide basis. There are three day centres, an average of 60 places in 15 minimum support homes and two 30-bedded hostels. There are six Social Services areas, each of which organises itself differently. Two of these areas cover the North District, one having a Specialist Team of Social Workers which deals with mental and physical handicap and illness.

Most of the social work support is provided by hospital based Psychiatric Social Workers who, in addition to work with in-patients and day patients, also offer support in the community to a substantial number of clients.

Details of the various services are as follows:-

A THE HOSPITAL

(a) Patients

Approximately 350 people live in 14 wards, of which approximately 86 live in ESMI (elderly severely mentally ill) wards and there are 72 in acute admission wards.

(b) Staff

There are 285 w.t.e. (whole time equivalents) nursing staff including learner and nursing officers.

20 Doctors including 8 Consultant Psychiatrists

15 hospital based Social Workers - 4 of whom work with the elderly mentally ill

	Establishment	Staff in Post as at 1.6.84.
<u>Psychology</u>	8 including 1 Technician	7
<u>Occupational Therapists</u>		
General	1 Head II	1
Psychiatry	1 Head IV	1
	1 SEN. I	-
	1 sen. II	1
	1.5 Basic Grade	-
	1 Technical Instructor	1
	7.1 Helpers	5.8
ESMI Service	1 SEN. I	-
	1 Basic Grade	-
	3 Helpers	2.6
<u>Other Therapists</u>		
Drama Therapist	1	1
Art Therapists	1 SEN. II	1
	1 Basic Grade	- (Appointment advertised)
	0.72 Helpers	0.72
Music Therapist	0.5 (NHS Funding)	- Appointment pending
Physiotherapists	2.33 (wte)	Established and staff in post

(c) Hospital Support Services

These include cleaning, administration, works, laundry, portering, catering, hairdressing and a shop.

B OUTPATIENTS

There are approximately 2000 outpatients i.e. people maintained in the community, most of whom have an established home and family network. In 1983 there were a total of 11,672 outpatient attendances.

C GROUP HOMES AND HOSTELS

The number of patients in the hospital has decreased by 150 over the past eight years and most of these people are living in group homes or hostels of some kind.

Group Homes

Social Services Department provides a total of 60 places for the whole of Manchester. There are also two independently run group homes.

Other Homes and Hostels are:-

Social Services Department Hostels

Plymouth House 30 places

Forester House 30 places

Richmond Fellowship Hostel

Birchcroft 12 places

Three Quarter Way House 3 places

Aged Persons Homes

Manchester Social Services has 42 Aged Persons Homes of which residents of the North District have access to 15.

Sheltered Housing (Resident Warden and some communal facilities)

There are 13 Sheltered Housing Units in North District. Area 2 has 6 with 331 places.

Southfield (Private Hostel)

30 places plus 12 places in the annexe (Seper House)

Homeless Persons Hostels

There are approximately 1000 places available in Manchester.

Facilities for Alcoholics

For the homeless drinking alcoholic there are 3 Salvation Army Hostels in Manchester and 7 other centres including 1 for women.

For alcoholics wanting help there is specialist advice available at:-

Alcoholics Anonymous

Greater Manchester Council on Alcoholism

Specialist Worker from Social Services - Miss Pam Cook

There are 3 Treatment Units at:-

Kingswood Clinic (Prestwich)

Withington Hospital

North Manchester General Hospital

For sober alcoholics wanting help in staying dry there are 5 hostels in the Manchester area.

Other Facilities

(a) Community Groups (Not mental health orientated)

Neighbourhood Care Groups

Church Groups/Clergy

Mothers Union

Solo Clubs etc.

(b) Social Services Department Mental Health Day Centres

Harpurhey 40 places

Daisy Bank 40 places

Baguley 40 places

(c) Groups Assisting With Accommodation

LANCE Project for the single homeless

CHAR Campaign for single homeless

NACRO National Association for Care and Rehabilitation of Offenders

CAP Community Action Project

Housing Associations e.g. Family Housing Association, Northern Counties Housing Association, etc.

Shelter

(d) Other Voluntary Groups

MIND 4 place group home
 Information Centre and Drop-In Centre

AGE CONCERN 2 Day Centres each taking 12 elderly, mentally ill patients

MARS Manchester Alcoholics Recovery Service

LEAGUE OF
FRIENDS Visiting in the Hospital and running social and fund raising
 events.

UMIST Run social events in the hospital.

ST. VINCENT DE PAUL SOCIETY Visiting in the Hospital.

(e) Self Help Groups

Well Women Clinics, 42nd Street, Lifeline (Day Provision), 'People not Psychiatry', North West Fellowship (for schizophrenia sufferers and families), Alcoholics Anonymous, Alcohol Concern, etc.

APPENDIX V.

LIVING AT HOME

To determine the needs of the person with respect to housing it will be necessary to get to know a great deal about the person in a variety of settings, about their skills, preferences and needs. Following this, a flexible plan of action should be drawn up aimed at aiding the person to live in his own home, except in the very few cases where this is not possible, due to severe physical or mental infirmity.

The service should gradually build up the clients ability to make decisions. This should include helping the clients to experience positively the advantages of living outside, so they can make realistic informed decisions.

The person should be slowly introduced to the idea of living independantly and given practical help in learning all the skills necessary for living in his/her own home.

Help is needed in finding a place to live depending on the person's needs. This may range from a staff member, or volunteer going out with the person to look for accommodation, to making arrangements with the Local Authority for housing priority.

The siting of the accommodation is dependent on the clients wishes foremost, but also on availability of community resources and knowledge and links into a particular area.

The people and their families have a right to independent lives but practical and emotional support should be given to those families who want to care. This should include time off for the family e.g. where staff could take over the care of the client in his own home whilst the family go on holiday.

There should be assistance with financial matters, including obtaining resettlement grants and benefits whilst the clients are only living part-time in their own home.

The people must have the folowing needs met by themselves or someone else. Every effort should be made to enable them to meet the need themselves.

- a) Provision of meals - shopping, cooking
- b) Mobility
- c) Personal care, bathing etc.
- d) Cleaning
- e) Laundry
- f) Dealing with bills, rent, budgeting, using money

APPENDIX V (continued)

- g) Acquiring furniture and other personal possessions
- h) Practical activities such as hanging curtains, mending clothes, etc.

The person needs advice, encouragement and support in these activities.
This could come from:-

- * Staff living in, or nearby
- * Relatives
- * Co-residence schemes: where a tenant in return for a lower rent agrees to help the client
- * Friends
- * Volunteers from local care group or church groups etc.
- * Befrienders
- * Home Helps
- * Wardens
- * Adult Education classes on cooking, cleaning, sewing
- * Luncheon Club, Meals on Wheels, or other provided meals
- * Social Service carers
- * Adult fosterers
- * Good Neighbourhood Schemes: neighbours are paid a small amount to look in on the client and do some household chores.
- * Neighbours

Training, advice and support is needed for all of these helpers.

APPENDIX VI.

WORK

A Job finding and support service should:-

- * Assess preferences and the level of support needed
- * Make information about jobs available, give encouragement and support where it is needed and attempt to safeguard against disillusionment and fear of failure.
- * Arrange work experience, practical training sessions, practise interviews and gradual introductions to work. This could start before the client leaves hospital.
- * Arrange co-workers to provide support at the work place. This would be particularly important during the initial period. The co-workers would also help the person to make the social contacts most of us make at work.
- * Create links with employers to encourage recruitment, sympathetic attitudes and to develop employment possibilities - placement schemes for example.
- * Attempt to safeguard against discrimination, try to create and enforce a quota system, particularly in the N.H.S. and Local Authorities. (These could act as models of good practise). The results of these efforts should be monitored and attempts made to make management accountable.
- * Make full use of Government Training and Job Creation Schemes. The use of the Sheltered Industrial Group should be explored.
- * Persuade employers to hold jobs open during periods of illness where patients are already in employment.
- * Look at skills sharing, cooperatives and other initiatives.

Many of the aspects of this work are already covered by the functions of the Disablement Resettlement Officer. However, it might be useful to establish some sort of Employment Development Officer specifically for Mental Illness in addition to the D.R.O. This person could then undertake detailed liaison with employers possibly over a smaller area, could recruit and train co-workers at the workplace, research into job creation or expansion possibilities and could monitor the effectiveness of any anti-discriminatory measures. Alternatively, pressure could be exerted on the Manpower Services Commission to increase the number of D.R.O.'s and the scope of their work.

The Industrial Therapy Unit at the hospital and it's manager already do some of this work. In particular existing links with local industry could be built upon.

A SERVICE FOR VOLUNTARY/UNPAID WORK.

There should be:-

- * An assessment of the clients preferences and needs, along with an attempt to inform, motivate and interest people to enable them to make real choices.
- * Information should be collected about all local groups, whether they use volunteers, what kind of work they do, etc., and links established with them.
- * There should be close liaison with existing Community Care/Neighbourhood Groups, and attempts made to involve them in the resettlement process. Where possible, this might entail an expansion of the group with the help of outreach workers, volunteer training programmes, etc.
- * 'Co-volunteers' should be recruited and trained to provide support to the new volunteer, preferably through the auspices of a Neighbourhood Care Group or similar organisation. This process of encouragement and support may gradually become less necessary as the client becomes capable of an independent role in the voluntary organisation.
- * Any problems involving the clients' eligibility for social security or sickness benefit when doing voluntary work should be anticipated and sorted out the with the D.H.S.S.

Obviously this is likely to be a long and difficult process and maximum effort should be made to encourage and motivate clients throughout. Support may be needed to overcome possible feelings of inadequacy or fear of failure on the part of the client and this support should be readily available and accessible.

APPENDIX VII.

FINANCIAL ASPECTS OF RESETTLEMENT

Cost of Running a 26-Bedded Long-Stay Psychiatric Ward

It has been estimated that the average cost to the Health Authority of a typical long-stay ward amounts to a total of £233,513 per annum.

To enable the level of savings which could be achieved following the closure of such a ward to be identified, these costs may be broken down as follows:-

Immediate Savings (non staff costs)

Medical and Surgical Equipment	£ 1,286
Pharmacy Services	£ 4,678
Diagnostic Services	£ 1,186
Other Medical and Para Medical Items	£ 7,409
Laundry Services	£ 4,524
Linen Services	£ 6,951
Provisions	£11,876
Domestic Equipment	£ 0,480
Total	<u>£38,390</u>

Eventual Savings

(staff costs)

Nursing Staff (excluding learners)	£70,953
Domestic Staff	£20,086
Catering Staff	£12,362
Total	<u>£103,401</u>

It is estimated that a period of 3-7 years would allow staff to be lost through natural wastage, although re-deployment, if this is appropriate and acceptable to those concerned, would be an alternative.

The costs relating to Nurse Learners (30,579) and non patient related general services (61,143) have not been included in the above breakdown, as these costs are not likely to be realised as savings.

APPENDIX VII. (CONT)

COST OF THE COMMUNITY RESETTLEMENT TEAM

(To be met by bridging loan from region and after 3 years from savings from ward closures.)

. Senior Psychologist	13,200
. Nurse Therapist (Senior Nurse 7)	11,000
. Senior I Occupational Therapist	10,529
. Community Psychiatric Nurse	10,534
. Genral Administrator	8,142
. Volunteers Organiser (G.A. Grade)	9,642
. Community Liaison Worker	13,200
. Day Activities, Leisure & Employment Officer	13,200
	<hr/>
	89,447
	<hr/>
. 4 Carers (each £6,500)	26,000
	<hr/>
	115,447

All these staff are costed at mid-point of salary scale + 16 1/2% and £1500 travel element (Except for Administrator).

APPENDIX VIII.

LIST OF PEOPLE INVOLVED IN THE "GETTING TO KNOW YOU PROJECT"

LOUISE FREEMAN	ASSISTANT UNIT ADMINISTRATOR
LINDA GARNER —	OCCUPATIONAL THERAPIST
ELAINE TAZIKER	OCCUPATIONAL THERAPIST
BILL FOX —	PSYCHOLOGIST
CHRISTINE MARKLOW *	PSYCHOLOGIST
CHRISTINE ADCOCK —	PSYCHOLOGIST
DR. JUDITH GRAY —	SPECIALIST IN COMMUNITY MEDICINE
DR. NEILL SIMPSON *	SENIOR REGISTRAR IN PSYCHIATRY
NIGEL ROSE —	RESEARCH ASSISTANT
DOROTHY CULLIGAN —	RESEARCH ASSISTANT
ALAN SMITH —	HONORARY RESEARCH ASSISTANT
ANN HOSIE	DIRECTOR OF NURSING SERVICES - PSYCHIATRY
BINESS BUDOO *	COMMUNITY PSYCHIATRIC NURSE
ROY CHESNEY *	NURSING OFFICER
SUE HUGHES *	NURSING OFFICER
JOE FOSTER —	DEPUTY CHARGE NURSE
KEN BARNES —	CHARGE NURSE
DON WRIGHT —	CHARGE NURSE
CHRIS RUSSON —	DEPUTY CHARGE NURSE
JANE TURNER * —	DEPUTY CHARGE NURSE
MIKE SLY * —	CHARGE NURSE
DAVID BUCKLEY —	ART THERAPIST
JEAN JESSON	THERAPIST AT HARPURHEY DAY CENTRE
GLADYS BROCKLEHURST	FAMILY SUPPORT ORGANISER
PEGGY HULME	FAMILY SUPPORT ORGANISER
ROGER MAXIM	SOCIAL SERVICES AREA DIRECTOR
SYLVIA EDWARDS	SOCIAL WORK CO-ORDINATOR - PSYCHIATRY
TONY RILEY	MIND

* Those asterisked attended less than half of the preliminary meetings.

Many thanks are also extended to Diane Whittaker and Martin Kirk without whom the production of this document would have been impossible.

