OPENSHAW* OUTREACH MENTAL HEALTH PROJECT — SECOND DRAFT

INTRODUCTION

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At present, the psychiatric facilities for the adults of North Manchester Health District are based in the most part on or around the North Manchester General Hospital site. This means residents of Clayton, Beswick, Openshaw and Higher Openshaw (the most southern parts of North Health District) face a long bus journey or in many cases a long ambulance drive to obtain treatment. This may deter people from seeking treatment until their condition has greatly worsened, as may the stigma attached to attending a psychiatric facility. One of the psychiatric teams based at North Manchester General Hospital has for some time been holding regular sessions at the two health centres at Beswick and Clayton, which helps to alleviate the transport difficulties of a few of their clients. However, it is felt that a locally based psychiatric service would both help with transport difficulties, lessen the stigma of attending psychiatric services, and would be able to play a greater preventive role.

The areas covered are amongst the most disadvantaged in the Health District with respect to recreation facilities, housing, pollution, employment, etc. These factors together with the high unemployment, the large percentage of elderly people and young mothers, all correlate with a high prevalence of mental illness.

A mixed disciplinary team (see below) from North Manchester General Hospital and Social Services met on four separate occasions to consider what form a locally based psychiatric service would take. This document is a resumé of our discussions, which is being sent out to all interested people and groups that live or work in the areas, or have an interest in psychiatric service provision in Manchester. We invite you to comment on, add to, or disagree with the tentative conclusions we have made.

OBJECT, AIMS

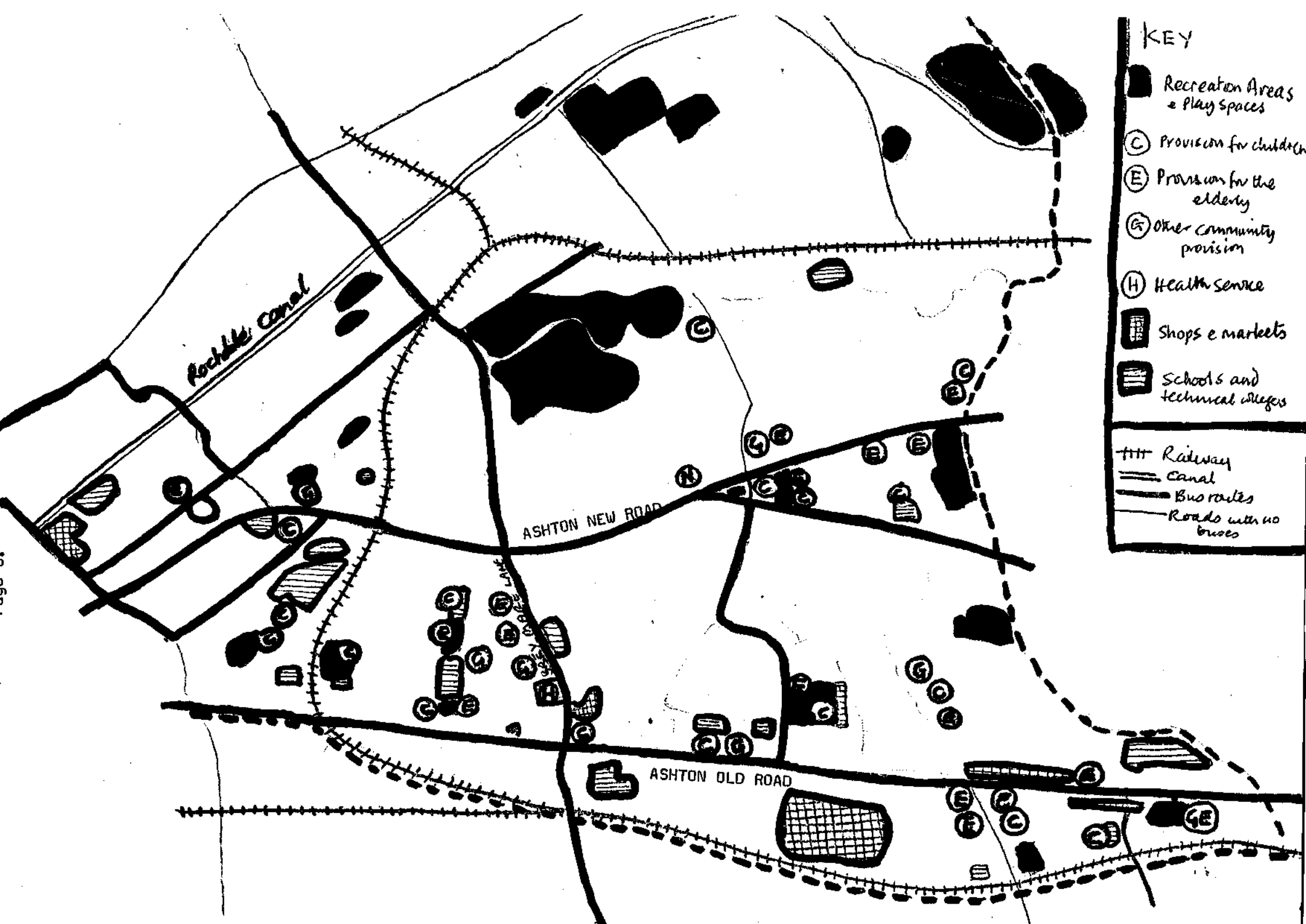
1) To look afresh at the needs of the clients for whom we wish to provide a service.
2) To propose a service that avoids the depersonalisation that often accompanies services
3) To propose a service that not only helps to relieve the illness or immediate problem of a client, but contributes to identifying and altering the factors surrounding their illness.
4) To propose a service that keeps clients in the community and does not compound their difficulties by stigmatising them.
5) To propose a service that encourages relationships outside those with other clients and professionals.
6) To propose a service which is suited to the need of people who live in Clayton, Beswick, Openshaw and Higher Openshaw.

* Openshaw is used to mean Clayton, Beswick, Openshaw and Higher Openshaw in the title of the project.

CLAYTON, BESWICK, OPENSHAW, HIGHER OPENSHAW

These four areas form most of the two wards, Bradford Ward and Beswick & Clayton Ward. They are among the most disadvantaged in Greater Manchester. Clayton and Openshaw have the highest airborne pollution in the country due to the surrounding heavy industry. Beswick has the notorious Fort Beswick, several blocks of flats, which are now being knocked down only ten years after their completion. All the areas (but to a lesser extent Clayton) have experienced extensive demolition, rehousing and renovation of housing, within recent years. Beswick, Openshaw and Higher Openshaw had most of the housing, on either side of Ashton Old Road, knocked down or made derelict, as part of a road widening scheme which had to be cancelled because of lack of money. This resulted in Openshaw being left with very few shops, no chemist and no post office, but many eyesores. Beswick's shopping facilities were increased with the building of the precinct in Fort Beswick and the opening of Grey Mare Lane Market and this now forms a main shopping area for the two Wards. Because of its accessibility Grey Mare Lane was considered by the discussion team to be one of the most suitable sites for the service. Also the area between Openshaw and Higher Openshaw was suggested as being the most central to the two Wards.

Beswick has suffered most from the housing re-arrangement so that little of the original community exists. There are very few community groups except for the advice centre and the University Settlement Project, and it is only in the last two years the area has shown signs of becoming more settled. Clayton has a strong working class community, many of the families having lived there for two or three generations, but it's decline is noticeable. There are a large number of elderly and unemployed people and the former relative affluence of the area is diminished. There a few facilities, no swimming pool, cinema or restaurant, though there are some strong community groups. Openshaw and Higher Openshaw are both totally working class and used to be envied and very respectable neighbourhoods. Higher Openshaw was the more affluent end, as the larger houses testify, but this no longer holds true. There is high unemployment and large numbers of elderly people and children under five, which the present facilities only cater for to a limited extent. Entertainment at night in the area is limited to pubs and a few clubs, as it is in Beswick and Clayton. Many of the people in these areas feel in some way they have been neglected.

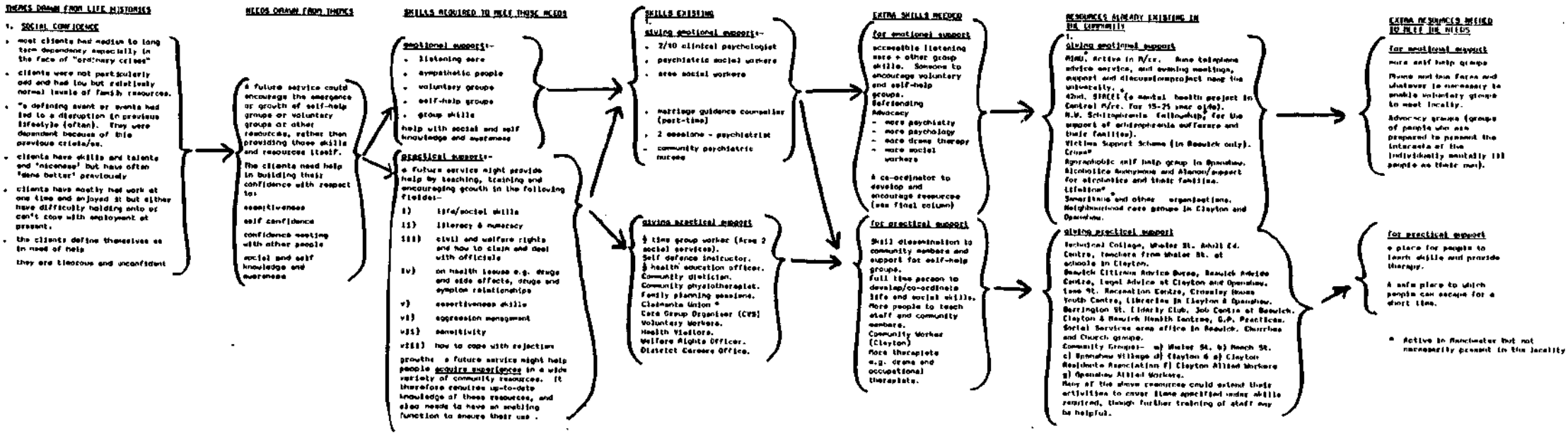

KEY
Recreation Areas & Play Spaces
(C) Provision for children
(E) Provision for the elderly
(G) Other community provision
(H) Health service
Shops & markets
Schools and technical colleges
Railway
Canal
Bus routes
Roads with no buses
Rochdale Canal
ASHTON NEW ROAD
ASHTON OLD ROAD

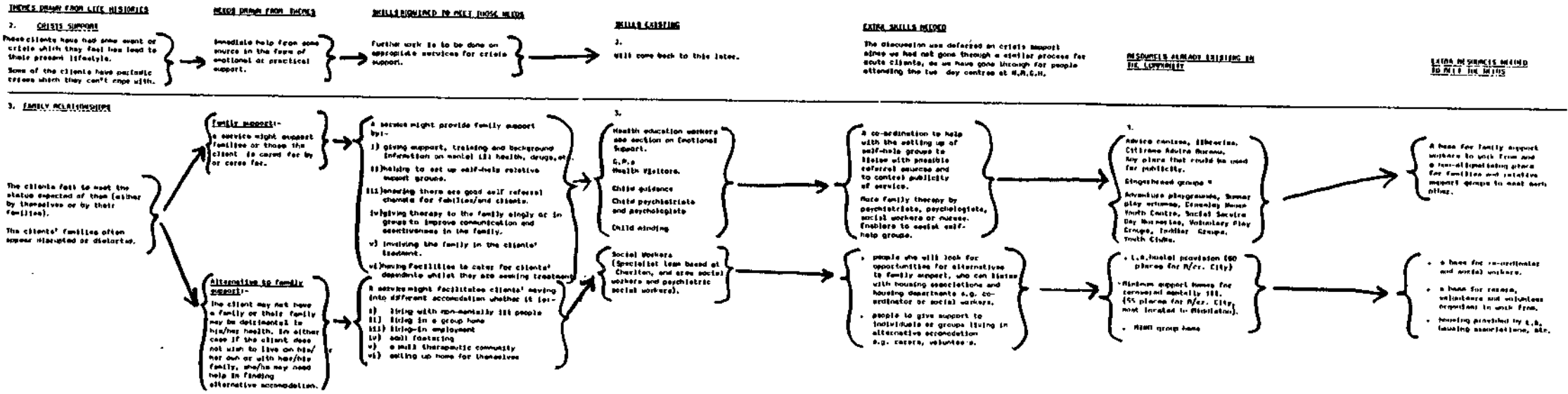
OUR APPROACH

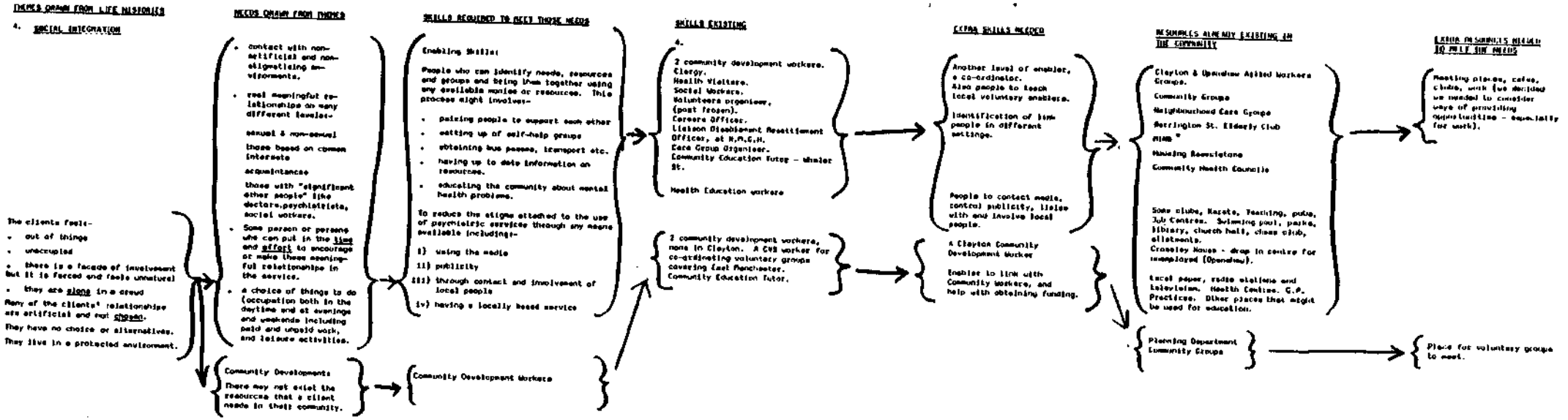
Please read this section carefully, as it explains the diagrams that follow, which contain much of the material and ideas the team gathered together.

In order that the future service should meet the real needs of the clients we began our discussion by looking at the lives of certain individuals who use the present psychiatric day facilities at North Manchester General Hospital, or attend the sessions that take place at Clayton and Beswick Health Centres. We tried to build up a picture of their present lives and their history, seeing what they had in common with other people, and what differences there were (1). These themes were then translated into the needs of the clients (2), and the sort of skills and resources that might be needed to fulfil these needs (3). We constructed a list of the skills already present in the areas (4), and from this inferred what extra skills were needed (5). Next we built up a profile of the areas under scrutiny including the housing, social composition, community strengths and weaknesses and other resources of the areas to appreciate which of the needs of the clients were already met by resources in the community (6), or could be encouraged to emerge within the community (7). This process enabled us to put forward a model for a day service, the staff and building required, its relation to the community, and the design principles under which it would work. Much of the work done is embodied in the diagrams following.

1) Themes drawn from life histories
2) Needs drawn from themes
3) Skills required to meet those needs
4) Skills existing
5) Extra skills needed
6) Resources already existing in the community
7) Extra resources needed to meet the needs


THEMES DRAWN FROM LIFE HISTORIES
1. SOCIAL CONVICTANCE
• most clients had medium to long term dependancy especially in the face of "ordinary crises"
• clients were not particularly odd and had low but relatively normal levels of family resources.
• "a defining event or events had led to a disruption in previous lifestyle (often). They were dependent because of this previous crisis/es.
• clients have skills and talents and 'niceness' but have often "done better" previously
• clients have mostly had work at one time and enjoyed it but either have difficulty holding onto or can't cope with employment at present.
• the clients define themselves as in need of help
they are timorous and unconfident
NEEDS DRAWN FROM THEMES
A future service could encourage the emergence or growth of self-help groups or voluntary groups or other resources, rather than providing these skills and resources itself.
The clients need help in building their confidence with respect to:
assertiveness
self confidence
confidence meeting with other people
social and self knowledge and awareness
SKILLS REQUIRED TO MEET THESE NEEDS
emotional support:-
• listening ears
• sympathetic people
• voluntary groups
• self-help groups
• group skills
help with social and self knowledge and awareness
practical support:-
A future service might provide help by teaching, training and encouraging growth in the following fields:-
i) life/social skills
ii) illiteracy & numeracy
iii) civil and welfare rights and how to claim and deal with officials
iv) on health issues e.g. drugs and side effects, drugs and symptom relationships
v) assertiveness skills
vi) aggression management
vii) sensitivity
viii) how to cope with rejection
growth: A future service might help people acquire experiences in a wide variety of community resources. It therefore requires up-to-date knowledge of these resources, and also needs to have an enabling function to ensure their use.
SKILLS EXISTING
1.
giving emotional support:-
• 2/40 clinical psychologist
• psychiatric social workers
• some social workers
• marriage guidance counsellor (part-time)
• 2 sessions - psychiatrist
• community psychiatric nurses
giving practical support
½ time group worker (Area 2 social services).
Self defence instructor.
½ health education officer.
Community dietician.
Community physiotherapist.
Family planning sessions.
Claimants Union *
Care Group Organiser (CVS)
Voluntary Workers.
Health Visitors.
Welfare Rights Officer.
District Careers Office.
EXTRA SKILLS NEEDED
for emotional support
accessible listening ears + other group skills. Someone to encourage voluntary and self-help groups.
Befriending
Advocacy
- more psychiatry
- more psychology
- more drama therapy
- more social workers
A co-ordinator to develop and encourage resources (see final column)
for practical support
Skill dissemination to community members and support for self-help groups.
Full time person to develop/co-ordinate life and social skills.
More people to teach staff and community members.
Community Worker (Clayton)
More therapists e.g. drama and occupational therapists.
RESOURCES ALREADY EXISTING IN THE COMMUNITY
1.
giving emotional support
MIND. Active in N/cr. Runs telephone advice service, and evening meetings, support and discussion/project near the university. *
42nd. STREET (a mental health project in Central N/cr. for 15-25 year olds).
N.W. Schizophrenia Fellowship for the support of schizophrenia sufferers and their families).
Victims Support Scheme (in Newwick only).
Crime*
Agoraphobic self help group in Openshaw.
Alcoholics Anonymous and Alanon/support for alcoholics and their families.
Lifeline*
Samaritans and other organisations.
Neighbourhood care groups in Clayton and Openshaw.
giving practical support
Technical College, Whaler St. Adult Ed. Centre, teachers from Whaler St. at schools in Clayton.
Newwick Citizens Advice Bureau, Newwick Advice Centre, Legal Advice at Clayton and Openshaw.
Love St. Recreation Centre, Crossley House Youth Centre, Libraries in Clayton & Openshaw.
Barrington St. Elderly Club, Job Centre at Newwick.
Clayton & Newwick Health Centres, G.P. Practices.
Social Services area office in Newwick, Churches and Church groups.
Community Groups:- a) Whaler St. b) Beech St. c) Brownshaw Village d) Clayton & e) Clayton Residents Association f) Clayton Allied Workers g) Openshaw Allied Workers.
Many of the above resources could extend their activities to cover those specified under skills required, though further training of staff may be helpful.
EXTRA RESOURCES NEEDED TO MEET THE NEEDS
for emotional support
more self help groups
Phone and face to face and whatever is necessary to enable voluntary groups to meet locally.
Advocacy groups (groups of people who are prepared to represent the interests of the individually mentally ill people on their own).
for practical support
a place for people to learn skills and provide therapy.
A safe place to which people can escape for a short time.
* Active in Manchester but not necessarily present in the locality


THEMES DRAWN FROM LIFE HISTORIES
2. CRISIS SUPPORT
These clients have had some event or crisis which they feel has lead to their present lifestyle.
Some of the clients have particular crises which they can't cope with.
NEEDS DRAWN FROM THEMES
Immediate help from some source in the form of emotional or practical support.
SKILLS REQUIRED TO MEET THOSE NEEDS
Further work is to be done on appropriate services for crisis support.
SKILLS EXISTING
2.
Will come back to this later.
EXTRA SKILLS NEEDED
The discussion was deferred at crisis support since we had not gone through a similar process for acute clients, as we have gone through for people attending the two day centres at W.A.C.H.
RESOURCES ALREADY EXISTING IN THE COMMUNITY
EXTRA RESOURCES NEEDED TO MEET THE NEEDS
3. FAMILY RELATIONSHIPS
The clients feel to meet the status expected of them (either by themselves or by their families).
The clients' families often appear disrupted or distorted.
Family support:-
a service might support families or those the client is cared for by or cares for.
Alternative to family support:-
The client may not have a family or their family may be detrimental to him/her health. In either case if the client does not wish to live on his/her own or with her/his family, she/he may need help in finding alternative accomodation.
A service might provide family support by:-
i) giving support, training and background information on mental ill health, drugs, etc.
ii) helping to set up self-help relative support groups.
iii) ensuring there are good self referral channels for families/and clients.
iv) giving therapy to the family singly or in group to improve communication and assertiveness in the family.
v) involving the family in the clients' treatment.
vi) having facilities to cater for clients' dependants whilst they are seeking treatment.
A service might facilitate clients' moving into different accomodation whether it is:-
i) living with non-mentally ill people
ii) living in a group home
iii) living-in employment
iv) adult fostering
v) a small therapeutic community
vi) setting up home for themselves
3.
Health education workers see section on Emotional Support.
G.P.s
Health Visitors.
Child guidance
Child psychiatrists and psychologists
Child minding
Social Workers (Specialist team based at Cheriton, and area social workers and psychiatric social workers).
A co-ordinator to help with the setting up of self-help groups to liaise with possible referral sources and to control publicity of service.
Make family therapy by psychiatrists, psychologists, social workers or nurses. Enablers to assist self-help groups.
• people who will look for opportunities for alternatives to family support, who can liaise with housing associations and housing departments e.g. co-ordinator or social workers.
• people to give support to individuals or groups living in alternative accomodation e.g. carers, volunteers.
3.
Advice centres, libraries, Citizens Advice Bureau.
Any place that could be used for publicity.
Gingerbread groups *
Adventure playgrounds, Summer play schemes, Canonsleigh House Youth Centre, Social Security Day Nurseries, Voluntary Play Groups, Toddler Groups, Youth Clubs.
• L.A. hostel provision (60 places for M/cr. City)
• Minimum support homes for terminal mentally ill. (65 places for M/cr. City, most located in Middleton).
• Night group home
A base for family support workers to work from and a non-stigmatising place for families and relative support groups to meet both other.
• a base for re-orientator and social workers.
• a base for nurses, volunteers and voluntary organisations to work from.
• housing provided by L.A. housing associations, etc.


THEMES DRAWN FROM LIFE HISTORIES
4. SOCIAL INTEGRATION
The clients feels-
• out of things
• unoccupied
• there is a facade of involvement but it is forced and feels unnatural
• they are alone in a crowd
Many of the clients' relationships are artificial and not chosen.
They have no choice or alternatives.
They live in a protected environment.
NEEDS DRAWN FROM THEMES
• contact with non-artificial and non-stigmatising environments.
• real meaningful relationships on many different levels-
sexual & non-sexual
those based on common interests
acquaintance
those with "significant other people" like doctors,psychiatrists, social workers.
• Some person or persons who can put in the time and effort to encourage or make these meaningful relationships in the service.
• A choice of things to do (occupation both in the daytime and at evenings and weekends including paid and unpaid work, and leisure activities.
Community Development:
There may not exist the resources that a client needs in their community.
SKILLS REQUIRED TO MEET THOSE NEEDS
Enabling Skills:
People who can identify needs, resources and groups and bring them together using any available monies or resources. This process might involve-
• pairing people to support each other
• setting up of self-help groups
• obtaining bus passes, transport etc.
• having up to date information on resources.
• educating the community about mental health problems.
To reduce the stigma attached to the use of psychiatric services through any means available including-
i) using the media
ii) publicity
iii) through contact and involvement of local people
iv) having a locally based service
Community Development Workers
SKILLS EXISTING
4.
2 community development workers.
Clergy.
Health Visitors.
Social Workers.
Volunteers organiser, (post frozen).
Careers Officer.
Liaison Disablement Resettlement Officer, at R.M.C.H.
Care Group Organiser.
Community Education Tutor - Whalley St.
Health Education workers
2 community development workers, none in Clayton. A CVS worker for co-ordinating voluntary groups covering East Manchester.
Community Education Tutor.
EXTRA SKILLS NEEDED
Another level of enabler, a co-ordinator.
Also people to teach local voluntary enablers.
Identification of link people in different settings.
People to contact media, control publicity, liaise with and involve local people.
A Clayton Community Development Worker
Enabler to link with Community workers, and help with obtaining funding.
RESOURCES ALREADY EXISTING IN THE COMMUNITY
Clayton & Openshaw Allied Workers Groups.
Community Groups
Neighbourhood Care Groups
Barrington St. Elderly Club
MIND *
Housing Associations
Community Health Councils
Some clubs, Karate, Teaching, pubs, Job Centres. Swimming pool, parks, library, church halls, chess club, allotments.
Crossley House - drop in centre for unemployed (Openshaw).
Local paper, radio stations and televisions. Health Centres. G.P. Practices. Other places that might be used for education.
Planning Department
Community Groups
EXTRA RESOURCES NEEDED TO MEET SOME NEEDS
Meeting places, cafes, clubs, work (we decided we needed to consider ways of providing opportunities - especially for work).
Place for voluntary groups to meet.

THE PROPOSED SERVICE

The service should use existing resources in the community rather than provide a 'total' environment for its clients which caters for all their needs. It should enable the use of these resources, e.g. clubs, education, centres, libraries, voluntary groups etc., and encourage the emergence or growth of resources if those available do not match the needs of the clients. Using this approach, keeping clients in the community, and perhaps by catching clients earlier in their illness we hope to encourage the client's independence and prevent the kind of dependence that exists in some of the present psychiatric facilities.

The service will foster community initiatives likely to improve the mental health of individuals in the community e.g. nursery provision, cafes, housing. It will also identify and work closely with outside resources, e.g. education centres, community workers, welfare rights officers, and enable clients to use them. Up to date information on resources in the area will be available from workers, written material and other sources. A community co-ordinator will be appointed whose main task will be to liaise with and learn about people and resources in the area, to publicise and make known the services and resources available and to encourage the growth and emergence of resources.

The building will be located in a residential district in one of the areas under scrutiny and will hopefully be in two medium sized terraced houses. There will be some alterations inside, but the outside of the buildings will be kept intact, there will be no special mental health label attached to the outside which distinguishes it from next-door buildings. This building will provide,

a) places for counselling and therapy (including groups)
b) access for those clients attending the centre who have physical disabilities
c) rooms for community and voluntary groups to use
d) a safe place for records and equipment
e) a place for self-help groups to meet
f) a creche
g) offices/phones/Xerox
h) a reception room containing information, leaflets, etc. and somewhere to sit down and have a cup of tea and a chat.

The staff employed at the service will include a senior psychologist, a social worker, a nurse therapist, a secretary/receptionist (possibly through M.S.C. funds) and other skills provided on a sessional basis e.g. a psychiatrist, possibly a welfare rights officer, drama therapists, community development workers. Their tasks will include not only the counselling and therapy (individual and group therapy) which takes place at the building, but also fostering links with voluntary groups, training or teaching others in how to help people with mental health problems, participating in the management and development of the service. Together with the community co-ordinator, community development workers and voluntary groups, the staff will try to help the clients not only to solve their immediate problems, but to lead a more balanced and full life. Staff and volunteers will not confine their activities to the building, but use their skills wherever they are most appropriate. A future service will seek to add and promote the development of skills and resources that the community lacks rather than duplicate existing facilities.

The discussion team realises that it may not be possible, due to financial limitations, to set up the project in exactly the way described above, it may only be feasible to start the project two or three days a week to begin with. Next to buying or renting a building as outlined above, and the attached revenue costs, heating, maintenance, rates, etc., (the cleaning might be done by volunteers), the team felt the community co-ordinator to be the most essential post. This appointment is central to the entire project, as is additional social worker and psychologist support. It has been suggested that joint financing be put aside for the social work support and the community co-ordinator. An application for £60,000 has been made for inner cities money, for the building and money to pay a psychologist. In the event of inner cities funding being unsuccessful N.H.S. funds would be sought at least for the psychology post and the building. It may prove possible to rent a building from the local authority or a housing association.

DESIGN PRINCIPLES

1) We should make the design principles and model explicit to all involved.

2) There should be consumer, family and community (including people working there e.g. G.P.'s,community workers, teachers) involvement in,

   a) planning

   b) regular review of policy with the view to development in the community and in the building

   c) therapy

   d) evaluation (with the help of outside agencies if necessary)

   This requires frequent and regular meetings (more often in case of (c)).

3) All staff (paid or unpaid), working at the house should be involved in planning, development and review of policy.

4) There should be involvement of primary care workers (e.g. G.P.s, health visitors)in the service for particular clients, unless client objects.

5) Referral will be accepted from any source (including self-referral).

6) There will be no exclusions just on basis of age though focus is on adults (17-65). On the whole we will only deal with children if they come along because an adult relative is a client. The service will be flexible and make appropriate referral elsewhere. We will exclude patients with severe organic syndrome (brain damage and dementia).

7) Clients should be offered the choice of primary or key worker, after having been given all information relevant to that choice.

8) We will work towards clarity about worker roles in the building and in the community.

9) Regular in-service training of staff (paid and unpaid and volunteers) will be an essential freature of this project as will pre-training of staff.

10) Support of other kinds e.g. sensitivity groups, equipment, information and advice etc., are available to all people who work there.

11) Where possible, everyday environments should be used to provide the framework of the service. We should not attempt to cater for all the needs of a client when these needs may well be serviced in the community. Extracting the client from the community though in some cases necessary, in most, will lead to further problems. Adult education centres, citizens advice bureaus, libraries and any other useful facility in the community could be used and developed.

12) If there are facilities in the community that are needed every effort will be made to encourage their emergence or growth.

13) Staff (paid and unpaid) will be allowed to move freely in the community visiting clients whenever possible at their home (if the client wishes).

14) The outside and inside of the building should fit in with surrounding buildings. There should be no notice declaring its presence outside it. The building should be clean, smart, without the clinical coldness of many service buildings. Every effort should be made to create a non-stigmatising environment, in which the service could take place.

FUTURE ?

The discussions that have so far taken place have only dealt with, in essence, a psychiatric day time service. We hope to widen the scope of our discussions, in the future, finally ending up with a model for a comprehensive psychiatric service based on a community approach, for the areas of Openshaw, Clayton & Beswick. This will involve a similar approach to that already taken for day patients, but dealing with those people labelled 'chronic' psychiatric patients and for others whose situation is in a more critical condition who need almost immediate intensive help. Alternative living accommodations, crisis support must all be taken into account as ways of giving the most effective service for these clients. These discussions, as does this proposal for a service in Openshaw, Beswick & Clayton, form part of the continuing evaluation and development of psychiatric services in North Manchester.

PEOPLE WHO ATTENDED MEETINGS

	Dr. N. Bishay	-	Psychiatrist
	Mr. F. Lillie	-	Principle Psychologist
	Mr. D. Flanagan	-	Drama Therapist
*	Ms. R. Lockyer	-	Psychologist
*	Mr. G. Wakefield	-	Principal Assistant, Residential & Day Care Services
*	Mr. R. Maxim	-	Area Director, Area 2, Social Services
	Ms. C. Adcock	-	Health Education Officer
	Mrs. S. Edwards	-	Senior Psychiatric Social Worker
*	Ms. L. Freeman	-	Administrator - Psychiatry
*	Mr. B. Scott	-	Divisional Nursing Officer of Psychiatry
*	Dr. D. Marshall	-	Psychogeriatrician
	Dr. S. Shafar	-	Psychiatrist
*	Dr. M. Burton	-	Psychologist
	Mr. N. Rose	-	Research Assistant
	Dr. J. Gray	-	Community Physician

* did not attend every meeting