

I. NATIONAL CONTEXT

A Framework for Mental Health Services in Scotland” remains the key national strategy document. It is intended to assist the people who use these services, those who care for them and staff in voluntary and other agencies to play their part as partners and stakeholders.

The Framework considers the service needs of people with severe and/or enduring mental health problems. This is taken to mean people who have a mental health problem such as schizophrenia or severe affective disorder who may experience a substantial disability as a result. They may have an inability to care for themselves independently, sustain relationships or work. They may be either currently displaying obvious and severe symptoms; or have a remitting/relapsing condition. They may have experienced recurring crisis leading to frequent admission/intervention and may occasion significant risk to their own safety or that of others.

The Framework seeks to assist staff in health, social work and housing agencies to develop a joint approach to the planning, commissioning and provision of integrated mental health services.

Main Issues

The main issues in terms of people with severe and/or enduring mental health problems are as follows:

- *The particular needs of women, especially those with dependent children*
- *Home based treatment and day services may be a viable alternative for some individuals, even in acute psychiatric emergencies*
- *Some people require high levels of observation and support to prevent relapse even once they are no longer acutely unwell.*
- *Some people may require respite as part of their planned medical care, or as social support*
- *Some people will require rehabilitation as a result of long in-patient stay and/or disabling effects of mental health problems. Rehabilitation should focus on supporting people in their own environment.*
- *Early identification of a crisis and immediate response is needed if people who have received a service for a long time are to have the maximum opportunity of maintaining independent living.*
- *People with mental health problems who are potential offenders should be identified and diverted from appropriate institutions. The priority groups are people who either present a potential danger to the public, to themselves when in detention or who continuously commit minor offences and need treatment for mental health problems.*

Our National Health: A plan for action, a plan for change echoes some of the themes of **Modernising Community Care** and **Designed to Care** in terms of a desire to make a difference by improving the speed, responsiveness and the quality of care through:

- *an assessment process to find out what is needed with the clear intention of early delivery*
- *better and quicker decisions made together with the people using the services and their carers*
- *more flexible responses to needs*
- *resources put to better use through efficient working*
- *better information for people on how and where to access services, particularly for people who are hard to reach*
- *services and agencies working in partnership*

It also makes a commitment to accelerate the implementation of the **Framework for Mental Health**.

The Adults with Incapacity (Scotland) Act 2000 replaces parts of the Mental Health (Scotland) Act 1984 with new provisions, particularly in relation to guardianship and the management of patients' funds. **The Millan Report on the Review of the Mental Health (Scotland) Act 1984** recommends that there should be a new Mental Health Act, which should clarify and improve the rights of service users and carers, and make it easier for these rights to be used effectively. In particular, it should ensure that care and treatment are provided, wherever possible, without resort to compulsion.

Community Care services will respond to the requirements of the **Clinical Standards Board for Scotland - Schizophrenia Standards (November 2000)**.

2. LOCAL CONTEXT

Ayrshire and Arran Health Board, Health Improvement Programme, 2000-2005

Adult Mental Health Services

It is widely recognised and accepted that the traditional style of mental health treatment in large Psychiatric Hospitals is outdated and that wherever possible, people should receive care, treatment and support in the least restrictive environment possible.

Ayrshire and Arran Health Board in partnership with the Primary Care Trust, three Local Authorities, user/carer groups and non statutory services have embarked on a strategy to develop a 24 hour, 7 day a week comprehensive mental health service.

The aim is to provide a flexible effective and responsive service that can meet the variety of health and social needs identified in people with mental health problems.

Desired Outcomes

- *Upgrade wards at Ailsa Hospital*
- *Improve admission and discharge arrangements for acute care*
- *Develop and expand rehabilitation services in each local authority area*
- *Develop and expand the range of accommodation within the community*
- *Develop and expand advance day services*
- *Develop home based teams in each local authority area*
- *Develop a psychiatric liaison service*
- *Extend the volunteer helpline service*
- *Develop and expand services linked to General Practitioners*

Ayrshire and Arran Primary Care NHS Trust, Trust Implementation Plan 2000-2005.

- *Expand capacity of Care Programme Approach to other client groups*
- *Develop self help groups/carers support network for dual diagnosis clients*
- *To provide an alternative to hospital admission to clients who are experiencing crises*
- *To review Landlady schemes*
- *Work with key partners to initiate and develop function of drop in centres and clubhouses*
- *Through a process of consultation with other Statutory and Voluntary Agencies consider the development of child care provision to support people with mental health problems access health, social, recreational and educational services*
- *Expand current rehabilitation provision to provide community support and subacute care for people in each Local Authority district*
- *Reorganisation of the co-ordination of respite services and to provide suitable respite care provision*

Mental Health Strategy

A number of projects are ongoing:

- ***Mental Health Strategy Co-ordinator***
- ***Training/support of primary care staff***
- ***Care Packages Team***
- ***Community Forensic Mental Health Services***
- ***Accident and Emergency Liaison Nursing Team***
- ***Home Option Team***
- ***Counselling in Primary Care***
- ***Primary Care Psychological Services***

Mental Health Stakeholder Conferences were sponsored by the Health Board

The top priorities were identified as:

- ***Co-ordination***
- ***Services***
- ***Education***
- ***Community Involvement***
- ***Influence***
- ***Social Inclusion***
- ***Communication/Information***
- ***Continuity***
- ***Integrated Service Delivery***

Looking Forward to the Future, a conference for service users and carers, also sponsored by the Health Board, was held on 23/2/01. Information to carers, opportunities for both service users and carers to have a break and access to services over a 24 hour period were seen as the top priorities.

Conclusions from the Fact File

The majority of support to people with significant mental health problems is provided in a hospital setting.

The vast majority of people with mental health problems receiving social work support are supported by staff who are based in hospital settings

3. ACTION PLAN FROM LAST COMMUNITY CARE PLAN

Objective

- *To have in place an adequate infrastructure of community based services for people with severe and/or enduring mental health problems*

ACTION	ACHIEVEMENTS
<p>Develop a joint approach to the planning, commissioning and provision of integrated mental health services</p>	<ul style="list-style-type: none"> • A multidisciplinary Care Package Team has been established, involving social workers and nurses working together to develop packages of care to facilitate the discharge of people with complex needs from continuing care wards within Ailsa Hospital • A report has been compiled by the Care Package Team in association with the Community Mental Health Teams detailing the perceived needs of 40 people supported by Community Mental Health Teams who were felt to have enduring and complex needs. • In an ongoing exercise, the Care Package Team is working with Community Mental Health Teams to monitor the changing support needs of the 10 clients on each Community Mental Health Teams caseload with the most profound and enduring needs. • Based on the assessments carried out by the Care Package Team, a supported living service for people with severe/enduring mental health problems has been commissioned.

ACTION	ACHIEVEMENTS
<p>Housing Advice</p>	<ul style="list-style-type: none"> • The weekly Housing Advice Service continues at Ailsa Hospital • A new policy for the allocation of houses to Community Care Service Users came into effect on 2 October 2000. This policy introduced the Community Care Category onto the waiting list which gives priority to Community Care Service Users who meet one of the following criteria: <ul style="list-style-type: none"> • Person being discharged from long term hospital care • Person is leaving Residential Care to move into the community • Person is at risk of reception into Residential Care • Prevention of person being admitted to hospital • Accommodation suitable to the applicant's needs will be offered as soon as it becomes available. The policy aims to provide a sensitive and effective service which takes into account both housing and support requirements.
<p>Develop an effective response to homeless people with mental health problems</p>	<ul style="list-style-type: none"> • Applicants with mental health problems would also be covered by the amendment to the Allocations Policy. The only statistical information we have is from the Royal Sleepers Initiative on Homeless applicants with mental health problems. The statistics on clients referred to the project show that 8.9% have a mental health problem. A Health Development worker has recently been appointed to the Royal Sleepers Initiative for Ayrshire. She will be involved in assessing the health needs of clients and developing a strategy to meet those needs.
<p>Implement the Care Programme Approach</p>	<ul style="list-style-type: none"> • An evaluation of the implementation of Care Programme Approach in Ayrshire was published and widely disseminated in December 1999/January 2000. The evaluation focused on demographic details, identified needs and risk factors associated with those receiving Care Programme Approach. Additionally, the views on Care Programme Approach from the Steering and Local Operational Groups, Service Users and Workers were included. The benefits of Care Programme Approach were highlighted.

ACTION	ACHIEVEMENTS
<p>Implement the Patients in the Community Act</p>	<ul style="list-style-type: none"> Only two people in South Ayrshire have become the subject of Community Care Orders during the life of the 1998/2001 Community Care Plan. Both remain subject to these orders at this time. Evaluation of the effectiveness of the orders has been on a casework basis rather than via an overall view of the usage and effectiveness of Community Care Orders. In each case there is evidence to suggest a positive outcome in terms of relative stability in the community and an absence of admission to hospital. The law in relation to Community Care Orders seems likely to change during the term of the 2001/04 Community Care Plan following the recommendations of the Millan Committee.
<p>Support schemes aimed at increasing opportunities for people with mental health problems to derive the benefits of employment, training and leisure opportunities</p>	<ul style="list-style-type: none"> Registerable day places are no longer viewed as an appropriate model A wide-ranging multi-agency group including voluntary and statutory agencies has been formed to "map" existing opportunities/provision identify gaps, make recommendations for the future and provide a forum for ongoing networking and support. Ayrshire Job Coaching (formerly Southworks) is now in operation and providing a service to people with mental health problems
<p>Establish an Advocacy Project</p>	<ul style="list-style-type: none"> The Panel of Reference originally developed by Ayr Action for Mental Health has now become a fully independent group with an Ayrshire wide focus. The group is kindly accommodated, in terms of office base, by Ayr Action for Mental Health. Ayr Action for Mental Health successfully tendered for an Advocacy Project to provide individual advocacy to people with mental health problems. This is now on the point of being operational and will build on the experience of the collective Voice Advocacy Project through pooled funding.

ACTION	ACHIEVEMENTS
<p>Identify and divert people with mental health problems from inappropriate institutions</p>	<ul style="list-style-type: none"> • Appropriate Adult Scheme was activated in July 1999 with South Ayrshire having operational responsibility. • Referrals have been fairly low with most of the crimes involved being at the high tariff end of the scale. • There is to be a relaunch/review of the scheme in May 2001 which will seek to strengthen local links • East Ayrshire will take over operational control for the Ayrshire scheme in June/July 2001. • Mentally disordered offenders were specified by the Scottish Executive as one of three priority groups for Diversion from Prosecution. South Ayrshire Council receives in the region of £15,000 per annum to promote Diversion from Prosecution and during the year ending 31.3.01 the Council received a total of 16 referrals from the Procurator Fiscal of which 9 converted into Diversion cases. Approximately 1/3 of these were people with mental health problems. The aim of diversion from Prosecution is to prevent entry into the Criminal Justice system for persons committing low tariff offences where the Procurator Fiscal decides it may not necessarily be in the public interest to proceed with prosecution. The persons coming onto Diversion receive a maximum of 6 months assistance from the Social Work Department and if during this period there are no further offences and the programme of assistance is completed then the Procurator Fiscal will decide to take no further action.

Objective

- *Shift the balance from long term hospital care to community based services to achieve a more appropriate balance*

ACTION	ACHIEVEMENTS
<p>Implement robust discharge protocols</p>	<ul style="list-style-type: none"> • A multi-disciplinary group (including representatives from South Ayrshire Social Work, Housing & Health, hospital ward and community based health staff, service users and carers) has drafted an audit tool to monitor the effectiveness of the Discharge Protocol. The tool has been approved by the relevant ethics committees. The group intends piloting the tool in 2001 and instituting a rolling programme of monitoring and auditing the protocol's effectiveness.
<p>Provision of purpose built Housing Association properties convertible to ordinary housing</p>	<ul style="list-style-type: none"> • 28 have been people identified to be discharged from Ailsa Hospital in Phase 2. 14 of those 28 are likely to want to be re-housed in South Ayrshire. It is the view of local authority housing staff and the relevant housing associations that providing 14 houses from normal housing stock is likely to be achievable. • To date 4 people have been discharged from Ailsa Hospital on Phase 2 who now currently live in South Ayrshire Council.

4. WHAT HAS BEEN ACHIEVED DURING THE LIFE OF THE PLAN?

A focus group of people with experience of using mental health services felt that the following services had been aided/enhanced by the 1998/2001 Community Care Plan:

- ***Advocacy pilot project. Service users applauded this work which laid the foundation for the newly commissioned Voice Advocacy Project (expansion) which will see a far more comprehensive service available to mentally disabled residents of South Ayrshire with representational needs.***

- *More tangible presence of social workers and social work assistants in the various community teams.*
- *Clear, committed consistent support to Ayr Action for Mental Health's activity - especially with regard to support for the direct employment of service users.*
- *The commissioning of Job Coaching Ayrshire (formerly Southworks) to provide Job Coaching.*

Service user feelings of ownership of 1998/2001 Plan

- *Service users were clear that the Council had made far greater and more positive attempts to engage them meaningfully in discussion and design of services, through e.g. Panel of Reference, local focus groups etc. but that, all too often, the notice and timescale for meaningful participation was inadequate.*
- *It was also clearly expressed that where the 1998/2001 plan talked of "mapping exercises", "evaluate....". That this information was not necessarily disseminated to service users.*
- *There were clear feelings of commitment by senior managers in "empowerment and inclusion" principles, but that often the "system" made it difficult to be, as involving/interactive as individuals (even senior officials) would ideally wish.*

The experience of someone who accepted support

I would like to tell you how I am enjoying myself living in the community through receiving one of the new care packages. I have made many new friends. I have a part time voluntary job working with the P.D.S.A. retail shop in Ayr. I have my own council flat. I have a care support team consisting of three members who do shift work and are always on hand any hour of the day if I need them. The care support team I have are from an organisation called Partners of Inclusion, they are part of the organisation called Inclusion Glasgow. I was allowed to interview two organisations. I was also allowed to interview and pick my own care support team workers and also decide who was going to be the team leader. Partners of Inclusion is directed by Doreen Kelly, our manager is June Jeffrey, and I have a team leader and two support workers. I also have members in the care package team who are based in the hospital. I still have my consultant. It took more than a year for this to happen.

There are plans for my care to be put together, hours plus sleepovers to be decided also the working policy to be put together for everyone who is involved with me, including ward staff and myself.

On several occasions I told everyone to go and what to do with care packages as at one point I was beginning to think the packages were going to fall through as there seemed no progress was being made. The staff on Crossraguel Ward, Ailsa Hospital, had a tough time with me during the 1 and a half years it took for the package to be set up. I have a lot to thank the staff for because I hated them at times but they stuck by me and I will not forget them.

I do not look at the care support team I have as workers - they are more friends than anything else. We go out socialising together and three of us are going to Belgium for six days (I am really looking forward to that!) So if you have been accepted for a care package, just bide your time and accept that it will not happen overnight. I am glad I did because I have never been so happy for a long, long time. I can look forward for the first time in many years. Thank you to my consultant Dr. J. Flowerdew, social workers and care package team for accepting me, also Crossraguel staff for putting my name forward for the care package.

Finally, to any one of the patients who are awaiting for a package I say "It will change your life as I am a completely different person"

Liz

Ayr

5. WHAT REMAINS TO BE ACHIEVED?

A focus group of service users commented on:

- **Empowerment/Inclusion** - *There is a need to complete the loop from informing and consulting people to involve timeous feedback, making more strenuous efforts to ensure that notice of, and timescales for involvement is more realistic and manageable for service users*
- **Respite** - *Service users felt that social respite, where intensive clinical care and institutional placement were not appropriate, was lacking. It was felt that such respite could be particularly successful where the supports of e.g. friends, family, Home Options Team, could be co-ordinated.*
- **Realistic employment/occupational pathways** - *whilst service users acknowledged the good work of Job Coaching Ayrshire (formerly Southworks), their success (to date) was mainly with learning disabled people. Service Users also felt that people with mental health problems of a long-standing nature would need a range of "stepping stones" to mainstream employment.*

Trust - A Carer's Network would like to see a greater recognition of the specific needs of carers for people with mental health problems. Carers would like to be able to have more information about their relative's illness particularly at times of crisis and to have more information about services. Respite for carers is also seen as important but should be based on the people they care for having a real quality of life and the opportunity to be as independent as possible.

Professionals involved in mental health noted:

- ***More people need to be discharged from long term institutional care. In general terms we need to move beyond the objective set in the 1998/2001 plan "to have an adequate infrastructure of community based services" to providing the kind of support that would enable people with severe/enduring mental health problems to be genuinely included within their community. This needs to be an interagency and corporate responsibility across the council.***
- ***Work being done by the Care Package Team with the Community Mental Health Teams on the shortfall in provision for the most vulnerable people is showing the need for Care and Repair and Holidays/Shortbreaks***

6. ACTION PLAN 2001 - 2004 (TO BE FUNDED FROM EXISTING BUDGETS)

Objective

- *To have in place an adequate infrastructure of community based services for people with severe/enduring mental health problems*

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
To continue to pursue a joint approach to the planning, commissioning and provision of integrated mental health services	<ul style="list-style-type: none"> • The Care Package team will continue to undertake its assessment and care planning role in relation to people with complex needs who require to be discharged from hospital. The Care Programme Approach will continue to provide a service to people assessed as requiring it.
To continue to fund existing community based services to their current level	<ul style="list-style-type: none"> • The services currently provided by Richmond Fellowship, Ayr Action for Mental Health, Copeline, Job Coaching Ayrshire will continue, will be evaluated and future developments identified.
To work closely with our partners in health to work up funding bids when and where appropriate	<ul style="list-style-type: none"> • It will be possible to identify new community based services which have been developed as a result of joint funding.
To facilitate joint training	<ul style="list-style-type: none"> • At least one joint training event per year will have taken place.
To retain a strong commitment to meaningful involvement of service users	<ul style="list-style-type: none"> • The Panel of Reference will report that they have been appropriately used as a means of user involvement in strategic planning. • Regular, quarterly focus groups will have taken place to regularly monitor activity which happens as a result of the planned objectives.
To relaunch/review the Appropriate Adult Scheme in May 2001 (operational control for the Ayrshire scheme to transfer to East Ayrshire in June/July 2001)	<ul style="list-style-type: none"> • The new scheme will have strengthened local links and be receiving a wider range of referrals
To review the supervision of Community Care Orders in light of any change in the law regarding these.	<ul style="list-style-type: none"> • Arrangements will be in place to ensure the appropriate support and supervision of people in keeping with relevant mental health legislation.
To increase the number of people with mental health problems Diverted from Prosecution	<ul style="list-style-type: none"> • Increase overall referrals to Diversion from Prosecution Scheme to 50 per annum resulting in 25 to 30 cases per annum diverted. Approximately 1/3 of these would be people with mental health problems.

Objective

- *To shift the balance from long term hospital care to community based services to achieve a more appropriate balance.*

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
<p>To continue to fund packages of care from selected providers to support people in the community who have been resettled from Ailsa Hospital.</p>	<ul style="list-style-type: none"> • The 32 people currently supported in this way will continue to live in the community.
<p>To use the £30,000 currently designated as a flexibility budget for people with mental health problems to be supported in the community.</p>	<ul style="list-style-type: none"> • Packages of care to support people with mental health problems in the community will be funded to a total of £30,000.
<p>To continue to monitor the effectiveness of the discharge protocol</p>	<ul style="list-style-type: none"> • An audit tool will have been implemented and a rolling programme of monitoring and auditing undertaken.
<p>To continue to build on the increasing expertise around sensitive allocation and housing supporting.</p>	<ul style="list-style-type: none"> • A monitoring process will indicate how many people with mental health problems have been allocated housing as a result of the allocations policy. All of these people identified to be discharged from Ailsa Hospital in Phase 2 wishing to be re-housed in South Ayrshire (approx. 14) will have been provided with housing. Training will have been provided to staff and the elements of good practice clearly identified. • The health needs of homeless people with mental health problems will have been assessed and a strategy put in place to meet them.

7. PRIORITIES IF ADDITIONAL FUNDING IS MADE AVAILABLE

Objective

- *To have in place an adequate infrastructure of community based services for people with severe/enduring mental health problems*

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
To increase the resources of the Adult Mental Health Flexibility Budget through funding bids.	<ul style="list-style-type: none"> • The yearly budget will have trebled from £30,000 to £90,000 by 2004.
To raise funding with our partner authorities to contract with Copeline to enable them to remunerate their volunteer staff.	<ul style="list-style-type: none"> • £9,000 paid to Copeline over the next 3 years and volunteer staff being remunerated.
To facilitate parents with mental health problems accessing support	<ul style="list-style-type: none"> • Crèches developed through closer links with Surestart.
To support the annual service user conference.	<ul style="list-style-type: none"> • Joint funding in place
To support a collaborative initiative around the provision of a respite facility for people with sub clinical/social need	<ul style="list-style-type: none"> • Joint funding in place. Clear strategy for development and implementation of respite facility in place.
To support the enhancement of Local Exchange Trading Schemes, which build social capital	<ul style="list-style-type: none"> • Infrastructure in place to support Local Exchange Trading Scheme
To support “stepping stones” to maintain employment etc.	<ul style="list-style-type: none"> • Joint funding in place. Clear strategy for development and implementation of employment options.
To support social opportunities service for people with mental health problems	<ul style="list-style-type: none"> • Service commissioned to: <ol style="list-style-type: none"> 1. Provide direct support to people with mental health problems to take part in activities of their choice within their own community. 2. Develop methods of informal support for people with mental health problems.

Objective

- *Shift the balance from long term hospital care to community based services to achieve a more appropriate balance*

ACTION	HOW WILL WE KNOW WE HAVE ACHIEVED IT?
<p>To purchase Supported living services from providers selected through the commissioning process to supported living services for the remainder of those identified as Phase 2 of the Ailsa Resettlement Programme</p>	<ul style="list-style-type: none"> • Remaining people identified as Phase 2 of Ailsa Hospital Resettlement being supported in their own homes in the community.
<p>To review overall progress of Mental Health Strategy on a multi-agency basis</p>	<ul style="list-style-type: none"> • Review exercise completed and priorities identified for action.

SERVICES TO PEOPLE WITH A MENTAL HEALTH PROBLEM

ACTION	2000/2001	2001/2002	2002/2003	2003/2004	2004/2005	PROVIDER	FUNDING SOURCE
SUPPORT SERVICES							
Ailsa Hospital Team	194320	194320	200150	206154	212339	Local Authority	Social Work, Housing & Health AAHB
Ailsa Resettlement Project	24200	24200	24926	25674	26444	Local Authority	Social Work, Housing & Health AAHB
Community Mental Health Team	98620	98620	101579	104626	107765	Local Authority	Mental Illness Specific Grant/ AAHB
Advocacy Service	14000	23500	24205	24931	25679	Ayr Action for Mental Health	AAHB
Job Coaching Service	13760	13760	14173	14598	15036	The Wise Group	Social Work, Housing & Health/ESF
SAMH (Outreach)	26930	26930	27738	28570	29427	SAMH	Mental Illness Specific Grant/
							Social Work, Housing & Health
RESIDENTIAL CARE							
Permanent - 1 place	6000	6000	6180	6365	6556	SAMH	Social Work, Housing & Health
SUPPORTED ACCOMMODATION							
Ayr Scheme - 10 places	201600	201600	207648	213877	220294	Richmond Fellowship	Social Work, Housing & Health AAHB
Prestwick Scheme - 11 places	212470	212470	218844	225409	232172	Richmond Fellowship	Social Work, Housing & Health AAHB
Maybole Scheme - 6 places	97950	97950	100889	103915	107033	Richmond Fellowship	Social Work, Housing & Health AAHB
DAY SERVICES							
Day Care	165500	165500	170465	175579	180846	Ayr Action for Mental Health	Mental Illness Specific Grant/
							Social Work, Housing & Health
Gardening Project 7 placements	11170	11170	11170	11170	11170	SAMH	Social Work, Housing & Health
Flexible Care Packages	113330	113330	116730	120232	123839	Independent Sector	Social Work, Housing & Health AAHB
Intensive Home Support	6620	7420	7643	7872	8108	South Ayrshire Dementia Support Association	Social Work, Housing & Health AAHB
Total	1186470	1196770	1232338	1268973.04	1306707		