

## WHO IS A CARER?

A carer is a person who gives up their own time often without payment, recognition or thanks to help another person who is disadvantaged due to physical or mental illness or disability. They may be expected to be available 24 hours a day, 365 days a year. Without training, they may be expected to act as nurse, companion, taxi driver and financial advisor.

Carers are, in fact, normal people who out of a sense of love, duty and compassion, struggle to live their own lives and, at the same time do their best to help a spouse, sibling, offspring or friend to achieve something in their lives. This may be the only person who is trusted by the unwell friend or relative.

They ask only to be given guidance, information and a little time to understand and learn how to cope with the situations that, if they did not deal with, would be a burden on the community in both time and money. They recognise the role of the professionals in the various disciplines and appreciate the pressure that they work under. Carers ask that their expertise is also recognised and that people talk to them and keep them informed of what is happening.

The information found in this pack is designed to assist the carer in accessing information that will help them to do their job in the most caring manner. It has been written by a carer for carers, someone who knows what it is like.

The fact that this information pack exists will help carers access information out of normal working hours and is seen as a godsend to a carer in desperation

*A local carer*

**October 2005**

# THE MAIN MENTAL ILLNESSES

The following summaries of the most common mental illnesses provide a brief insight into the main features of each one and is not intended to be viewed as a comprehensive source of information. For more details on a particular illness, please refer to the section on useful contacts.

## **SCHIZOPHRENIA**

In people experiencing an episode of schizophrenia, the mental processes of thinking become distorted, making it hard for them to distinguish reality from what is imagined. When severe, this can lead to immense panic, anger, depression, elation or over activity, perhaps punctuated by periods of withdrawal.

The symptoms of schizophrenia are divided into two groups, called 'positive' (for example, hallucinations and delusions) and 'negative' (for example, slowness to move, think, speak or react). These may occur separately, together or alternately. It is a relatively common condition with approximately one in one hundred people worldwide experiencing an episode of schizophrenia at some time during their lives although highest incidence is in the late teens and early twenties. In about one quarter of cases, there is eventually a full recovery. The majority continue to have problems, but usually they also have long periods of good functioning.

### Treatment

Effective treatment involves a number of different approaches. Ideally it is most effective when given in the early stages of the illness. Some form of medication is essential for most people, however, this should be given in combination with education about the disorder, emotional support and help with learning how to manage any continuing symptoms.

*For more information: Contact Rethink (see Useful Contacts).*

## **DEPRESSION**

Anyone can get depressed; about 1 in 20 will suffer from severe depression. Men and women suffer depression the same. When people are severely depressed, they feel that life has little to offer them and that things will never get better. This low mood is more than being fed up or unhappy: it is persistent and coincides with disturbed sleep, appetite and libido and markedly affects daily functioning. Depression is an illness that can be treated and should not be ignored.

People who are depressed may be pre-occupied with negative thoughts and become socially withdrawn. People can become depressed as a result of external events (e.g. the death of someone close, loss of job, etc.). However, sometimes there is no obvious cause.

### Treatment

Anti-depressant medication is a common treatment for depression. They work on chemicals in the brain to lift the mood. These are usually used in conjunction with giving people the opportunity to talk about their feelings and any possible causes of the depression. It can also be useful for people who have depression to meet others who have experienced the illness, so attending a support group might be beneficial. It can help to break down the feelings of isolation and it can help to hear how other people have coped.

*For further information: Contact The Depression Alliance (see Useful Contacts).*

### **BI-POLAR DISORDER (MANIC DEPRESSIVE ILLNESS)**

This is a mental health problem that is characterised by periods of deep depression and of very excited behaviour known as mania. About one in a hundred people are diagnosed as having manic depression. Around 15% of people who have a first episode of manic depression never experience another one.

Changes in mood are a daily occurrence for everyone but for people who suffer from manic depression the moods are extreme. During the manic or 'high' phase, people are very overactive. They may see things or hear things that other people can't. They may be unable to sleep, feel extravagant and spend large amounts of money that they may or may not have. During these periods people are liable to be irritable or over talkative, sometimes to the point of being incoherent. During the 'low' phase of the illness, people may feel overwhelmed by despair, guilt and feelings of unworthiness. They may be very apathetic and totally unable to do the simplest task. Episodes of highs and lows may occur directly after each other or there may be periods of stability.

### Treatment

Medication is often effective in managing manic depression but learning to self manage the mood swings is also an invaluable part of stabilising the condition and can work alongside medical treatment.

*For further information: Contact the Manic Depression Fellowship (see Useful Contacts).*

### **ANXIETY AND PHOBIAS**

Anxiety disorders are quite common, affecting about 5% of the population at any one time but many people do not seek help. Anxiety and fear are normal human emotions and are often found as reactions to stress. However, normal anxiety becomes abnormal when the symptoms are so intense that people are stopped from coping well with day-to-day activities because they are so painful and distressing. Abnormal fears, sometimes called phobias, are intense fears of things which would not make the average person frightened.

People who suffer from abnormal anxiety find it difficult to concentrate, tend to sleep badly and get tired easily. The body shows the effects of anxiety by increased heart rates, tension and pain in muscles, inability to relax, sweating, over breathing, dizziness, faintness and bowel disturbances. Sudden unexpected surges of anxiety are called panic attacks. Someone who has a phobia has symptoms of intense anxiety or panic but only in particular situations. Phobias lead to avoidance of the things which are feared.

### Treatment

Talking about the problem to trusted friends and relatives often helps and may give a sense of perspective. Most of us tend to avoid stressful situations, but in the case of anxiety disorders it tends to make the situation worse due to the fear it induces. However, more intensive talking treatments may be required such as Cognitive Behaviour Therapy (CBT). This helps people to recognise, understand and manage anxiety. Learning to relax with advice from professionals or by using tape cassettes or books can help to bring tensions and anxieties under control. Medication such as tranquilizers or anti-depressants may be used to help ease anxiety during the day or help sleep at night.

*For more information: Contact the National Phobic Society (see Useful Contacts).*

### **OBSESSIONAL COMPULSIVE DISORDER (OCD).**

OCD is a disorder characterized by obsessions and/or compulsions. OCD is common, affecting approximately 1 in 30 people. It usually appears in childhood or adolescence but continues into adulthood. It is an exaggeration of normal thoughts and actions which happen in nearly everyone. Most people find that from time to time, they have worrying thoughts which they cannot get out of their head or they carry out repetitive actions which are not really necessary. Obsessions are recurrent, persistent thoughts or ideas that they person may feel are senseless but is unable to ignore them. Compulsions are repetitive, ritualistic behaviour which the person feels driven to perform. Obsessions and compulsions in OCD can cause a lot of distress to the individual and their family. They can be very time consuming, interfering with people's daily lives.

### Treatment

Cognitive Behaviour Therapy has been shown to be very helpful in treating OCD. It involves learning to manage the situations which would normally provoke compulsive actions. Sufferers may learn to resist the compulsions and to tolerate the discomfort they experience as a result which gradually lessens with time. It also aims to change the way sufferers think about the situations associated with their OCD.

Sufferers of OCD can benefit from self-help techniques, either individually or within a group.

*For further information: Contact Obsessive Action (see Useful Contacts).*

## **PERSONALITY DISORDERS**

This is one of the most controversial psychiatric diagnoses. There are a number of categories of personality disorder which cover a wide range of attitudes and behaviour. The word 'personality' refers to the enduring patterns of thoughts, feelings and outward behaviour which are characteristic of an individual. Most people are flexible enough to be able to learn from past experiences and change their behaviour in order to cope more effectively. However, personality disorders are characterized by long lasting, inflexible and limited ranges of attitudes and behaviours which are expressed in a wide variety of settings and deviate from the expectations of that person's culture, causing distress to themselves and others. Having a personality disorder can make it difficult for sufferers to develop friendships, maintain stable partnerships and work co-operatively with others.

Personality disorders differ in the degree to which they disrupt the person's life or the lives of others and in the extent to which they can be treated. They often begin or become noticeable during adolescence or early adulthood.

This inflexibility is often related to having suffered severe trauma in childhood and the sufferer should not be blamed for their condition.

### Treatment

Personality disorders are difficult to treat because they involve long-term pervasive patterns of thoughts, feelings and ways of relating to other people. More positive outcomes tend to be associated with personality disorders which are comparatively mild. However, research focusing on more severe personality disorders also suggests that over a period of years some people are capable of modifying and changing their outlook.

## **EATING DISORDERS**

Anorexia Nervosa and Bulimia Nervosa are the two main eating disorders. People with anorexia nervosa can have extreme weight loss as a result of very strict dieting. Some people may also make themselves sick, abuse laxatives or do excessive exercise to try and control their weight. In spite of their low weight, people with anorexia nervosa believe that they are fat. It starts most commonly in the mid-teens. About one in one hundred 16-18 year olds have the illness and it is commonly found in girls.

People with bulimia nervosa crave food and eat in binges, afterwards making themselves sick or misusing laxatives to get the food out of their bodies. Unlike anorexia nervosa, the distress experienced by those suffering from bulimia may go unnoticed. The person may be any weight or size and not look ill. They may appear to be in control of their external lives, coping fairly successfully on a day-to-day basis, but they are likely to be tormented by an unpredictable cycle of chaotic eating, ranging from periods of starvation to eating thousands of calories.

Bulimia nervosa is usually more common in girls and is more common than anorexia nervosa although people who have this condition do not always ask for treatment.

### Treatment

In both anorexia nervosa and bulimia nervosa, self help strategies can be very helpful. Eating problems can be very isolating. Support and self help groups provide an opportunity to meet regularly with others who have had similar experiences.

If self-help is not enough, health professionals may suggest a course of psychotherapy to help the individual and the family to understand why the illness developed and how to overcome it. The aim will be to help that person change their attitude, behaviour and ways of thinking to enable them to cope with the strains of life without the eating disorder as a protection.

However, if someone has lost a dangerous amount of weight, the first step will be to help the person start to regain that weight in order to survive and this may involve being admitted to hospital in order to support the individual.

*For further information: Contact the Eating Disorders Association (see Useful Contacts).*

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# PLANNING CARE

## INTEGRATED CARE PROGRAMME APPROACH

*The Integrated Care Programme Approach - I.C.P.A. - is the process by which an individual's health and social care needs can be assessed, so that their care and support can be planned delivered and reviewed by the person, their relatives (carers) and the professionals involved.*

The approach consists of four key stages:

1. **ASSESSMENT** - During this period all concerns and difficulties should be explored. This can include health and social issues. The person should be seen in context and carers should be included in the process. This should ensure that all the problems identified can begin to be addressed. If specialist mental health services are required then stage two of the process can begin.
2. **CARE PLAN** - This should tackle the problems highlighted in the assessment period, what is going to be done to help and who is responsible for making it happen. The person who is unwell must be at the centre of this plan and be agreeable with the proposals. *Carers too, should feel that their concerns and opinions are valued.* It is important that all aspects of the person's life are considered and that the services needed to enhance this and aid recovery are available. Where services are not available to meet the identified needs a record should be kept so that they may be considered by managers responsible for service development. There must be agreement by all as to the course of action and those responsible for its delivery.
3. **CARE CO-ORDINATOR** - This is the named person responsible for co-ordinating the care plan. It should be someone who is able to maintain a good relationship with all parties and to whom concerns can easily be brought should they arise. The choice to change this person should be available without fear of affecting the quality of service offered.
4. **REVIEW** - The Care Co-ordinator has to make sure that the care plan is reviewed regularly, at least annually, by all involved: identify what is working well, what needs changing, what else needs to be included, so that recovery is ongoing and support can be altered as the individual's needs change.

Carers now have a statutory right to their own assessment of needs, which may be offered at the time of the I.C.P.A. process or at the review stage, or at any time the role has been identified. It may be a difficult thing to do: admitting being a

carer, admitting how much it involves, but it should enable you to identify where you can get support to improve how you cope with your role.

## **Planning for an Emergency/Crisis**

Crises happen at all the most inconvenient times - late at night, over a weekend etc. etc. At such times it is not easy to respond in the best or most appropriate way.

It is helpful, therefore, to try to think about some of the worst-case scenarios in advance, how might you respond, who might you call on and where to keep this information safe and handy. In this way if things do get difficult you have some sort of plan set up to help you through.

You will need to know the numbers of out of hour's services that are available in your area and have them by the phone or in the phone book.

Similarly you need the numbers for relatives and friends who can be called on at short notice, either to give you support in your home or if you have to go away, support for those left behind. This is especially vital if it is you that has an accident or crisis rather than the relative or friend with the mental illness.

Contact numbers for all services involved in your relative's care and others who support you should be kept with you at all times. With agreement, they should also be written in to your relative's notes so that they are readily accessible to any persons who might need them.

These plans should be drawn up and agreed by you and the relative/friend you provide care for when that person is calm and in a stable condition so that everyone is clear about what will happen. This is not always easy, when someone is well you are trying to be positive and not think about the bad times. However, if you can have some contingency plan it may be helpful in actually avoiding a really serious crisis.

This might also be the time to think about drawing up a confidentiality agreement. If you are the person responsible for your relative/friend being sectioned or admitted to hospital even voluntarily, you will possibly be the last person that they will wish to be told about what is being done for them. Patient's confidentiality can

sometimes be a convenient screen for professionals to hide behind and not discuss any matters relating to the unwell person. As you are likely to be someone helping with your relative/friend's care when they leave hospital you will obviously wish to be informed about what is happening and how things will be managed in the future and how you will be included in the process. You may need to find some way of encouraging your relative/friend to include you in the discharge planning, helping them to realise that you will be a useful ally in their care.

In order for the agreement to carry weight with professionals you need to ensure that you have discussed it thoroughly with your relative and have had it signed by the independent third party. It will probably be a more acceptable arrangement to your relative/friend if he/she feels that some pieces of information are retained as being confidential e.g. discussions in therapy groups or individual counselling sessions or seeing the written notes kept on the ward. In this way they can still keep a certain feeling of thinking for themselves, while allowing you access to information which they feel is in their own best interest for you to know. This is beneficial for all parties and ensures that professionals do not breach any of their guidelines.

#### TELEPHONE NUMBERS THAT YOU MAY NEED IN AN EMERGENCY

Emergency Duty Team .....  
(Social Services)

Crisis Home Team .....  
(Medical Services)

Care Co-ordinator .....

Community Psychiatric Nurse .....  
(CPN)

Social Worker .....

G.P. ....

Relatives/Friends/Others .....

Carer Support Worker .....

# CARERS' RIGHTS

As a carer I have only three statutory rights:

1. I am entitled to a *Carer's Assessment*, even if the person I care for does not wish to engage with services.
2. I am entitled to my own care plan.
3. It is a requirement that I am told that I am entitled to a *Carers' Assessment*.

BUT

the following is an informal charter which we could all refer to in times of need and which has been adapted from the code of family rights approved by the New Zealand Schizophrenia Fellowship's National Council 1998.

As a carer I can expect to:

- o Be taken seriously when expressing concerns.
- o Be treated with understanding and respect.
- o Be informed on the range of relevant services and support available.
- o Be afforded a rapid response in an emergency situation.
- o Be provided information if this is in the best interest of the patient and other members of the family.
- o Be informed about a relative's illness, the diagnosis, treatment and possible side-effects of the treatment.
- o Be included in a family-centred approach to treatment and support.
- o Be included in care-planning, implementation and review.
- o Be helped with problems created or exacerbated by caring for a relative with a mental illness.

- o Know the names of other members of the care-giving team.
- o Be offered culturally accepted treatment options which are inclusive of the family.
- o Seek other opinions regarding the diagnosis and treatment of a relative.
- o Be informed of mechanisms of complaint and redress.
- o Be consulted about a relative's discharge plan.
- o Receive a mental health service that recognises the need for families to participate in shaping the service and invites families to take part in service planning, implementation and evaluation.
- o Be encouraged to take time out when required, to prevent 'burnout' or to cope with stress.

(Adapted from the New Zealand Schizophrenia Fellowship's National Council. *World Schizophrenia Fellowship Newsletter*, Fourth Quarter, 1998).

**Correct at the time of going to press.**

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## CARERS' ASSESSMENTS

Carers have a statutory right to their own assessment, even if the person they care for does not wish to engage with services. Carers often feel that if the person who is ill is receiving the right services then their needs are being met. It is important to realise that this is not an assessment of your ability to care or your financial status.

It can be a difficult process to go through: admitting being a carer, admitting how much it involves. However, if the assessment is offered at the appropriate time and by someone willing to spend time helping you through it, it should enable you to identify where you may need support and how to get it. This should improve your ability to cope with your role.

The assessment may be offered during the Care Plan meeting, by the Care Co-ordinator. If not, then it is perfectly alright for you to request one when you feel comfortable about it. If it is offered in front of the person you care for you might feel uncomfortable accepting it. If you do turn it down this does not stop you approaching the care co-ordinator later to accept the carers' assessment. Ask, also, that whoever carries out the assessment will actually spend time with you, helping you to fill out the form. You may find that discussing different issues helps you to be clearer about your role, your needs and what if anything can be done to lighten the burden.

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## UNDERSTANDING THE JARGON

People coming into the mental health system for the first time often think that they have landed in a foreign country. Professionals use terms and abbreviations which are unfamiliar to the layperson. However, if someone is speaking to you and using abbreviations or unknown phrases that you do not understand always ask them to explain what they mean. Don't feel that you will look foolish or ignorant; people often forget that not everybody uses the same language on a daily basis. Below is a list of some of the more common terms used.

### Approved Social Worker (ASW)

Each local authority has a responsibility to provide sufficient numbers of social workers specifically trained and approved by the local authority under the Mental Health Act 1983. Their role is to assess people for hospital admission and if they consider there is no alternative, to authorise admission and make the necessary arrangements. This is an enhanced role and different from the usual remit of Social Workers. However, the Social Worker who may be involved as part of the care team does not have to have this extra qualification and is still able to make a valuable contribution in advising on suitable housing, appropriate benefit claims and generally giving support in the community.

### Assertive Outreach Team

This service aims to help people with a severe mental illness who may be difficult to engage with. The service is available in the community 24 hours a day, usually visiting the person in their own home. Team members have smaller caseloads than colleagues in Community Mental Health Teams (CMHT's), which enables them to spend more time with their clients helping with practical tasks as well as encouraging the use of medical treatments.

### Atypical/Anti-psychotic Medication.

These are recently introduced forms of medication used to treat psychosis. Some of the more frequently prescribed are Amisulperide, Clozapine, Olanzapine and Risperidone, because they are thought to cause fewer side effects. Clozapine may be used when two or more of the above are ineffective.

### Bi-polar (Manic) Depression.

The name of the illness which causes excessive change in mood from deep depression to hypomania.

#### Care Co-ordinator (or maybe Key Worker)

This is the member of the team who will co-ordinate the Integrated Care Programme Approach (ICPA) and act as the link/contact for the Service User, Carer/s and other team members.

#### Clinical Psychologist

Someone who can use psychological knowledge and techniques to help in understanding and treating illness.

#### Cognitive Behaviour Therapy (CBT)

This is a way of helping people to cope with stress and emotional difficulties by making the connections between how we think, how we feel and how we behave.

#### Community Mental Health Team (CMHT)

The providers of mental health services on a local basis. These Teams include Psychiatrists, Clinical Psychologists, Community Psychiatric Nurses, Social Workers and Occupational Therapists, all of whom will work jointly in trying to develop a care plan to meet the needs of the person using the services.

#### Community Psychiatric Nurse (CPN) or Community Mental Health Nurse

A qualified nurse who will provide out patient and follow-up care when the individual is living at home/or in the community.

#### Crisis Resolution and Home Intervention Service

This service can be an alternative to in-patient hospital admission. Its aim is to resolve crisis in the home. It may be that this will provide a short-term solution.

#### Depot Injections.

Long acting medication often used where people are unable or unwilling to take tablets regularly.

#### Dual-diagnosis.

This can be a combination of a mental illness with other conditions such as alcohol abuse, drug abuse, learning/physical disability.

#### Electro-Convulsive Therapy (ECT)

It is most commonly used for severe depression where medication has failed. ECT is always administered under general anaesthetic and produces a mild shock to the brain similar to an epileptic fit. People are often concerned when ECT is discussed but administered in the right way it can be an extremely effective, life saving treatment.

### Emergency Duty Team (EDT)

The team provides a social work service outside of office hours at night, weekends and bank holidays.

### Forensic Service.

This is the area of mental health service which deals with people who commit criminal offences whilst being mentally ill.

### Holistic.

This means considering the whole person in the treatment of the illness - i.e. their physical, emotional, psychological, spiritual and social needs.

### Integrated Care Programme Approach (ICPA)

This is a means of planning and monitoring the care of someone recovering from the effects of severe mental illness and who is considered to be a vulnerable member of society. The central features of ICPA are assessment of need, involving the Service User and Carer/s, the allocation of a Care Co-ordinator and an agreed Care Plan, which is reviewed at regular intervals.

### Mental Health Act, 1983.

These are the regulations in place at the moment - a new Bill is currently under review. You may have heard of 'sections'. This refers to a section of the Mental Health Act. These allow certain mental health care professionals to make assessments and admit people compulsorily to hospital, where they are thought to be a risk to themselves or others, or in danger of serious deterioration if compulsory intervention is not undertaken.

Section 2. This is a period of assessment in hospital that lasts for up to 28 days. It can be applied for by an Approved Social Worker (ASW) or the person's nearest relative and must be backed up by recommendations from two doctors, one of whom must be a senior psychiatrist.

Section 3. This is an admission for compulsory treatment lasting for up to six months. Application is similar to Section 2.

### Occupational Therapist (OT)

OT's are trained to work with people to help them to improve their ability to cope with daily living as independently as possible. They not only help with practical tasks, but can improve coping strategies as well as helping to encourage participation in recreational, educational and vocational activities.

#### Primary Care Trusts (PCT's).

These are the legally established bodies who provide and commission personal medical and dental services.

#### Psychiatrist.

A medical doctor who has trained and specialised in psychiatry - the branch of medicine concerned with mental health, diagnosis, treatment and care.

#### Psychosis.

A broad term that describes a severe mental disorder where a person loses touch with reality. Their emotional responses, thinking processes, judgement and ability to communicate are so affected that day-to-day living becomes unmanageable. An individual's experiences of psychosis can be quite different and it is often valuable to talk to the person about what its like for them.

#### Schizophrenia.

A specific term for a mental illness where symptoms can include psychosis. (See Main Mental Disorders for a more detailed definition.)

#### Voluntary Organisations.

Bodies governed by unpaid members, registered as charities with some paid members of staff.

These are some which are specifically helpful for people experiencing mental health problems:

Mental After Care Association (MACA).

Mind

Rethink

Samaritans

Saneline

(For more details see Useful Contacts sheet.)

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## A CHECK LIST OF QUESTIONS

Families often feel anxious and psychiatrists are usually busy: this can mean that you do not always know who to ask about your relative/friend's illness. It is a good idea to have a list of the things you want to know, ready before you have a meeting with any of the team involved in your relative's care.

This checklist is designed to help you get the information you need concerning the diagnosis, treatment and care plan of your relative/friend. These questions have been included as a framework for you to use: you may not find them all helpful and there may be others that are not included.

This assumes that your relative/friend is happy for the member of the team to discuss these issues with you. However, if your relative/friend is unwilling for information to be shared there will be a problem with confidentiality. It is probably best to work through this issue prior to any meetings so that you are aware of where you stand. It may be helpful to have a confidentiality agreement set up whilst your relative/friend is agreeable and co-operative (see section on planning for an Emergency/Crisis).

### **About the diagnosis**

- What illness does my relative/friend have?
- What symptoms/signs suggest this?
- What is known about the causes of the illness?
- What is likely to happen in the future? Will it get better or worse?
- Where can we get more information about this disorder?
- If there is no diagnosis yet what are the possibilities?
- How long will it be before there is a diagnosis?
- What help will I get with dealing with the behaviour/symptoms in the meantime?

### **About the assessment**

- What tests have been done?
- Will any more tests be needed?
- What are the results of the tests? How will these be acted upon?

## **About care and treatment**

- What are the aims of the care and treatment?
- What part will the care co-ordinator play in my relative's care?
- Who else will be involved in the treatment?
- How often will you see our relative?
- What is your plan for treatment? How long will it last?
- Would psychotherapy (talking treatments) of any sort be helpful? If so, is it available locally?
- What happens if our relative/friend refuses treatment?

## **Integrated Care Programme Approach (ICPA)**

- Would you explain how the ICPA will be used to help our relative/friend?
- When will there be an ICPA meeting and will we be invited to it?

## **The family and the treatment**

- Will the family/friend be involved in discussions concerning the treatment of our relative's illness?
- What can we do to help?
- Can we be referred to the Family Work Service?
- Are there any local self-help or carers' groups?

## **Getting help**

- Who do we contact if we are worried about something?
- How can we get in touch with you?
- Who do we contact in an emergency?
- How can we get a second opinion (you are entitled to this)?

## **Medication**

- What medication is to be used?
- What should the benefits of this medication be?
  - Short-term
  - Long-term
- What are the possible side effects of this medication?
  - Short-term
  - Long-term
- Why have you chosen this particular drug?
- Will it be necessary to take it for life?

- Are there any other drugs that could be used if this one does not work?
- What signs/symptoms might mean that the drug should be changed?
- What will happen if he/she stops taking the medication?
- Do you have any written information about this medication?

### **Hospital treatment**

- What happens if there is no bed available?
- How long will he/she need to stay in?
- What arrangements will need to be in place in order for our relative/friend to leave hospital?
- If transport is difficult, can our relative/friend be housed near us?
- Can arrangements for Benefits be installed/reinstated immediately on discharge so financial security/housing does not become a problem?
- Who will inform utilities etc. that someone is admitted/discharged so that there is no danger of non-payment summons being incurred?
- If it is not appropriate for our relative/friend to return home, what other options are available in our area?
- Who can advise/inform us about this?

### **Your own questions:**

# DEALING WITH DIFFICULT BEHAVIOUR

## DAY TO DAY DO'S AND DON'TS

*DEFUSION* : is a term for verbal and non-verbal ways of reducing tension.

*These tips work - they were developed from practice and experience.*

*The more you try these tips the better you will become.*

- The Principle is: Change 'acting out to talking out': try talking things through, rather than acting impulsively.
- Don't invade defensible space: people like their own bit of territory - their own chair etc.
  - o Stay an arm's length away.
  - o Avoid being in a corner, or cornering the person.
  - o Always knock on their door.
- Get to know signs of rising tension: rocking, stuttering, colouring of the face, pacing, hand wringing.
- Keep neutral body postures.
  - o Keep hands in sight - showing the palms is a sign of peaceful intentions.
  - o NO clenched fists, hands on hips, pointing, leaning over people.
  - o Make eye contact - but don't stare!
  - o 90% of communication is non-verbal so SMILE!
- If you defuse the situation you are successful. If the person has not lost face, has kept their pride - then they are successful.
- Self-awareness : this is not a vague thing. If you are in a grotty mood don't pretend you are feeling great, or that it doesn't matter. Just being aware of your mood can help you make adjustments to how to deal with any given situation.
- Establish a warm environment
  - o physically turn up heat (a side effect of some medication can be to feel chilly).
  - o Sit in a warm place to talk.
  - o Be sensitive about colour schemes - décor, clothing etc.
  - o Keep a quiet place for talking or for space to get away.
- "Walk don't run", apply this in different ways: lower the voice, walk slowly.

- Count to ten - this really does work. When first faced with a situation start counting. As you do: check your mood, assess the situation, decide on a first course of action, confirm it to yourself then do it. You will be more likely to gain control because unwell people are very often frightened people and do not know what will happen next. If you come up with safe solutions the unwell person will develop confidence in you.
- Use humour. A good one-liner can be worth all the other tips put together. Avoid negative humour like sarcasm, put-downs or jumping to conclusions - one may jump back!
- Empathise: this means, "I think I know how you feel." You can't always, but if you think you do then use it.
- Sympathise: this means, "I agree with you."  
Someone may be right to show anger or distress - develop this by talking about ways of doing something about it.
- Ventilation: once someone is talking, let them let off steam, don't try to stop them. Don't interrupt and don't argue with them.
- Ask open-ended questions like "How did that make you feel?" rather than closed ones like "Did you do that?"
- Make general statements:
  - o "Lots of people feel like that when they're ill."
  - o "You're not alone in thinking like that."
  - o "That's not you that's the illness."
- Split up the antagonists: take one off for a chat or get them both talking to you rather than at each other.
- Sit out a threat: employ a stand-off - NEVER join in a scrap. This will be appreciated because you become safe. By setting a limit you reassure. Always take threatened violence to an individual seriously. Ask for weapons to be put down NOT handed over.
- Individuals have different strengths in defusing situations; there are natural differences between the sexes. So if your partner is dealing successfully with the situation just be visible; be around to be called on.
- Physical contact: don't wake someone abruptly or aggressively; this carries a high risk of an equal response. Don't touch the back of the neck during tension. Don't take a grip on an arm.
- Don't put up with the unacceptable - zero tolerance of violence or aggression has to be the rule. Discuss this in a calm setting not when a situation has reached crisis. Set limits and keep to agreed ground rules.
- Know who to call and how to call for help in an emergency.  
Keep important numbers (e.g. Crisis team), next to the phone or in the phone memory.

- Don't become involved in an argument; try to divert the conversation to a subject which is not controversial.
- Develop ways of defusing situations that are appropriate to your family, your personality, or the person who is ill. Apply the solution that fits at the time.
- Discussion after a tense situation - wait for a cooling off period. Then have a family conference to devise a plan. Always try to have a plan in place that has been agreed by everybody for an emergency or crisis. If you think things through before a problem arises you will be better able to cope and to continue coping.
- Down tools. Accept that your life has changed - at least for as long as your loved one is ill. There may be times when you just have to stop everything, in order to keep yourself or your loved one safe. It won't hurt to ignore a deadline or be late for something. Take breaks yourself - even if that inconveniences someone - no one is indispensable! If you become unwell you cannot continue to care. Your health is important too!

## TALKING TO SOMEONE WITH DELUSIONS (Unusual Beliefs)

- Don't dismiss the delusions. Recognise that these ideas and fears are very real to the person - but show that you do not agree with them. Try, for example, "I don't believe ... is out to get you, but I can see you are really upset about it."
- Don't act horrified by bizarre words or unfinished sentences etc. Say, "I don't really understand what that means." Or remind them what the conversation was about "Remember we were talking about..."
- Don't let others laugh about the hallucinations or the strange talk.
- Don't ask the person to try to force the voices to stop.
- Do act calm.
- Do try to distract the person by involving them in something interesting, looking for something, chatting or mixing with close friends or family.
- Do give the person space and time if they don't want to talk. Say, " I can see you don't want to talk now, but I'll be here if you want to talk later." Allow them time to recover their pride, their thoughts, their composure etc.
- Do find someone to talk to, to let off steam yourself - another carer, a support group, a professional who can guide/advise.

Take a break to recharge the batteries, you will need it. Have a carer's assessment - it's a legal right - it can help you to identify where help and support may be available to further enhance your ability to care and to help you stay well yourself. It may be difficult to go through this process, for example admitting how much you actually do, but it should help you to resolve things in a more positive light.

Compiled with grateful thanks to Rethink.

**October 2005**

## HELPING SOMEONE WHO HAS PROBLEMS WITH ALCOHOL

Alcohol is one of the most commonly used drugs in our society. It is legal and a depressant, impacting on the brain to affect mood, emotion, co-ordination, reaction times and our ability to assess situations. Alcohol is used for many reasons: to enjoy the taste, to celebrate, to accompany food, to show hospitality, to feel more relaxed and have less inhibitions in social groups, to de-stress following a busy day or week at work or to forget about general worries and concerns and their accompanying negative emotions. For the majority of people, alcohol consumption is not a problem. However, some people drink too much, and this can cause problems for the drinker and for his or her family members, carers and friends.

Evidence suggests that there is a strong link between alcohol misuse and mental health problems. You may have heard of this called 'dual diagnosis' or 'co-morbidity' but it is becoming more common to refer to people as having 'multiple' or 'complex' needs. People who have mental health problems may drink alcohol for very particular reasons - to try and cope with or hide away from the mental health problems and the life problems that this brings.

People who have alcohol problems and mental health problems are seen as a hard to treat group, but a group that is very vulnerable and therefore in need of help from both alcohol and mental health services. Often the symptoms of the alcohol misuse and the mental health problem will be very similar, making it hard for families, carers and professionals to identify and try to 'treat' the problem.

It is important to remember that if your relative has a mental health problem, and an alcohol problem, that this could have a big impact on your life. Living with an alcohol problem can be a very difficult experience: there may be physical and psychological health problems to deal with, money problems, difficulties with work as well as your relationship with the person you care for. You may even find that your own alcohol consumption is a bit higher as you try to relax, cope etc. This is all very similar to the kinds of difficulties that you might experience in being a carer to someone with a mental health problem. Caring for somebody with both problems can make it even harder. It can be hard for other members of the family as well. Traditionally, services have not tended to offer help to family members, but this is slowly changing and there is help available.

### **Responding to your relative:**

- Use much the same kind of techniques and strategies for either or both problems together. (See notes on dealing with difficult behaviour)
- Try not to criticise, shout or be judgemental. Remember how hard it must be for your relative and how bad they must feel because of their problems. Acknowledge that there is a problem, but that it is possible to get help.
- Show your relative how much you care for them and want to try and help them. Letting them know that there is someone they can turn to for support, and who may be able to help them get further support, is very important.
- Having contingency plans in place ready to use in an emergency is vital and can often prevent a difficult situation from becoming a crisis.
- Try to find help that is appropriate for both you and your relative. You may need to get extra help in accessing treatment and support because of the higher level of need.
- But, remember your own needs as well!

National and local services that may be able to provide information/offer help to you and the person you are caring for.

Alcohol Concern is the national agency on alcohol misuse, and contains lots of helpful resources and links. This includes an online alcohol service directory, library and a series of Factsheets (including one called 'Alcohol and Mental Health'). The website for Alcohol Concern is <http://www.alcoholconcern.org.uk>

Drinkline (National Alcohol Helpline) 0800 917 8282

Al-Anon, national number (will put you in touch locally) 020 7403 0888 or <http://www.al-anon.alateen.org>

Health Development Agency 020 7383 3833 or <http://www.had-online.org.uk>

Families Plus (Wiltshire)

ACAD (Bristol, Bath and W-s-M).

See local contacts sheet for other numbers.

**All numbers correct at time of going to press.**

**October 2005**

## HELPING SOMEONE WHO HAS PROBLEMS WITH DRUGS

We all have opinions about drugs, and we may have differing attitudes. Our opinions may be influenced by whether they are legal, our attitudes to risk, what we have used ourselves and what we have read and seen on television. It is important to think about those attitudes before talking about them with relatives. It can be very difficult to start a conversation about something that may be causing a lot of distress and tension. It is helpful to realise that understanding drug use is more than knowing what the different drugs are and their effects.

Unfortunately drug use among young people is very common: in one study of 14 to 16 year olds over half had tried an illicit drug; cannabis and amphetamines were the most common. Most by the age of 16 had been offered an illicit drug at some time. It may be considered more normal in some peer groups to use drugs, than not. It is not only younger people that struggle with peer pressure.

People who use drugs are often unable to communicate what is happening to them and why. When they are struggling with the problem, they are unlikely to give satisfactory answers or explanations about what is going on. For people living with, or caring for someone using drugs it can be very frustrating, as you can see the harm that the drugs do, but are unable to help the person to realise it for themselves.

When trying to help, it is important to find a way to see the world the way they see it, to understand their journey. This journey towards managed use or a life without drugs is one that you will all have to undertake. You will have your own symptoms and setbacks, feelings and fears. It is OK to have feelings of denial, blame, anger, despair and hopefully acceptance and moving on. Acceptance is not resigning yourself to the situation, but seeing what is there, what help is available and looking at the next stage. Like the person you care for the journey may move forwards and back, you may relapse also. Your relationships may change, you may need to change your own life to help your relative, or to protect yourself and your family. Understanding this will help you manage your own journey too.

### So why do people take drugs?

This is a common question that parents and partners ask - usually before blaming themselves! There is no one answer. However, here are some reasons that have been given, that are easy to relate to:

- To have fun and relax
- Because they were easily available
- To join in with the crowd

These may be viewed as 'positive' choices that people decide to make.

However, there may be negative reasons also:

- Trying to get away from something, escaping difficult or painful feelings or situations
- Because they are bored and there is nothing better to do
- To help 'self medicate' an underlying illness or condition; cannabis may reduce anxiety, or amphetamines may help a low mood.
- To replace prescribed medication, because of the unwanted side effects that the anti-psychotic medication may produce, e.g loss of libido or weight increase.
- To have a social network and be identified as a 'drug user'; this has more street credibility and often more friends than someone with a 'mental illness'.

### **Drug use and mental health**

The relationship between the effects of the drug and someone's mental health is complex and it is often difficult to get a clear understanding. Everyone is different and there is no simple answer. Here are some common questions:

#### Do drugs cause mental illness?

No. But they may make symptoms worse for people who are vulnerable to mental illness. To make things more complicated, some aspects of drug use will make people feel better also, such as reducing anxiety.

#### What do you treat first, the drugs or the mental illness?

Research has shown that you need to treat both together, this is called integrated treatment. It is a four stage process:

- Engaging with the patient to fully understand their problems.
- Developing the patient's awareness to the problems and increasing motivation.
- Active treatment to reduce or stop drug use.
- Relapse prevention to maintain the progress that has been made.

Other important parts of the treatment include:

- Stabilisation of their mental illness
- Appropriate and monitored medication
- Social support
- Something to do with real meaning

**Research has also shown that people do better in treatment when carers play an active part in their programme.**

## How can I talk to someone about drugs?

Talking about something as big and new as 'drugs' is difficult, here are some tips:

- Be specific. Don't make sweeping statements. Talk about the actual aspects of your relationship that you think are a problem.
- Be direct. Talk about how the behaviour affects you or the rest of the family.
- Be calm. This is easier said than done but try not to shout or let the discussion become an argument. Better to leave it and return to it later.
- Be open. Listen to what your relative has to say. Write it down and consider it later.
- Try to look at the wider context. Think about everyone who might be affected.
- But it is important that you look after yourself as well.

You may need someone else to sit in with you or you may need to write things in a letter at first. Do try to keep talking.

Many young people find it difficult to stop altogether, even if there are big negative consequences such as relapsing into a psychotic illness. Try to look at ways of reducing the harm that drugs may cause by setting agreed goals and then seeing if they reduce problems. Some examples:

- Reduce the strength of cannabis, e.g. no skunk (high active ingredient).
- Only smoke cannabis in the evenings or at weekends.
- Do not mix different drugs; it can increase the risk of overdose.
- If injecting, ensure only clean 'works' e.g. clean needles are used.

## Cannabis is the most commonly used drug

**Cannabis.** (puff, weed, dope, blow, pot, grass, hash, ganja, marijuana)

Commonly as light to dark brown block, like a stock cube or dried herbs, more rarely as an oil. It can be smoked in a pipe or cigarette by itself or with tobacco. It can be eaten or made into a tea and drunk. There is evidence for psychological and some physical dependence.

**Effects:** In small amounts, it can make people relaxed, in larger amounts drunk/sleepy.

**Risks:** In the short term it affects your ability to concentrate or drive a car. Longer term use, like tobacco, may lead to breathing problems or cancer.

**1 in 4 will experience psychological problems, ranging from temporary confusion and paranoia to a worsening of mental health problems, such as a full psychotic relapse. It doesn't cause mental illness, but, for those that are vulnerable to mental illness, it can exacerbate it.**

Other drugs that are used include:

amphetamines, ecstasy, benzodiazepines (prescribed for anxiety or sleep problems e.g.'s valium or temazepam), 'crack', cocaine and heroin.

For more detailed information, ask ward staff, community staff, or telephone the National Drugs Helpline, FRANK, 0800 77 66 00

If you require further help and support as a carer, ADFAM produces a range of supportive information. These are available by calling on 020 7928 8898 or visiting the ADFAM website at [www.adfam.org.uk](http://www.adfam.org.uk).

Further information, support and access to local self help groups can be accessed by Families Anonymous, they can be contacted on 0845 1200 660.

**All information correct at time of going to press.**

**October 2005**

## HELPING SOMEONE WHO SELF-HARMS

People injure themselves for many reasons. It may replace emotional distress with physical pain. Many people say that when they cut themselves they experience a release of tension and so they often feel calmer. In a strange way, self-injury may help people feel that they can achieve some degree of control back in their lives.

Self-injury is very often not a suicide attempt, however, people who do self-harm are at a greater risk of suicide than the general population and should never be dismissed as just 'attention seeking' or being 'manipulative'.

Relatives, friends or professionals trying to help the person can find it very stressful, especially when the person does not want to talk about or explain their behaviour. It is easy to feel 'shut out' and just left to pick up the pieces at times of crisis. If someone we care about is deliberately damaging his or herself and not willing to let us help, we can feel isolated and powerless.

The person usually has very low self-esteem and poor self worth and they think that others will see them in the same light and be critical. There are therapies which can be used that have been shown to be effective in breaking the negative cycle. (An organisation called SPEAR, based in Swindon can give further help and advice. Phone: 01793 520111.)

### Useful Pointers:

- Respond to an incident of self-harm in the same way that you would for the victim of an accident; provide first aid as for any other physical injury.
- Do not assume that the person either enjoys or does not feel pain. A response which implies criticism or some form of punishment simply reinforces the person's feelings of self-blame and guilt.
- Acknowledge the person's distress. Say something like 'I can see you are very upset. How can I help you?' This can be very reassuring and can help the process of communication.
- Aim to be positive and comforting; don't be negative or highly emotional. It may be hard but don't be judgemental, critical or dismissive. This applies to non-verbal as well as verbal communication. Try to show concern rather than disapproval, facially as well as in what you say.
- Try not to be over protective i.e. promising that everything will be alright. Acknowledge that there is a problem, but that it is possible to get help.
- Having contingency plans in place ready to use in times of crisis is vital and can often prevent a crisis happening. Knowing what to do and who to contact in an

emergency can be very reassuring for the person and those who care for them.

- If you think someone may be suicidal then contact the relevant agencies such as the emergency services and anyone else involved in their care, like their care co-ordinator or the GP.

**October 2005**

## USEFUL CONTACTS in AVON

### HOSPITALS

Bath & North East Somerset	Miles House Hillview Lodge	Day Hospital Cedar Ward Sycamore Ward The Cherries	01225 324200 01225 825341 01225 825353 01225 825333/4
Bristol North	Southmead	Clifton Ward Weston Ward Mason Ward	0117 959 5864/65 0117 959 5893/94 0117 959 5877/78
Bristol Central/South	Barrow Hospital	Brockley House Dundry Villa John Cary House Mother & Baby Unit	0117 928 6593/94 0117 928 6568/69 0117 928 6560/61 0117 928 6598/99
North Somerset	Longfox	Main Switchboard Juniper Ward	01934 647069 01934 647084
South Gloucestershire	Blackberry Hill	Oakwood House Wickham House	0117 918 6865 0117 939 8801
South West Region	Medium Secure Unit	Fromeside Clinic	0117 958 3678

### COMMUNITY MENTAL HEALTH TEAMS (CMHT's)

Bath & North East Somerset	North CMHT South CMHT The Swallows, Radstock CMHT for older people, St Martins - Intensive Home Treatment Team (10am to 10pm) Assertive Outreach Team	01225 731631 01225 324215 01761 404410 01225 831483 01225 825328 01225 825833
Bristol North	Cabot CMHT Kingsweston Primary Care Liaison Team Middle Sector Primary Care Liaison Team Assertive Outreach Crisis Team (24 hours/7 days a week) Rehabilitation Team	0117 973 5142 0117 959 7570 0117 959 5822 0117 959 7575 0117 959 5811 0117 959 7580
North Somerset	North CMHT, Woodspring South CMHT, Weston Crisis Assessment and Treatment Service (9am to 10pm, 7 days a week).	01275 341811 01934 647984 01934 647112
Bristol Central	Inner City Primary Care Liaison Team East Primary Care Liaison Team Crisis Team Assertive Outreach Rehabilitation Team	0117 955 6098 0117 301 2300 0117 301 2345 0117 301 2400 0117 924 9479

Bristol South	South (East/West/Middle) Primary Care Liaison Teams Crisis Team (24/7 but main cover between 8am-10pm) Assertive Outreach Rehabilitation Team	01275 834048 0117 928 6439 0117 928 6434 0117 924 8824
South Gloucestershire	Kingswood CMHT Yate Health Centre Severn Vale CMHT (The Elms, Thornbury)	0117 975 8046/47 01454 338817 01454 271000

## **CARER SUPPORT**

Family Work for Psychosis Service - 01225 383653 (for details see the back of this pack)

Rethink  
 - Bath & North East Somerset - 0117 986 4706  
 - South Gloucestershire - 0117 969 5355  
 - Bristol South & North - 0117 903 1803

The Care Network, Radstock - (Office) 01761 431388/(Carers Line) 01761 431389

The Princess Royal Trust Carers' Centre - 0117 965 2200 ([www.carers-sg.co.uk](http://www.carers-sg.co.uk))

The Young Carers' Project - 0117 965 5980

Black Carers Project - 0117 914 4492 (web site: [www.blackcarersproject.co.uk](http://www.blackcarersproject.co.uk))

Severn Beach Carers' Group	}	
Yate Carers' Group	}	01454 851201
Thornbury Carers' Group	}	
Carers' Drop-in, Marshfield	}	

Fishponds Carers' Group (and young carers' project) - 0117 939 2562

Brunelcare - 0117 987 3500

Carer Support Worker, North Somerset - 01275 546753

Crossroads, North Somerset - 01934 622644

North Somerset education and Training Consortium Carlton Centre - 01934 643323

## **VOLUNTARY AGENCIES**

Bath Mind, Advocacy - 01225 464656

Bristol Mindline Weds to Sun, 8pm to midnight (Help Line) - 0808 808 0330

Bristol Mind (main office) - 0117 914 1234

Bristol Mind Advocacy (in patient) - 0117 914 1554

Bristol Mind Advocacy (community) - 0117 914 0300

A comprehensive contact sheet of local agencies can be obtained from Mind.  
Triumph over Phobia (TOP) - 0117 956 5249  
Womankind (women and mental health project) - 0117 925 5207  
Friend - 01934 622292

#### **CITIZENS ADVICE BUREAUX**

Bath - 01225 463333  
North Somerset - 01934 621908

#### **BENEFITS**

Swan Advice Network 01761 437176  
Benefits Enquiry Line - 0800 597 5976  
The Benefits Agency, Bath - 01225 303200  
Carers can Benefit (Bristol City Council) - 0117 922 2609  
Weston-Super-Mare (South) - 01934 634000  
Lodge House, Bristol (North) - 0117 958 9400

#### **DRUG AND ALCOHOL SERVICES**

Bath Area Drug Advisory Service (BADAS) - 01225 469479

#### **HOUSING**

Swan Advice Network (Helpline) - 01761 432445  
Somerset Housing - 01225 366000  
New Era Housing Association - 01225 786600  
Richmond Fellowship - 01225 743798  
Second Step Housing Association - 0117 909 6630  
Carr Gomm - 0117 933 9550  
Touchstone - 01275 342368

**All numbers correct at time of going to press**

**October 2005**

# USEFUL CONTACTS in WILTSHIRE

## HOSPITALS

Area	Hospital	Ward	Number
South Wiltshire	Fountain Way	Main switchboard Beechleydene Unit	01722 820100 01722 820150
Swindon	Sandalwood Court	Main switchboard	01793 836800
North Wiltshire & Kennet and West Wiltshire	Green Lane	Main switchboard	01380 731200

## COMMUNITY MENTAL HEALTH TEAMS (CMHT's)

Area	CMHT	Number
South Wiltshire	City CMHT Rural CMHT Emergency Duty Team (Evenings and Weekends)	01722 820116/117 01722 744997 0845 6070888
Swindon	The Mall (Main Number) - South, East, North West & Outer North CMHT's Emergency Duty Service (EDS) Assertive Outreach Team (Kingshill House) The Outreach and Recovery Team	01793 715000 01793 715000 01793 491917 01793 437605
North Wiltshire & Kennet and West Wiltshire	North CMHT, Rowden Hill, Chippenham South CMHT, Red Gables, Trowbridge Devizes CMHT Crisis Team 9am to 9pm Emergency Duty Team & Out of Hours Home Care Service	01249 456468 01225 354354 01380 731200 01380 731292  0845 6070888

## **CARER SUPPORT**

Family Work for Psychosis Service - 01225 383653 (for details see the back of this pack)

Swindon Family Work for Psychosis service - 01793 437697

Rethink Carer Support Group, - 01380 840200

The Bridge Project - 01225 358564

Saturday Club: Trowbridge/Chippenham/Marlborough/Warminster - (see The Bridge Project)

Carer Support Workers:

- North Wiltshire - 01249 444110 or e-mail: [office@carersnw.co.uk](mailto:office@carersnw.co.uk)
- Kennet - 01672 564265 or
- West Wiltshire (The Bridge Project) - 01225 358566

Carers Support, Salisbury - 01722 322746

Swindon Carer Centre - 01793 531133

(Member of the Princess Royal Trust for Carers)

Carer Support Worker, North Wiltshire - 01249 444110 or [office@carersnw.co.uk](mailto:office@carersnw.co.uk)

## **VOLUNTARY AGENCIES**

South Wiltshire Advocacy Network (S.W.A.N.) - 01722 341851

Together: Working for Wellbeing (previously MACA) - 01722 416077

Swindon Mind - 01793 432031

SPEAR (self harm advisory service) - 01793 520111

## **CITIZENS ADVICE BUREAUX**

Wiltshire - 0845 1203737

Bath - 01225 463333

North Somerset - 01934 621908

Salisbury - 01722 327222

## **BENEFITS**

Benefits Enquiry Line - 0800 597 5976

## **DRUG AND ALCOHOL SERVICES**

Alcoholics Anonymous (24 hour line) - 01380 729064

Druglink - 01793 610133

Swindon and Wiltshire Alcohol and Drug Service (SWADS Swindon) - 01793 695405

Swindon Specialist Drug and Alcohol Service - 01793 491917

West Wiltshire Specialist Drug and Alcohol Service - 01225 759940

Kennet/North Wiltshire Specialist Drug and Alcohol Service - 01380 736630  
Bath Area Drugs Advisory Service (BADAS Wiltshire) - 01373 824060  
Swindon and Wiltshire Alcohol and Drug Service (SWADS Trowbridge) - 01225  
776477

## **HOUSING**

The Salisbury Community Mental Health Team hold a directory - 01722  
820116/820117

Salisbury District Council Housing Department - 01722 336272  
Swindon Service

Housing Coordinator for accommodation advice and information - 01793 463181

Rethink run two units, both in Warminster:

- The Mead (long term residential) - 01985 215800

- Fairview House (short term/rehab) - 01985 847680

Bristol Churches Housing Association have accommodation in Chippenham. They can  
be contacted on 0800 4320004.

**All numbers correct at time of going to press**

**October 2005**

## USEFUL CONTACTS

### NATIONAL

Carer's National Association Headquarters

Ruth Pitters House, 20-25 Glasshouse Yard, London E/C1 4JS. Tel: 020 7490 8818.

National Carers Helpline: 0808 808 7777. Lines open Monday to Friday 10.00 am to 2.00 pm.

Manic Depression Fellowship

MDF The Bipolar Organisation, Castle Works, 21 St. George's Road, London, SE1 6ES.

Provides support, advice and information for people with manic depression, their friends and carers.

Telephone: 08456 340 540.

Internet: [www.mdf.org.uk](http://www.mdf.org.uk) (main MDF site)

[www.mdfwales.org.uk](http://www.mdfwales.org.uk) (MDF Wales site)

[www.pendulum.org.uk](http://www.pendulum.org.uk) (Pendulum journal site)

[www.steady.org.uk](http://www.steady.org.uk) (STEADY self-management course site)

Rethink, severe mental illness

**Front Door: 0845 456 0455** Advice line (Mon-Fri, 9am-5pm). Offers advice, support and information for people suffering from enduring mental illness, including schizophrenia, their families/carers. A wide range of leaflets is available.

28 Castle Street, Kingston upon Thames, Surrey, KT1 1SS. Tel: 020 8547 3937 (office).

[www.rethink.org](http://www.rethink.org)

Saneline, National Helpline: 0845 767 8000 (Mon-Fri 12 noon to 11pm and Sat/Sun 12 to

6pm). Website: <http://www.sane.org.uk>

A national out-of-hours telephone helpline for anyone coping with mental illness, whether

they are sufferers, carers or concerned relatives or friends.

Depression Alliance.

212 Spitfire Studios, 63 - 71 Collier Street, London N1 9BE. Tel: 0845 123 23 20

Website: <http://www.depressionalliance.org>

Information, support and understanding for people who suffer with depression and for relatives who want to help.

CITA (Council of Involuntary Tranquilizer Addiction).

Cavendish House, Brighton Road, Waterloo, Liverpool, L22 5NG.

Tel: (Helpline) 0151 932 0102

Tel: (Office) 0151 474 9626.

Web: [www.liv.ac.uk/~csunit/community/cita.htm](http://www.liv.ac.uk/~csunit/community/cita.htm)

Best time to telephone: Helpline: 10am - 1pm

Office: 10am-4pm

Monday to Friday (emergency number available at weekends)

Founded to help patients and their families cope with addiction to benzodiazapines and withdrawal from these drugs.

The Association for Post Natal Illness, 145 Dawes Road, Fulham, London, UK, SW6 7EB.

Telephone: 020 7386 0868

Offers information and advice on overcoming post natal depression. Also offers support for husbands and partners of depressed mothers.

National Phobic Society

407 Wilbraham Road, Chorlton, Manchester, M21 0UT. Tel: 0161 881 1937

National membership organization providing help and advice for sufferers, their carers and their families.

Obsessive Action.

Unit 20.8, Aberdeen Studios, Aberdeen Centre, 22-24 Highbury Grove, London, N5 2EA.

Tel: 020 7226 4000.

A national organization that offers advice to people suffering from Obsessive Compulsive Disorder and their carers.

Eating Disorders Association (EDA). Telephone Helpline (weekdays) 9am-6.30pm.  
Tel: 01603 621414.

A national charity offering help and information to people with Anorexia Nervosa and Bulimia Nervosa, their families and friends.

Mind (National Association for Mental Health)

Granta House, 15-19 Broadway, London, E15 4BQ. Tel: 020 8519 2122 (Head Office).

A national organization that aims to work for a better life for people diagnosed, labelled or treated as mentally ill. It does this through campaigning, community development, training, publishing and a comprehensive information service.

Mind Information Line: 0845 766 0163.

Hearing Voices Network

79 Lever Street, Manchester, M1 1FL. Tel: 0845 122 8642 (Mon - Fri 10am to 4pm)

Website: <http://www.hearing-voices.org>

National Self Harm Network - Po Box 16 190, London, NW1 3WW

Website: <http://www.nshn.co.uk/about.html>

National Drugs Helpline, FRANK, 0800 77 66 00. Website:

<http://www.talktofrank.com>

ADFAM, Waterbridge House, 32-36 Loman Street, London, SE1 0EH. Tel: 020 7928 8898

Website: [www.adfam.org.uk](http://www.adfam.org.uk). Produces a range of supportive information for family members facing problems with drugs or alcohol.

Families Anonymous. Tel: 0845 1200 660. Website: <http://www.famanon.org.uk>

For Relatives and Friends Concerned About the Use of Drugs or Related Behavioural Problems.

**All numbers correct at time of going to press.**

**October 2005**

## BOOKLIST AND WEBSITES

The following booklist is intended as a guide to what publications are available that may be of interest to those who are caring for/supporting someone who has a mental health problem. Details of the books have been given when known but we are not able to recommend any particular publication unless specifically stated as useful by individual carers.

**MIND** have a wide range of publications and also a wide range of leaflets and booklets containing information on the main mental illnesses and the various treatments available including the following:

anxiety	phobias and depression	self harm
depression	hearing voices	how to cope as a carer
manic depression	post natal depression	medication
schizophrenia	personality disorder	
how to cope with someone who is suicidal		

**"MAKING THE MOST OF BEING A CARER" - A PRACTICAL GUIDE TO LIGHTENING THE LOAD.** Ann Whitfield.

"Carers can often feel isolated and overwhelmed as Ann Whitfield, herself a carer, knows only too well. This guide gives advice and support to those who are caring for a person with special needs and outlines your rights under the Community Care Act, tells you what financial help is available and also tackles how to take care of yourself and find support to deal with the emotional stress of caring" Mind.

**CARING: HOW TO COPE.** Janet Harwood.

"Drawing on carers' experiences this book contains a wealth of practical information including chapters on carers' feelings, getting help, organizing money and a list of useful addresses". Mind.

**All available from Mind Publications on 020 8519 2122 Ext 223.**

PHONE AT NINE JUST TO SAY YOU'RE ALIVE. Linda Hart.

A personal account of someone who suffers with schizophrenia, of her experiences whilst in hospital. **ISBN 0330 35180-X.**

CARING AND COPING - A RESOURCE PACK FOR NEW CARERS.

"A practical resource pack designed to help new carers of people with schizophrenia. It tells the carer in jargon-free language what the condition is, possible causes, what can be done and where to get help. It also explains the Mental Health Act and other relevant legislation, plus the benefits system".

Rethink - (Serious Mental Illness).

THE RIGHTS OF THE NEAREST RELATIVE, RETHINK.

A booklet covering the rights of the nearest relative under the 1983 Mental Health Act, 1990 NHS and Community Care Act, Supervision Registers, 1995 Carers Act and the Patients Charter.

UNINVITED GUEST. Jenny Robertson.

The story of a mother coming to terms with her daughter's schizophrenia. Written from a Christian perspective and includes many of the author's poems. Rethink.

**All available from Rethink, 28 Castle Street, Kingston upon Thames, Surrey, KT1 1SS. Tel: 020 8547 3937 and ask for the publications department.**

SERIOUS MENTAL ILLNESS - A FAMILY AFFAIR. Gwen Howe.

This book provides crucial background information. It explores the emotional impact that a breakdown can have on the family and makes it easier to talk to doctors and other health care professionals. It gives valuable pointers on practical issues. **Sheldon Press. ISBN 0-85969-752-5.**

A CARERS GUIDE TO SCHIZOPHRENIA: A NEED BASED APPROACH. Gwen Howe.

A practical handbook for all professionals working with people suffering from schizophrenia, concerned with promoting real understanding of their experiences and developing effective ways to facilitate them to maintain a reasonable quality of life. Features contributions from sufferers, carers and service providers. **Jessica Kingsley Publishers, 116 Pentonville Road, London, N1 9JB.**

A CARERS GUIDE TO SCHIZOPHRENIA. Greg Wilkinson, Tony Kendrick and Bruce Moore. **The Royal Society of Medicine Press. ISBN 1-85315-408-3.**

"DIAMONDS BEHIND MY EYES". Nicola Pagett and Graham Swannell.

A very easy to read, personal account of manic depression. **ISBN 0-575-06500-1.**

## WEBSITES

There is a vast source of information on the web, so this is a small list of a few sites that are easy to access and are 'Carer friendly'. Many have links to other sites, so once you are in the system you will probably find more places of interest for yourself. Do let us know about any really good ones and happy browsing.

Rethink <a href="http://www.rethink.org">www.rethink.org</a> 'FRONT DOOR' helpline - 0845 456 0455	National Institute for Mental Health England (NIMHE) <a href="http://www.nimhe.org.uk/links.asp">www.nimhe.org.uk/links.asp</a>
National Alliance for Mentally Ill (NAMI) <a href="http://www.nami.org/index.html">www.nami.org/index.html</a>	World Fellowship for Schizophrenia <a href="http://www.world-schizophrenia.org">www.world-schizophrenia.org</a>
BBC on line: Mental Health <a href="http://www.bbc.co.uk/health/mental">www.bbc.co.uk/health/mental</a>	Mind Out for Mental Health <a href="http://www.mindout.net">www.mindout.net</a>
Carers UK <a href="http://www.carersonline.org.uk">www.carersonline.org.uk</a>	A Service User's Website <a href="http://www.madnotbad.co.uk">www.madnotbad.co.uk</a>
Early Psychosis Prevention and Intervention Centre (EPPIC) <a href="http://www.eppic.org.au/resources.html">www.eppic.org.au/resources.html</a>	Institute of Psychiatry, King's College, London <a href="http://www.iop.kcl.ac.uk">www.iop.kcl.ac.uk</a>
<a href="http://www.schizophrenia.com">www.schizophrenia.com</a>	<a href="http://www.mentalhealthintheuk.co.uk">www.mentalhealthintheuk.co.uk</a>
Mentality - Mental Health Promotion <a href="http://www.mentality.org.uk">www.mentality.org.uk</a>	Mental Health Matters <a href="http://www.mental-health-matters.com">www.mental-health-matters.com</a>

Personal Additions:

## **COMPLAINTS & COMPLIMENTS**

The Avon and Wiltshire Mental Health Partnership N. H. S. Trust has a praise/complaints/ suggestion form, which is included in this pack. On this form there are also details about advocacy agencies, such as Mind, Rethink, Advocacy Works, Black Orchid (for black carers) etc. Similar information is included in the useful addresses and phone numbers section.

If you have any problems, initially, always try to speak to the named nurse or key worker. Failing that, arrange to speak to the Ward Manager or Modern Matron. These people's names and numbers are on the contact sheet.

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To the Carers, Service Users, Support Workers and Professionals who gave their time to read and make comment on the draft contents.

Lu Duhig, a carer:

I have compiled this pack for carers because I have experienced much of the bewilderment, anxiety, frustration and anger that you may be suffering at the moment. When mental illness first touched my family we felt alone and frightened. Remember that you are not alone; there are people who can help you too, at this difficult time. Other carers can be a great support, they understand what you are going through.

You can contact me and other carers by phone on 01225 323137 or by e-mail at [L.Duhig@bath.ac.uk](mailto:L.Duhig@bath.ac.uk)

October 2005

## FEEDBACK FORM

I hope that you have found this support pack useful and that it has answered some of the questions you may have had. The pack will be updated at regular intervals so it would be valuable to have your views as to what was or was not helpful. If there is any other information, organisation, book, website etc. which you have found particularly useful and should be included I would like to have details. Please help to make this pack better by adding as much or as little comment as you feel able and return it to the address below. Thank you

What did you find most useful in the pack?

What would make it better? What was missing?

What has been the most important source of support to you since you became a carer?

Someone to talk to who really knows, like another carer.

Joining a support group.

Having information like the support pack.

Any other comments.

Please return this form to Lu Duhig - Carers' Support - at :  
The Family Work Service, Wessex House 7.25, University of Bath,  
Claverton Down Bath BA2 7AY.  
Or e-mail your comments to: [L.Duhig@bath.ac.uk](mailto:L.Duhig@bath.ac.uk)