



**An information pack for relatives and
friends who care for people with
mental health problems**

www.somersetcarers.org

<u>CONTENTS</u>	Page
Are you a mental health carer?	2-3
The Mental Health Act	4
Carers' Rights	5-6
Planning Care	7-10
Who Can Help Me?	11-12
The Main Mental Illnesses	13-27
Dealing with Difficult Behaviour	28-30
Helping Someone Who Self Harms	31-32
A Checklist of Questions	33-35
Understanding the Jargon	36-39
Support Services Available	40-43
Other Resources for Carers	44-45
Employment Support Services	46-47
Carers' Views	48
Support Groups	49
Useful Contacts	50-55
Booklist	56-58
Websites	59-60
Complaints and Compliments	61

ARE YOU A MENTAL HEALTH CARER?

The information found in this pack is designed to assist Carers in accessing information that will help them in their caring role.

You are a mental health carer:

- If you look after a relative, partner, friend or neighbour who needs support because of mental ill health.
- If you are receiving any payment for the care that you provide (excluding carers' benefits).
- Regardless of your age. You may be under 18 years of age and caring for a parent or relative with mental health problems.
- Whether or not you live in the same house or area as the person you care for.
- Regardless of whether you provide full-time or part-time support to the person you care for.
- Whether or not you are the only person looking after the person you care for, or one of a number of people, both professional and non-professional.

You are entitled to be registered as a carer with your GP surgery.

Please see on the next page a letter to your GP which you can take to request this to happen.

Registering as a carer with your G.P.

Dear Dr

'Carers look after family, partners or friends in need of help because they are ill, frail or have a disability. The care they provide is unpaid'. – Carers (UK) definition.

As a patient at your surgery I am writing to inform you that I care for

I would like to ask you to tag my notes to identify that I am a carer and add my name to your Carers' Register.

There is also a child/children in this family situation that is/are affected. Their name(s) are

Please also include their name(s) in your register.

I would be interested to receive any information you have that would be relevant to me (and my child/children) as a carer.

I would wish to be directed to any support that is available to me (and my family) in the role

Thank you

Yours sincerely

THE MENTAL HEALTH ACT

Many people are admitted to (name of ward) informally. This means that they have agreed or requested to be admitted and that unless there is a significant concern for their safety and wellbeing, or that of any other person, they may leave the unit at any time.

Others may be admitted and placed under the Mental Health Act (1983). This means that they are detained under a "section" for a given period of time. The most frequently used sections are:

Section 2 Called "Admission for assessment". This is for a period of up to 28 days, after 2 Doctors and an approved social worker have decided that someone has a mental disorder and needs to be assessed in hospital. Within the first 14 days a detained client may appeal in writing to the Mental Health Act Review Tribunal (M.H.A.R.T) for their discharge. A hearing will then be arranged within the next few days. The detained client or their nearest relative may also write to the hospital managers at any time to request discharge. The managers can take 72 hours to look at this and obtain a medical report from the Doctor.

Section 3 Called "admission for treatment". This is for a period of up to 6 months, after 2 Doctors and an approved social worker all believe that staying in hospital to receive treatment for a mental health disorder is necessary. As with section 2, a detained client or their nearest relative may apply to the hospital managers for discharge. However, an appeal to the M.H.A.R.T may be made at any time during the 6 months.

If you would like any further or more detailed information about The Mental Health Act please ask a member of staff.

CARERS' RIGHTS

As a carer I have only two statutory rights:

- [1] I am entitled to a Carers' Assessment, even if the person I care for does not wish to engage with services.
- [2] I am entitled to my own care plan.

As a carer I can expect to:

- Be taken seriously when expressing concerns.
- Be treated with understanding and respect.
- Be informed of the range of relevant services and support available.
- Be afforded a rapid response in an emergency situation.
- Be provided with information if this is in the best interest of the patient and other members of the family.
- Be informed about a relative's illness, the diagnosis, treatment and possible side effects of the treatment.
- Be included in a family-centred approach to treatment and support.
- Be included in care planning, implementation and review.
- Be helped with problems created or exacerbated by caring for a relative with a mental illness.
- Know the names of other members of the care-giving team.
- Be offered culturally accepted treatment options that are inclusive of the family.
- Seek other opinions regarding the diagnosis and treatment of a relative.
- Be informed of the complaint procedure.
- Be consulted about a relative's discharge plan.
- 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.
- Be encouraged to take time out when required, to prevent 'burnout' or to cope with stress.

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 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 Care Co-ordinator may offer the assessment during the Care Plan meeting. If not, then it is perfectly all right 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. 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.

CARERS CHARTER

We have developed a Carers' Charter which outlines your rights as a Carer. This can be obtained from your Carers' Assessment Worker or the Carers' Service Administrator at Somerset Partnership 01373 455854.

PLANNING CARE

RECOVERY CARE PROGRAMME APPROACH

The Recovery Care Programme Approach – R.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.

[2] RECOVERY 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 this 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. Clients should be able to change this person 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 during the R.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. 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 you might respond, who you might 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 hours 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 (*see page 36*) 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 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 an 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 their records. In this way they can still keep a certain feeling of thinking for them selves, 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 Intervention/ Home treatment Team	
Care Co-ordinator	
Community Psychiatric Nurse (CPN)	
Social Worker	
GP	
Relatives/ Friends/Others	
Carers' Assessment Worker	
Carers' Counselling Service	

WHO CAN HELP ME

WARD

The named nurse is: _____

You can speak to him / her to answer any questions or talk about your concerns.

On Ward:	
Telephone Number:	
Visiting Times:	
Ward Rounds:	
Consultant/Doctor:	
Ward Manager/ Service Manager	

IN THE COMMUNITY

Other carers you can talk to:

Name	Contact Details

Your local support group is held at:

Address:-----

The date of the next meeting:-----

THE MAIN MENTAL ILLNESSES & DISABILITIES

The following summaries of the most common mental illnesses and disabilities provide a brief insight into the main features of each one and are 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 what is imagined from what is real. 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. It is most effective when begun 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].

TALKING TO SOMEONE WITH DELUSIONS, UNUSUAL BELIEFS OR HALLUCINATIONS

A hallucination is not a delusion and neither is it a false belief, hallucinations are sensory perceptions and can involve any of the 5 senses, hearing voices is the most common but other senses can be involved in hallucinations, these can be evident in a number of illnesses as well as schizophrenia, probably the most common being some anxiety states and high temperatures especially in the very young and elderly population.

- 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 delusion, 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 for you 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.

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 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. This works on chemicals in the brain to lift the mood. It is 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].

BIPOLAR DISORDER [MANIC DEPRESSIVE ILLNESS]

Bipolar disorder, also known as manic depression, is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function. Different from the normal ups and downs that everyone goes through, the symptoms of bipolar disorder are severe. They can result in damaged relationships, poor job or school performance and even suicide. But there is good news; bipolar disorder can be treated, and people with this illness can lead full and productive lives.

Episodes of mania and depression typically recur across the life span. Between episodes, most people with bipolar disorder are free of symptoms, but as many as one-third of people have some residual symptoms. A small percentage of people experience chronic unremitting symptoms despite treatment.

Treatment

Most people with Bipolar disorder - even those with the most severe forms - can achieve substantial stabilisation of their mood swings and related symptoms with proper treatment. Because Bipolar is a recurrent illness, long-term preventative treatment is strongly recommended and almost always indicated. A care plan that combines medication and psychosocial treatment is best for managing the disorder over time.

People with bipolar disorder can be prescribed a number of medications. A combination of anti-psychotics, antidepressants and mood stabilisers is usually prescribed in both the treatment and prevention of Bipolar disorder. Anti-psychotics are especially good for reducing manic episodes while antidepressants are used primarily during depressive episodes. Mood stabilisers help reduce both manic and depressive episodes and are usually taken continuously as a preventative measure.

As an addition to medication, psychosocial treatments - including certain types of talking therapy - are helpful in providing support, education, and guidance to people with bipolar disorder and their families. Studies have shown that psychosocial interventions can lead to increased mood stability, fewer admissions to hospital, and improved functioning in several areas.

For further information contact the Manic Depression Fellowship or Rethink [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 that 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 that 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 tranquilisers 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 that happen in nearly everyone. Most people find that from time to time, they have worrying thoughts that they cannot get out of their head or they carry out repetitive actions that are not really necessary. Obsessions are recurrent, persistent thoughts or ideas that the person may feel are senseless but are unable to ignore them. Compulsions are repetitive, ritualistic behaviours that 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 that 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 that cover a range of attitudes and behaviour. The word 'personality' refers to the enduring patterns of thoughts, feelings and outward behaviour that 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 characterised by long lasting, inflexible and limited range 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 can be related to having suffered severe trauma in childhood. 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 people. More positive outcomes tend to be associated with personality disorders that are comparatively mild. However, research focussing 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 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 the 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 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].

DEMENTIA

What is dementia?

The term “dementia” is used to describe the symptoms that occur when the brain is affected by specific diseases and conditions. These include Alzheimer’s disease and stroke.

Dementia is progressive, which means the symptoms will gradually get worse. How fast dementia progresses depends on the individual. Each person is unique and will experience dementia in their own way.

Symptoms of dementia include:

- Loss of memory – for example, forgetting the way home from the shops, or being unable to remember names and places
- Mood changes – particularly as parts of the brain that control emotion are affected by disease. People with dementia may also feel sad, frightened or angry about what is happening to them.
- Communication problems – a decline in the ability to talk, read and write.

In the later stages of dementia, the person affected will have problems carrying out everyday tasks and will become increasingly dependent on other people.

What causes dementia?

There are several diseases and conditions that cause dementia. These include:

Alzheimer’s disease

This is the most common cause of dementia. During the course of the disease the chemistry and structure of the brain changes, leading to the death of brain cells.

Vascular disease

The brain relies on a network of vessels to bring it oxygen-bearing blood. If the oxygen supply to the brain fails, brain cells are likely to die and this can cause the symptoms of vascular dementia. These symptoms can occur either suddenly, following a stroke, or over time through a series of small strokes.

Dementia with Lewy bodies

This form of dementia gets its name from tiny spherical structures that develop inside nerve cells. Their presence in the brain leads to degeneration of brain tissue. Memory, concentration and language skills are affected. This form of dementia shares some characteristics with Parkinson's disease.

Fronto-temporal dementia (including Pick's disease)

In fronto-temporal dementia, damage is usually focused in the front part of the brain. At first, personality and behaviour are more affected than memory.

Rarer causes of dementia

There are many other, rarer causes of dementia, including progressive supranuclear palsy, Korsakoff's syndrome, Binswanger's disease, HIV and Creutzfeldt-Jacob disease (CJD)

People with multiple sclerosis, motor neurone disease, Parkinson's disease and Huntington's disease may also be more likely to develop dementia.

Treatment

In most instances, there are no ways to cure the diseases that cause dementia, such as Alzheimer's disease. However, there are drugs available that may alleviate some of the symptoms; these can temporarily slow down the progression of symptoms in some people.

Complementary therapies

Public interest in complementary therapies is growing at a significant rate, easily outpacing the research conducted into their safety and effectiveness. People are often attracted to the "natural" and safe image of these therapies, particularly in treating chronic medical conditions, for which conventional treatments are often less than completely effective. There is little high-quality research into the treatment of dementia with complementary and alternative medicine. However, a number of therapies are providing some interesting preliminary results.

HELPING SOMEONE WITH MEMORY PROBLEMS

- Give background information to other people who are involved in the care of the person, this will make it easier for other people to see the person as a whole person rather than simply as someone with dementia.

- Dementia is nothing to be ashamed of. It is no one's fault.
- Dementia may cause the person to behave in ways that other people may find irritating or upsetting but this is not deliberate.
- A person with dementia may often remember the distant past more clearly than the recent past and the present. They are often happy to talk about their memories. But remember, past memories may be painful.
- Names are important. It is important to make sure that other people address the person with dementia in a way that they recognise and prefer.
- Some people may prefer younger people or those who do not know them formally to use courtesy titles such as "Mr" or "Mrs".
- Be kind and reassuring without talking down to the person as though they were a child.
- Never talk about the person with other people while the person is present. Always include them in conversation.
- Avoid scolding or criticising the person – this will make them feel small.
- All these things will attack the fragile sense of self-worth of the person.
- Look for the meaning behind the words, even if, on the surface, they do not seem to make much sense. The person is almost certainly trying to communicate with you about how they feel.
- Give them plenty of encouragement. Let them do things at their own pace and in their own way.
- Do things with the person, rather than for them, so that they can preserve some independence.
- Break activities up into small steps so that they feel a sense of achievement, even if they can only manage a part of a task.
- Our self-respect is often bound up with the way we look. Encourage the person to take pride in their appearance and give them plenty of praise.
- Suggest that people always knock on their bedroom door before entering, for example: If the person needs help with intimate personal

activities such as washing or using the toilet, this should be done in a sensitive way. Make sure the door of the bathroom or the toilet is kept closed if other people are around.

The information here on dementia has been compiled with grateful thanks to the Alzheimer society'. More detailed information can be downloaded from their web site web site, www.alzheimers.org.uk – or www.wrongplanet.net/ or www.nas.org.uk/asperger

LEARNING DISABILITIES

Adults with learning disabilities who also experience mental illness may be referred to the Trust's Learning Disability Service, for specialist diagnosis & treatment. This service includes psychiatry, speech & language therapy, physiotherapy & specialist community learning disability nursing. These services are provided in community settings, including the family home, social services day & residential facilities. The service also works in conjunction with GP's, Social Workers, and alongside paid & unpaid carers. Learning Disability does not include those who have a 'Learning Difficulty', which is a more broadly defined education term. Generally speaking, the IQ will fall below 70.

Somerset Partnership NHS Foundation Trust's Learning Disability Service can be contacted on 01823 423126/423127

For help, information & support for carers in Somerset, contact Learning Disability Carers Coordinato on 07919 165162

For further advice on anything to do with learning disability, contact the National Learning Disability Helpline free (See Useful Contacts)

Autistic Spectrum Disorder & Asperger syndrome

Up to 1/3 of people with a learning disability are thought to have an Autistic Spectrum Disorder (ASD). This is a lifelong developmental disorder that affects the way a person communicates & relates to people around them. They experience difficulties with everyday social situations & interactions.

Their ability to develop friendships is generally limited, as is their capacity to understand other peoples emotional expression.

There is also a condition called Asperger syndrome.

Asperger syndrome is a form of autism, used to describe people at the 'higher functioning' end of the autistic spectrum.

People with Asperger syndrome find it more difficult to read the signals which most of us take for granted. As a result, they find it more difficult to communicate & interact with others. They often have fewer problems with language than those with autism – often speaking fluently, though their words can sometimes sound formal or stilted.

People with Asperger syndrome do not usually have the accompanying learning disabilities associated with autism; in fact they are often of average or above average intelligence.

They often develop an almost obsessive interest in a hobby or collecting. Memorising facts about a special subject is common - such as train timetables.

They also often prefer routines in daily life, & any unexpected alteration or delay to this routine can make them anxious or upset.

The causes of autism & Asperger syndrome are still being investigated. There is strong evidence to suggest that Asperger syndrome can be caused by a variety of physical factors, all of which affect brain development – it is not due to emotional deprivation or the way a person has been brought up.

Children with Asperger syndrome become adults with Asperger syndrome. Much can be taught to develop the basic skills needed for everyday life, such as how to communicate appropriately with people.

Because the condition is not as marked as the condition of people with autism, Asperger's may not be diagnosed for a long time. This can mean that their particular needs may go unrecognised, and parents may blame themselves, or worse still, blame their children for their unusual behaviour.

The Trust has a dedicated team, which specialises in the diagnosis of Asperger Syndrome.

Contact the Asperger Syndrome Consultancy Service on 01278 426203

The National Autistic Society (NAS) is the UK's leading charity for people with an autistic spectrum disorder. The NAS champions the rights & interests of all people with autism & Asperger syndrome, & those who carer for them.

(for contact numbers and addresses see Useful Contacts and the Book List)

Adult ADHD

Adult Attention Deficit Hyperactivity Disorder is a continuation of ADHD from childhood. The main difference is in the type of difficulties & symptoms experienced.

Work lives & relationships prove troublesome, & there is a likelihood to feel restless or 'on edge', & perhaps acting impulsively on occasions. A typical ADHD adult may have gone through life being constantly misunderstood. Smoking, drinking alcohol and, in some cases, drug taking are also more common among ADHD adults.

As an adult, getting a diagnosis of ADHD is not straightforward. ADHD adults will have experienced their symptoms for most of their life and, despite frustration, are likely to have reluctantly accepted them as part of their unique make up.

In most instances, its family, friends or work colleagues who instigate a visit to a doctor. Seeing a GP is the first port of call, and may be followed up by appointments with a psychiatrist or other specialist.

Although there is no complete cure for ADHD, a number of treatments can significantly help with the management & control of symptoms. The main treatments for adult ADHD are: behavioural therapy, psychotherapy and medication.

Further information is available from www.addiss.co.uk/adults. They also publish ADHD News & have a comprehensive book/video store.
(see *Useful Contacts and the Book List*)

Tourette Syndrome

Tourette syndrome symptoms generally appear before the age of 18. First symptoms are usually mild facial tics, such as eye blinking. A range of symptoms can also develop, from 'motor' tics that affect the face/neck muscles, through to those that affect other areas of the body & limbs. 'Vocal' tics can also be present, ranging from a simple clearing of the throat, through to grunts, sniffing noises & barks. Obscene words may be used, alongside repetition of the words of others, or of their own words.

There is a spectrum of Tourette syndrome, & other, more debilitating aspects may be present – such as obsessional compulsive disorder (OCD), learning disabilities, and depression.

The syndrome does not affect a person's IQ, & they have a normal life span. Males are affected 3 or 4 times more often than females. Although there is no cure, there are treatments available.

The cause of the syndrome is not known, but is probably caused in part by abnormal genes, that alter how the brain uses its chemical transmitters. Some people benefit from medication, if the symptoms are of a more severe nature.

Further information is available from: www.tsa.org.uk & www.tourettes.me.uk

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.
- Stay an arm's length away.
- Avoid being in a corner, or cornering the person.
- 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.
- Keep hands in sight – showing the palms is a sign of peaceful intentions.
- NO clenched fists, hand on hips, pointing, leaning over people.
- Make eye contact – but don't stare! 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. Physically turn up heat [a side effect of some medication can be to feel chilly].
- Sit in a warm place to talk.
- Be sensitive about colour schemes – décor, clothing etc.

- Keep a quiet place for talking or 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 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.
- 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:
 - “Lots of people feel like that when they’re ill.”
 - “You’re not alone in thinking like that.”
 - “That’s not you, that’s the illness.”
- If others are arguing, 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 standoff – NEVER join in a scrap. This will be appreciated because you become safe. By setting a limit you reassure. Always take threatened violence to any 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 grip 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 an important too!
- Take a break to recharge the batteries, you will need it. Have a carers' 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.

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 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 him- 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 that can be used that have been shown to be effective in breaking the negative cycle.

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 all right. 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.

A CHECKLIST 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 ready a list of the things you want to know, 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 treatment] of any sort be helpful? If so, is it available locally?
- What happens if our relative / friend refuses treatment?

Recovery Care Programme Approach [RCPA]

- Would you explain how the RCPA will be used to help our relative / friend?
- When will there be an RCPA 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 Support 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 made / 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?

Other questions

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 that 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 every-body uses the same language on a daily basis. Below is a list of some of the more common terms used.

Approved Mental Health Practitioner (AMHP)

Each local authority has a responsibility to provide sufficient numbers of mental health practitioners 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.

Assertive Outreach Team

This service aims to help people with severe mental illness who may be difficult to engage with. The service is available in the community, seven days a week, 24 hours a day, usually visiting the person in their own home. Team members have smaller caseloads than colleagues in Community Mental Health Teams [CMHTs], 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 Amisulpride, 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.

Bipolar disorder

Also known as manic depression, is a brain disorder that causes unusual shifts in a person's mood, energy and ability to function.

Care Co-ordinator [or may be Key Worker]

This is the member of the team who will co-ordinate the Recovery Care Programme Approach [RCPA] and act as the link / contact for the service user, carer 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 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 outpatient 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 extremely effective, life saving treatment.

Emergency Duty Team [EDT]

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

Forensic Service

This is the area of mental health service that 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.

Mental Health Act, 1983

These are the regulations in place at the moment. 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.

Occupational Therapist [OT]

OTs are trained to work with people to help them to improve their ability to cope with daily living as independently as possible. They help with practical tasks, and can improve coping strategies as well as help to encourage participation in recreational, educational and vocational activities.

Primary Care Trusts [PCTs]

These are the legally established bodies that 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. Each person's experience of psychosis can be quite different, and it is often valuable to talk to the person about what it is like for him or her.

Recovery Care Programme Approach [RCPA]

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 RCPA 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.

Schizophrenia

A specific term for mental illness where symptoms include psychosis. [See Main Mental Disorders for a more detailed definition].

'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.

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:-

- Mind
- Rethink
- Samaritans
- Saneline

[For more details see Useful Contacts sheet]

SUPPORT SERVICES

Somerset Partnership Foundation Trust

Provides specialist health and social care services for people in Somerset with severe and enduring mental health problems

For patients and carers this means they should have access to all the services they need from a single team in one location. The Partnership accepts referrals from GPs, or individuals can contact local teams for help.

Your local community Mental Health Team can provide information about:

- In-patient services
- NHS community services
- Day services
- Residential care/Nursing home care
- Respite care
- Psychological therapies
- Access to carers' assessment
- Employment support
- Eating disorders

Further information about Community Mental Health Teams can be obtained from the Somerset Partnership headquarters - Tel 01278 432000.

Website: www.sompar.nhs.uk

Patient Advice and Liaison Service (PALS) (Somerset Partnership)

Offers information, advice and support and responds to concerns, suggestions or questions from patients, their families and carers; helping them to sort out problems. Call 01278 432022

GP Surgeries

Your family doctor will provide a practice leaflet listing the services available at the surgery. These can include:

- District Nurse

- Counsellors
- Primary care mental health workers and link workers, who support people with mild to moderate mental health difficulties in their GP surgeries.

The Drug Interventions Programme (DIP)

is a new service for drug users who have been involved with the Criminal Justice System. It is a service for those over 18, who have been in trouble with the law in the past 2 years (arrested, in prison, in contact with probation etc) and use

<http://www.somersetcarers.org/substance-misuse.htm>

If you want to speak to current or ex users, people with experience of having treatment themselves, then please call the Lynk on 01823 257 359

SUPPORT SERVICES FOR CARERS

Carers' Assessment Workers (CAW)

Based in Community Mental Health Teams, Carers' Assessment Workers specialise in assessing the needs of Carers of someone with a mental health difficulty. They can provide advice on:

- Help with day to day caring
- How to access benefits and information about financial and legal matters
- Local carers' support groups
- Carers' help lines
- Carers' education programmes
- Carers' counselling
- Getting a break or holiday either on your own or with the person you care for
- How to access help in a crisis

Adults CAWs

Mendip: 01749 836597 / 07738 898774

Taunton: 01823 368396 / 07738 187822
07879 635408

South Somerset: 01935 428420 / 07738 898775

Somerset Coast: 01278 720238 / 07909 906811

Older Persons CAWs:

Mendip & South Somerset: 01373 455814 / 07909 877657

Taunton & Somerset Coast: 01278 720220 / 07738 898747

Carers' Support Workers (CSW)

Carer's Support workers are based in GP surgeries and offer advice, support, and information to Carers on all aspects of caring

You can contact your local CSW by phoning Somerset Direct 0845 3459133

Young Carer's Workers

Young Carer's Workers aim, to provide support and breaks for young people under the age of 18 with caring responsibilities.

You can contact your local Young Carers' worker by phoning Somerset Direct on 0845 3459133

OTHER RESOURCES FOR CARERS

Mental Health Carers' Support Groups

There are many local specialist Mental Health Carer's Support Groups, which will give you as a carer:

- An opportunity to meet other Carers
- Support, advice and a listening ear
- An opportunity to exchange information concerning local and national resources
- A forum for the exchange of information about specific problems and conditions
- Days out and leisure activities

To find out about local groups contact your local Carers' Assessment Worker

Carers' Support Groups

There are also many other support groups for Carers across Somerset. To find out about your local group contact Somerset Direct on 0845 3459133.

Counselling Service for Carers – “Care First”

This service is FREE and CONFIDENTIAL to all Carers in Somerset. Carers can self-refer by phoning Care First on 0800 174319. This service also provides a 24-hour, 7-day a week counselling support line

Carers' Breaks Scheme

If you are a carer of an adult under 65 with a mental health problem, you may be able to have a break or a holiday with or without the person you care for.

For further details please contact the Users' and Carers' Development Manager on (01749) 836606 or 07774 207458

“

Somerset Carers' Network”

Somerset's newsletter for mental health carers. Available from 01373 455854 or www.somersetcarers.org

Carers' Education courses

There are many and varied courses that run for carers. For further information please visit our website or contact you local Carers' Assessment Worker for further details

"Sitting Service"

The sitting service enables carers to take a break, time off, with peace of mind. The sitting service provides fully trained staff to care for people with a mental health problem or other disability.

This service is available on a regular or on an occasional basis on any day of the week between 8.00am and 11.00pm. Sessions may last from 2 hours up to a maximum of 8 hours each day.

For further details contact your CAW
or Somerset Direct 0845 345 9133 or www.somerset.gov.uk

Community Transport Services

Provides community transport services for disabled, older and socially isolated people

Mendip	(01749) 330100
Sedgemoor	(01278) 434881
South Somerset	(01935) 411572
Taunton	(01823) 331266
West Somerset	(01643) 707848

Disability Benefits helpline

0800 882200

Somerset Direct

Information and advice for older people and other adults, families & carers
0845 3459133

Employment Support Service

Information for Carers

A county wide employment support service for carers wishing to retain or return to paid work or self employment in Somerset.

Would you like more information about:

- Employment issues
- Finding paid work
- The right time to enter employment
- How paid work might affect your benefits/Carers Allowance
- Keeping your existing job
- Accessing legal advice
- Dealing with difficulties at work
- Self-employment

How we can help you

The Employment Support Service supports carers to gain or retain paid employment on a full or part time basis.

We can help you –

Find out what type of job would suit you

Make paid work part of your plans for the future

Search for work in your local area

Prepare a C.V, complete job applications and prepare for job interviews

Find positive ways to tell employers about your carer responsibilities

By supporting you in your workplace

With information and advice for your employer

Link in with Jobcentre Plus and other support organisations

Support for individuals already in work

If you are having difficulties at work, we can liaise with your employer to help find solutions to problems. We would get your permission to do this first.

Options to help you keep your job could include -

- Planning a successful return to work
- Looking at your work place and recommending ways to make it easier for you to do your job
- Support in your work place
- Supporting your employer to understand your carer needs

Benefits of Work

Some of the benefits of being in paid work are

- Improved confidence and self-esteem
- Having a valuable role
- Meeting people
- Improved physical health
- Increased motivation and energy
- A sense of achievement

What to do next

If you would like to take the next step towards paid employment, please speak to your Somerset Partnership Carer Assessment Worker who can put you in touch with us.

Further information

If you would like further information please contact Grahame Milroy.

County Employment Development Officer

01373 455819

CARERS' VIEWS

Carers' Participation

An independent group promoting and facilitating carer involvement in Somerset's mental health services

- It actively seeks to include carers in the planning, provision and evaluation of services.
- Provides opportunities to share experiences with other people in a similar position
- Carers' views and insights offer a realistic perspective.
- Influences change in services.
- Helps to improve the quality of life for the carer.
- Provides representatives to sit on Planning Groups in Social Services and Somerset Partnership

To become involved or to find out more, contact the Users' and Carers' Development Manager 01749 836606/07774 207458

SUPPORT GROUPS

For Carers of Adults with Mental Health Problems

Rethink Yeovil CMHT	Yeovil	Jackie Murphy 01935 428420/07738 898775
Rethink Carers & Relatives Support Group	Taunton	Vidette Quinnell or Jackie Jackson 01823 351 516
Rethink Mental Health Carers Group	Ilminster	Sally Ayres 01823 254288 Rethink 01823 354879
Taunton and District Mental Health Carers Group	Taunton	C/o Chris Winter 01823 368396 07879 635408
Mendip Mental Health Carers Group	Wells	Sue Chappell 01749 836597 07738 898774
Bridgwater Carers Group	Bridgwater	David Bobbett 01278 720238 07909 906811
Windows, Somerset Coast Carers Support Group	Highbridge	Tony Monaghan 01278 785177
Taunton Deane Aspergers Carers support group	Taunton	Liz Pooley 01823 345167
For Carers of Older Persons with Mental Health Problems		
Alzheimer's Society	Glastonbury, Wells, Shepton Mallet	Ann Porter 01749 344774
Somerset Partnership	Frome	Lynn Rendell/Pat King 01373 455836
Somerset Partnership	Yeovil	Celia Smith 01935 431725
CHMT-Older adults	Chard / Ilminster	Sue Hardy 01460 678777
CMHT- Older adults	Bridgwater	Cynthia Crean 01278 720250
CMHT- Older adults	Burnham on Sea	Charmaine Dobson 01278 786876 (Day hospital)

USEFUL CONTACTS

LOCAL ADVICE SERVICES AND HELPLINES

AGE CONCERN SOMERSET

01823 326212

Mon – Fri 9am – 1pm, 2pm – 5pm

ALZHEIMERS SOCIETY SOMERSET BRANCHES

Mid Somerset Branch 01749 344774

Mon, Wed & Fri 9.30am–11.30am

South West Somerset Branch 01460 67877

Mon–Fri, 9am–5pm

CARERS' UK BRANCHES

Local branches of the national organisation

Carers' UK Taunton and District Branch:

07737 432153

Carers' UK East Somerset Branch:

01373 836438

EQUILIBRIUM (THE BIPOLAR ORGANISATION)

01823 323362/0845 4349901

Mon – Fri 9.15 – 5.15

MIND

Provides a telephone information service, plus day projects and groups, for people experiencing anxiety and depression.

Taunton [01823] 334906

Mon – Fri 9.30am – 4.30pm

Bridgewater New Directions:[01278] 446935

Minehead; [01643 708765

Mon – Fri 9.30am – 11.00am

Yeovil: [01935 474875

Mindline [01823] 276892

[Helpline: Fri – Sun, 8pm – midnight]

A Somerset-wide out of hours telephone support line for anyone suffering emotional distress, carers, family members and friends. Callers do not need to be in crisis but may need information, emotional support or understanding.

MENCAP –Somerset District Office: 01823 288061

NAS Somerset Branch

contact Mr Campbell Main on 01278 788776,
Email: camppbell.main@farming.co.uk

ON THE LEVEL

Offers a free, confidential service e throughout Somerset; for anyone under 18 or parents/guardians seeking advice and information on drugs and /or alcohol

Contact 01749 675766
www.onthelevel.org.uk

SOMERSET & WESSEX EATING DISORDERS ASSOCIATION [SWEDA]

Helpline [01458 448600] Wed 10—1, Thurs 4-7

SOMERSET GATEWAY [A Community Information Partnership]

For information, support and advice on such topics as:

- Sports, arts and leisure activities
- Education and lifelong learning
- Mobility and transport
- Employment and training
- Family, sex and personal issues
- Rights and legislation

Telephone: 01823 33637

Text: 07919 540839

Email: enquiry@somerset.gov.uk

Web:

www.foursite.somerset.gov.uk/cgi-bin/civis_server.sh

By Post: Enquiry Centre, The Library, Paul Street, Taunton, TA1 3XZ

TURNING POINT

A registered charity, provides advice, information & support for all drug & alcohol problems – this includes carer support. The service is confidential and free, and provides services for people with complex needs – including those affected by drug & alcohol misuse, mental health problems and those with a learning disability. 'Turning Point' is available throughout Somerset. Contact the number below to find your local centre.

Freephone 0800 389 8049

Taunton 01823 328463

Glastonbury 01458 83225

www.turning-point.co.uk

SOMERSET CARERS' SERVICES

Somerset Direct: 0845 3459133 information about support services for all carers in Somerset.

CARERS' BREAKS SCHEME

If you are a carer of an adult under 65 with a mental health problem you may be able to have a break or a holiday with or without the person you care for:

For further details please contact you local Carers' Assessment Worker.

SOMERSET CARERS' NETWORK

Somerset's Newsletter for mental health carers. Available from Carers information 01749 836606 or 01373 455854

Website: www.somersetcarers.org

Somerset Change: 0800 694 9999

Offers an outreach and advocacy service to anyone affected by domestic abuse.
Mon – Fri 9.00am – 5.00pm (not bank holidays).

Somerset Gay Health: 01823 327078

Mon – Fri 9.00am – 5.00pm

Councils for Voluntary Service (CVS)

Provide community transport services for disabled, older and socially isolated people.

Mendip	01749 330100
Sedgemoor	01278 434881
South Somerset	01935 411572
Taunton	01823 331266
West Somerset	01643 707484

MENTAL HEALTH & CARERS' HELPLINES

Al-Anon Family Groups	0207 403 0888	Ansaphone
Alcoholics Anonymous	0845 769 7555	24hrs, 7 days a week
Alzheimer's Society	0845 300 0336	8.30am – 6.30pm
Autism Helpline	0845 070 400	Mon – Fri 10.00 am – 4.00pm
Battle Against Tranquillisers	0117 966 3629	Daily 9.00am – 8.00pm
BME Mental Health Network	0207 582 0512	
Carers Counselling Service Free & confidential	0800 174 319	24hrs, 7 days a week
CITA (Council for Involuntary Tranquiliser Addiction)	0151 932 0102	Daily 10.00am – 1.00pm
Cruse – bereavement counselling line.	0870 167 1677	Weekdays 9.30am – 5.00pm
Depression Alliance	0845 123 2320	Information on how to download information Pack <i>www.depressionalliance.org</i> You are also able to leave name and address to receive an information pack.
Domestic Abuse Free Phone Line Support Service (DAFFS)	08006949999	24 Hrs 7 days a week
Drinkline	0800 9178282	Mon – Fri 9.00am – 11.00pm
Somerset Emergency Social Work Duty Team	01458 253241	Evenings, weekends & bank holidays
First Steps to Freedom Help for people with phobias, OCD, anxiety, panic, anorexia, bulimia and those wanting to come off tranquilisers. Also advice/support for carers/people with borderline personality disorder.	0845 1202916	Daily – 10.00am – 4.00 pm

Frank – National drugs helpline	0800 776600	24 hrs, 7 days a week.
Gamblers Anonymous	020 73843040	24 Hrs 7 Days a week
Manic Depression Fellowship –	0845 634 0540	Mon – Fri 09.00am - 5.00pm
Mankind Offers support on surviving male sexual abuse or assault	01273 510447	Mon - Fri 10am – 4pm
Mind Information Line	08457 660163	Mon - Fri 9.15am – 5.15pm
MIND – Minehead	01643 708765	9.30 – 11am for information
Mindline (Somerset)	01823 276892	Wed – Sun 8.00am - midnight
Narcotics Anonymous	0845 3733366	Daily 10.00am – 10.00pm
National Carers helpline	0808 808 7777	Wed & Thurs 10.00am–12.00 & 2pm- 4.00pm
New Directions (MIND in Sedgemoor)	01278 446935	Tues 11.00am – 3.00pm Wed 11.00am – 3.00pm and 6.00pm – 10.00 pm Thu & Fri 11.00am – 3.00pm Sat & Sun 11.00am – 5.00pm
NHS Direct	0845 4647	24 hour advice line
Night Time Anxiety Crisis Line	0808 808 0545	10.00pm – 10.00am every day (answer phone service only).
No Panic – for people suffering from panic attacks, phobias and OCD and other related anxiety disorders.	0808 808 0545	Daily 10.00am – 10.00pm answer phone crisis line.
Parents Against Drugs Abuse –	0845 702 3867	Leave a message and contact number.
Prisoners Family and Friends Service	0808 808 3444	Mon – Fri 10am-5pm
RETHINK National Advice Service	020 8974 6814	Mon, Wed, Fri 10am – 3pm Tues, Thurs 10am-1pm
Samaritans	0845 790 9090	24 Hrs
Saneline – for people with a mental health problem and carers.	0845 7678000	12 noon – 2.00am 7 days a week

SOBS (Survivors of Bereavement by Suicide)	0870 241 3337	Daily 9.00 am – 9.00 pm
Somerset Change – offers an outreach and advocacy service to anyone affected by domestic abuse.	0800 6949999	Mon – Fri (not Bank Holidays) 9.00am – 5.00pm
Somerset Gay Health	01823 327078	Mon-Fri 9am –5pm
SWEDA (Somerset & Wessex Eating Disorders Association)	01458 448600	Weds 10.00am– 1.00pm Thurs 4.00pm – 7.00pm
Transvestite/ Transsexual Helpline	01793 420262	(this line is not continuously staffed)
Triumph Over Phobia	0845 600 9601	Mon – Fri 09.00am - 5.00pm
Turning Point (helps people with drug and alcohol problems)	01278 447044	Mon, Wed, Thurs 9.00am – 5.00pm Fri 9.00am – 1.00pm
Women’s Aid National Helpline – for women facing violence within the home.	0808 200 0247	24 Hrs
Young Minds	020 7336 8445	Mon-Fri 9.30-5.30pm

BOOKLIST

The following booklist is intended as a guide to publications that may be of interest to those who are caring for/ supporting someone who has a mental health problem. It is by no means a comprehensive list. Details of the books have been given when known but we are not able to recommend any particular publication.

MIND has 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, organising money and a list of useful addresses” ***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 by someone who suffers with schizophrenia, of her experiences whilst in hospital. *ISBN: 0330 35180-X.*

“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”. 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.

“A SELFISH PIG’S GUIDE TO CARING”

Hugh Marriott, illustrated by David Lock, Polperro Heritage Press

ISBN 0954423313

“REMIND ME WHO I AM, AGAIN”

Linda Grant, Granta Books

ISBN 1862072442

“LIVING WITH THE BLACK DOG: HOW TO COPE WHEN YOUR PARTNER IS DEPRESSED”

Caroline Carr, White Ladder Press Ltd

ISBN 978-1-90541010-1

“TO WALK ON EGG SHELLS”

Jean Johnston

ISBN 0-9548092-1-1

NATIONAL AUTISTIC SOCIETY

Publications on autism & Asperger syndrome are available via the address below. You can request a free catalogue with over 120 books, videos & CD ROMs.

NAS Publications

The National Autistic Society

393 City Road

London

EC1V 1NG

ADHD

Information for adults with ADHD

They publish ADHD News & have a comprehensive book/video store

The ADDISS Resource Centre

10 Station Road

Mill Hill

London NW7 2JU

BOOK LIST FOR CARERS OF PEOPLE WITH MEMORY LOSS

Caring & Memory Loss.

Remind Me Who I Am Again; *Linda Grant.*

Have The Men Had Enough; *Margaret Forster.*

Iris; *John Bayley.*

Caring for Maria; *Bernard Heywood. (Heyward)*

Dementia; *Cayton, Graham, Warner.*

Caring for Someone who has Dementia; *Jane Brotchie – Age Concern England.*

36 Hour Day – Family Guide to Caring; *The John Hopkins University Press, Paul R. McHugh (Foreword) et al.*

Is the Cooker Turned Off? Caring for an Older Person with Failing Memory; *Josephine Woolf, Michael Woolf.*

Dementia, Alzheimers & Other Dementia; *Harry Cayton, Nori Graham, James Warne.*

The Best Friend's Approach to Alzheimers Care; *Virginia bell, David Troyell.*

Keeping Busy, A Handbook of Activities; *Nancy Mace (Foreword) James Dowlip.*

The Selfish Pig's Guide to Caring; *Hugh Marriott.*

Your Guide to Alzheimers; *Alistair Burns*

What to do when the doctor says its early stage Alzheimers; *Todd E Feinberg & Winnie Yu*

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

ADDIS Information & help for ADHD sufferers www.onthelevel.org.uk	Alzheimer's Society www.alzheimers.org.uk
AI-Anon www.hexnet.co.uk/alanon/alanon.htm	Association for Post Natal Illness www.apni.org
Autism & Aspergers www.wrongplanet.net/	
BBC Online/Mental Health www.bbc.co.uk/health/mental	www.belmontinfopoint.co.uk
www.borderlineuk.co.uk User led network of people with borderline personality disorder	Carers Uk www.carersonline.org
CITA www.liv.ac.uk/-csunit/community/cita.htm	www.citizensadvice.org.uk www.csip.org.uk
CRUSE www.crusebereavementcare.org.uk	Department of Health – Carers www.carers.gov.uk
Early Psychosis Prevention and Intervention Centre [EPPIC] www.epic.org.au/resources.html	Eating Disorders Association www.edauk.com
Families Anonymous www.famanon.org.uk	Headway Somerset the brain injury society www.headwaysomerset.org.uk
www.hearing-voices.org	Institute of Psychiatry, Kings College, London www.iop.klc.ac.uk
Manic Depression Fellowship www.mdf.org.uk	www.mencap.org.uk www.mentalhealthintheuk.co.uk
Mentality – Mental Health Promotion www.mentality.org.uk	Mental Health Matters www.mental-health-matters.com
Mind Out for Mental Health www.mindout.net	MIND www.mind.org.uk
National Alliance for Mentally Ill [NAMI] www.nami.org	National Autistic Society www.nas.org.uk/asperger www.somerset-autism-support.org.uk
National Learning Disability Helpline www.mencap.org.uk/html/easytoread/info_and_advice3.asp	National Institute for mental Health in England [NIMHE] www.nimhe.org.uk

National Drugs Helpline www.urban75.com/Drugs/helpline.html	National Phobics Society www.phobics-society.org.uk
National Self Harm Network www.nshn.co.uk	On The Level Free and confidential information on drugs and alcohol for young people www.onthelevel.org.uk
Princess Royal Trust for Carers www.carers.org	Rethink “Front Door” www.rethink.org
Samaritans www.samaritans.org.uk	SBDA Somerset black development agency www.sbda.org.uk
Saneline www.sane.org.uk	A Service User’s Website www.madnotbad.co.uk
World Fellowship for Schizophrenia www.world-schizophrenia.org	www.schizophrenia.com
Somerset Carers Network www.somersetcarers.org	Somerset Active Living www.somerset.gov.uk/somerset/communityliving/popp/index.cfm
Somerset Social Services www.somerset.gov.uk	SWEDA- Somerset & Wessex Eating Disorders www.onthelevel.org.uk
Tourettes syndrome www.tsa.org.uk www.tourettes.me.uk	Turning Point Advice information and support for alcohol & drugs problems www.turning-point.co.uk
Womens Aid www.womensaid.org.uk	Young Carers www.youngcarers.net
Young Minds www.youngminds.org.uk	

COMPLAINTS AND COMPLIMENTS

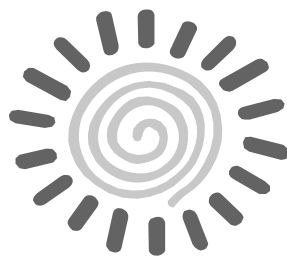
If you have any problems, initially, always try to speak to the care coordinator or team manager.

If you wish to make a formal complaint please contact the Complaints Manager 01278 432007 or write to the headquarters address.

PATIENT ADVICE AND LIAISON SERVICE (PALS) (SOMERSET PARTNERSHIP)

Offers information, advice and support and responds to concerns, suggestions or questions from patients, their families and carer, helping to sort out problems.

PALS officer 01278 432022 or write to headquarters address.





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www.somersetcarers.org

If you have any feedback or comments on the contents of this booklet please contact Users' & Carers' Development Manager on: [01749] 836606