

General information

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Professional resources

National service framework: Standards for mental health

1. Health services should:

- ❑ Promote mental health for all, working with individuals and communities.
- ❑ Combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

2. Any service user who contacts primary health care team with a common mental illness problem should:

- ❑ Have their mental health needs identified and assessed.
- ❑ Be offered effective treatments, including referral to specialist services for assessment, treatment and care if they require it.

3. Any individual with a common mental health problem should:

- ❑ Be able to make contact round the clock with local services necessary to meet their needs and receive adequate care.

- ❑ Be able to use NHS Direct as it develops for first level advice and referral onto specialist helplines or to local services.

4. All mental health users on the care programme approach (cpa) should:

- ❑ Receive care which optimises engagement, anticipates or prevents crisis, and reduces risk.
- ❑ Have a copy of a written care plan which: includes the action to be taken in crisis by the service user; their carer; and their care coordinator; advises how their GP should respond if the service user needs additional help; and is regularly reviewed by the care coordinator.
- ❑ Be able to access 24 hours a day 365 days a year.

5. Each service user who is assessed as requiring a period of care away from their home should have:

- ❑ Timely access to an appropriate hospital bed or alternative bed or place, which is:

in the least restrictive environment consistent with the need to protect them and the public, and as close to home as possible.

- ▣ A copy of a written after-care plan agreed on discharge which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in crisis.

6. All individuals who provide regular and substantial care for a person on cpa should:

- ▣ Have an assessment of their caring, physical and mental needs.
- ▣ Have their own written care plan which is given to them and implemented in discussion with them.

7. Local health and social care communities should prevent suicides by:

- ▣ Promoting mental health for all, working with individuals and communities (Standard 1).

- ▣ Delivering high quality primary mental health care (Standard 2).
- ▣ Ensuring that anyone with a mental health problem can contact local services via the primary care team, a help-line or an A&E department (Standard 3).
- ▣ Ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (Standard 4).
- ▣ Providing safe hospital accommodation for individuals who need it (Standard 5).
- ▣ Enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (Standard 6).
- ▣ Support local prison staff in preventing suicides among prisoners.
- ▣ Ensure that staff are competent to assess the risk of suicide among individuals at greatest risk.

NSF-Older people

The NSF sets out 8 standards

Standard One: Rooting out age discrimination

NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Standard two: Person-centred care

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Standard three: Intermediate care

Older people will have access to a new range of intermediate care services at home or in designated care settings to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Standard four: General hospital care

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Standard five: Stroke

The NHS will take action to prevent strokes,

working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multi-disciplinary programme of secondary prevention and rehabilitation.

Standard six: Falls

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their population of older people. Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention through specialised service.

Standard seven: Mental health in older people

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and their carers.

Standard eight: The promotion of health and active life in older age

The health and well-being of older people is promoted through a co-ordinated programme of action led by the NHS with support from councils.



Assessment under the Mental Health Act England and Wales 1983: A basic guide for General Practitioners

General Practitioners can be involved in Mental Health Act assessments in a variety of settings:

- ❑ Hospital: The patient may have already been admitted informally and is now wanting to leave or is refusing treatment.
- ❑ Home: The patient may be causing serious concern to a family or neighbours. If access is denied, section 135 (warrant to search for and remove patients) may be used. This warrant is obtained by an approved social worker (ASW) from a Magistrates' Court.
- ❑ Police Station: As a place of safety (section 136), or after arrest for an offence.

The 1983 Mental Health Act provides the legal framework in England and Wales for compulsory admission and treatment of patients suffering from mental illness.

Use of the Mental Health Act

Compulsory admission for assessment and/or treatment can only occur when:

- ❑ there is a mental disorder; and
- ❑ it is in the interest of the health and / or safety of the patient; or
- ❑ it is in the interest of the protection of others

The act allows the compulsory admission of a patient who is very distressed or ill (for example, actively psychotic or manic) solely in order to improve their health, even if they are

not thought to be at immediate risk of harming themselves or others. It cannot be used for the compulsory treatment of addictions unless the above criteria are also met.

Mental disorder comprises mental illness, mental impairment, severe mental impairment and psychopathic disorder. In the Act, mental illness is not defined but is a matter for clinical judgement.

The ASW will then take responsibility for co-ordinating the assessment, bringing relevant papers, ensuring the process complies with the law and arranging for the transport of the patient.

How to arrange a Mental Health Act assessment

A Mental Health assessment is activated by telephoning the duty-approved social worker (ASW) or the duty psychiatrist, depending on the local policy.

He/she will need the following information:

Name, date of birth, address, reason for assessment, previous history, including name of keyworker, next of kin (if known) and past history of violence or self harm (if known).

He/she will need enough information to decide if there is the possibility of an admission under the Mental Health Act, and that the full assessment process is warranted.

If you want to discuss the management of the patient, either telephone the duty ASW or the duty consultant.

Before the assessment

Information is an important component of the assessment.

- ❑ If you can access your records, check for previous history and response to treatment, risk of neglect, violence or self-harm, any known contact names,
- ❑ If there is a relative or informant, ask about the recent situation, its duration, whether there is any support, whether there have been threats or violence and if the patient is known to carry or have access to weapons.
- ❑ Liaise with the ASW about directions, access to premises, where to meet and the need for police attendance.
- ❑ It is good practice (because it is safer, communication is better and disruption of the patient is minimised) if the medical assessments take place jointly with the ASW at the same agreed time (although, if this is not possible, they are legally allowed to be five days apart. In any case, the two doctors must discuss their decision).

If the patient is suffering from the short-term effects of drugs, alcohol or sedative medication, discussion should take place about deferring the assessment until a more productive interview can take place.

During the assessment

The team necessary to implement a Section 2 (28 days for assessment) or Section 3 (six months for treatment) is:

- ❑ an approved psychiatrist (often the duty consultant or specialist registrar)
- ❑ a doctor with prior knowledge of the patient (ideally the GP)
- ❑ the ASW

The GP and others in the primary care team often have prior knowledge of the patient, including access to records and an existing relationship with the patient and or family, which facilitates the assessment. The psychiatrist may not know the patient, but often contributes clinical experience and expertise. The ASW makes a more comprehensive assessment of the social aspects of the case and advises on the legal issues that may arise during the process. He/she sees that the patient is interviewed 'in a suitable manner'.

The patient is interviewed as comfortably as possible, with all the following questions in mind:

- ❑ Is there any possible evidence of mental illness?
- ❑ Is there a risk to the health or safety of the patient or a danger to others?

If the answer to both of these questions is yes:

- ❑ Will the patient consent to informal admission, and if so, is that realistic, based on past experience or aspects of the current interview?
- ❑ Are there any community alternatives to admission? For example, giving medication at home, community psychiatric nurse visits, crisis services, day hospitals.

All professionals strive to reach a consensus and if the doctors agree to make the medical recommendations for compulsory admission, the social worker makes the application to admitting hospital managers.

Section 2 is appropriate if there is no previous history, the diagnosis is unclear or no treatment plan is in place.

Section 3 specifies the category of mental disorder and is mainly used for patients already known to the service. If the nearest relative objects to the detention, the application cannot proceed.

Arranging admission

If the decision of the team is to admit the patient, the level of security required should be considered. Arrangements are usually made by the psychiatrist for a bed and the ASW for appropriate transport. The ASW usually accompanies the patient and delivers the section papers in person. He/she is responsible for securing the premises of the patient's home. The ASW informs the patient and next of kin of the decision.

If the patient is not admitted

When the patient is not admitted to hospital, a package of follow-up care needs to be agreed with the patient and next of kin, if appropriate. Arrangements may need to be made to contact mental-health or social work teams during working hours to inform them of the assessment, to make a referral or both. GP's are entitled to submit a claim form (usually held by the ASW).

Useful local numbers

For Duty ASW (out of hours)

Gloucester Police Station and
Cheltenham Police Station: 0845 0901234

For Duty Psychiatrist (out of hours)

Gloucester Royal Hospital: 08454 222222
Cheltenham General Hospital: 01242 222222

Mental Health Hospitals

Wotton Lawn: 01452 891500 Charlton Lane:
01242 272181

This is not intended to be a comprehensive guide to the Mental Health Act. Consultation of the most recent Code of Practice is recommended. Taken from: World Health Organisation Collaborating Centre for Research & Training for Mental Health, eds. WHO Guide to Mental Health in Primary Care. London: Royal Society of Medicine Press, 2000.

New General Medical Services (nGMS) contract:

An introduction to the mental health targets

The new GMS contract came into effect for General Practitioners and Primary Health Care Teams in April 2004.

The contract aims to:

- ❑ Support the delivery of a wider range of higher quality services.
- ❑ Reward practices for delivering clinical and organisational quality.
- ❑ Facilitate the modernisation of the practice infrastructure.

The contract is between the practice and their Primary Care Trust. It sets out:

- ❑ What services the practice will provide.
- ❑ The level of quality to which services will be provided.
- ❑ The infrastructure and the support available.
- ❑ The financial resources to support this.

An important feature of the contract is the reward of achievement in a range of defined areas. Quality points achieved result in practice investment. One of these clinical areas relates to mental health. In the first years of this contract the emphasis is on providing better primary health care to patients with severe mental illness in order to support the prevention and early detection of physical illness.

A key element in reaching these targets is the setting up of a practice register of people with severe long-term mental health problems who require and agree to regular follow up. The

contract is unclear as to how this should be done and there has been lengthy discussion as to which patients should be included.

Which patients should be included in the practice register?

Patients should be considered for inclusion in the Register of patients with severe long-term mental health problems if either:

- ❑ They have a diagnosis of:
 - Schizophrenia
 - Psychosis
 - Bipolar disorder.
- ❑ They are receiving treatment with lithium for a mental health problem.
- ❑ They are considered by the Primary Health Care Team and/or Specialist Services to have a serious mental health illness (e.g. on Enhanced Care Programme Approach).

Practitioners in preparing the register should take the following points into account:

- ❑ The purpose of the register is to encourage the prevention and early detection of physical illness in those patients at increased risk due to their mental illness.
- ❑ Inclusion on the register should be according to patient need.
- ❑ No age limits should be applied.

Frequently asked questions

Who should be included in the register?

As a minimum it should be people with schizophrenia and bi-polar affective disorder, as the evidence base for their physical health needs is well documented. The guidance allows others to be included if it is felt appropriate.

Annex A of the Christmas guidance which describes prevalence rates for the clinical domains in the Quality Outcomes Framework (QOF) is based only on BNF 4.2 (anti-psychotics). It doesn't include dementia drugs, drugs used in children with behaviour disorders, or anti-depressants.

❑ What about people with personality disorder?

There is no specific evidence, in the same way that there is for schizophrenia or bi-polar disorder that these people have specific physical health needs.

❑ What about older people with dementia?

The needs of people with dementia have a different set of needs to people with severe mental illness. They warrant equal attention and care, but including them in a register of people with severe mental illness may not be in their best interest. Also it would skew the prevalence rates which are only based on 4.2 (anti-psychotics).

❑ What about children?

The same argument applies.

❑ What about people with chronic depression?

If the patient is maintained on lithium, then they would be included anyway. The proposed definition as above allows the Primary Health Care Team to include those patients considered to have a significant and ongoing mental illness.

You will have received a list from Gloucestershire Partnership Trust of patients receiving care from the Community Mental Health Teams. Please note that not all of these patients meet the guidelines shown here. However, it is useful in identifying patients on enhanced levels of care that may meet these criteria.

What Read code should be used for patients suitable for inclusion on the register?

9H8 is the read code for a mental health register, and 9H6 is for a register of people on an NSF mental health register. The distinction is slight, and is based on the NSF having a slightly different bias to developing a register.

For the sake of simplicity, we have just recommended just one code (9H8).

Who should not be included in the register?

See previous questions.

What are the problems with calling this "a register"?

Users of mental health services have a different understanding of the term "register" stemming in part from the introduction of a supervision register some years ago. The challenge for primary care staff is to help people understand that a register allows proactive care to be offered (and then if the person desires, to be declined), but if they are never put on a register that proactive care can never be offered.

What happens to people who do not want to be on the register?

The guidance recommends that a list of people who decline to accept services is maintained. For these patients use Read code 9H7 – this will be part of the search strategy for calculating the number of points scored.

There is no obligation to record (using read codes) the reason why a person has declined follow up/inclusion on the register although you may wish to enter the information

Is consent an issue?

Concerns have been expressed that patients with mental illness are being managed differently from other groups of patients. This discussion needs to be more thorough but the PEC leads feel the same processes for other groups of patients should be considered:

- ❑ Inclusion on the register according to finally agreed definition (9H8).
- ❑ Withdrawal from register if screening etc refused (9H7).

When do people come off the register?

So far as mental health needs are concerned, advice from the authors of the NICE guidance for schizophrenia is that a person should stay on the severe mental illness register life long. If the register is for the physical health needs however, there is no evidence one way or the other that risks of acquiring the various disorders change over time. On that basis it may be appropriate for people who have been put on the register not to come off it in the future. We recommend however, that inclusion on the register is reviewed each year.

Where can I get further help?

Dr Robin Hollands recently gave a lecture on the preparing of a register and the recommended content of review. Notes of this lecture, together with Read codes, are available.

LMC website: www.gloslmc.com

Primary Mental Health Care Team website: www.pmhsglos.org.uk

You may also contact the Primary Mental Health Care Team 01452 505362. The Mental Health Graduate workers are happy to

support practices in the setting up of the Registers:

The Mental health leads of the PCT Professional Executive committees are:

Cheltenham and Tewkesbury PCT
01242 522513

West Glos PCT
01452 509020

Cotswold and Vale PCT
01453 548666

Definition of “severe long-term mental health problems” in respect of the GMS Contract

The three Gloucestershire PCT clinical leads for mental health, PRIMIS, LMC and PCT managers have been discussing the preferred definition for severe long-term mental illness in respect of the new GMC contract. The Blue Book is very unclear and leaves considerable scope for interpretation. There are a number of factors that influence the decision:

- ❑ What best improves patient care?
- ❑ What meets national guidelines/new contract?
- ❑ What gives best standardisation within practices?

The following notes represent our current thinking on this issue.

Proposed definition

Patients should be considered for inclusion in the Register of patients with severe long-term mental health problems if either:

- ❑ They have a diagnosis of:
 - Schizophrenia
 - Psychosis
 - Bipolar disorder
- ❑ They are receiving treatment with lithium for a mental health problem.

- ▣ They are considered by the Primary Health Care Team and/or Specialist Services to have a serious mental health illness (e.g. on Enhanced Care Programme Approach).

Practitioners in preparing the register should take the following points into account:

- ▣ The purpose of the register is to encourage the prevention and early detection of physical illness in those patients at increased risk due to their mental illness.
 - ▣ Inclusion on the register should be according to patient need.
 - ▣ No age limits should be applied.
- ▣ We recognise the catch all phrase “...considered by the PHCT and/or Specialist Services to have a serious mental illness” is loose. We are concerned however, that there must be the opportunity to include patients with very severe depression or personality disorder (for example) who are at significant risk as a result of their mental illness and would therefore benefit from the increased level of support that will result from being included in the register.

Mental health severity matrix: Assessment tool

Use the matrix and key in conjunction with all the guidelines to decide severity of presenting problems and referral route.

In deciding severity consider symptoms, functioning and situation.

	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>
<i>Symptoms</i>	Patient has occasional distress in one or more areas, but feels in control. Patient is hopeful that things will improve.	Patient is clearly distressed and preoccupied with problems but feels/appears as though they have a degree of control. Patient accepts that things will probably get better.	Patient is severely distressed and feels/appears unable to cope. Patient is constantly preoccupied with symptoms and feels/appears as though they have little control. Patient feels hopeless about future. May be evidence of risk.
<i>Functioning</i>	Mostly able to function independently, though perhaps has minor problems with tasks. OR Patient mostly able to make supportive relationships though may have temporary relationship problem.	Inability to perform one or more complex skill like performing at a job interview or managing finances. Difficulty in caring for dependents/children. OR Major problem in socialising, though does attempt things if others take the initiative.	Persistent problems because of avoidance of social contact OR Major problems with functioning independently, self care may be severely affected OR Unable to care for dependents/children
<i>Situation</i>	Reasonable level of support from family/ friends/ community OR No dependants OR Accommodation appropriate to needs OR Some worries about finances but not affecting ability to purchase essentials OR Able to use community facilities	Adequate support from family/ friends/community OR Dependent others (e.g. young children at home, sole carer) OR Accommodation basically sound but may be some problems like poor repair, lack of security OR Some money problems like inability to manage debts	Inadequate support from any carers OR Dependent others OR Multiple problems with accommodation, or at risk of eviction/homeless OR Severe problems with money/inability to buy food

(Reproduced & adapted from Barking, Havering and Brentwood Adult Mental Health Trust)

May benefit from health information/self help advice... but patient appears to have social problems that might benefit from advice/ support from another agency, e.g. Citizens Advice Bureau

Care remains within Primary Health Care.
Supportive problem solving and bibliotherapy may help

Consider medication.
Consider patient preparedness/capacity to work on problems.
May benefit from further help from PMHT for Guided self-help, other self-help, problem solving and/or additional support. . Consult with Specialist/Link Clinician for advice if unsure. Consider referral to Specialist Services (if options above have been exhausted).

Maintenance of gains with level 1 support (see Psychological Therapies Guideline).
Consider medication. Consider referral to Specialist Services if level of risk high and an assessment is required.

Consider:
Referral to specialist mental health service (CMHT).
Inpatient admission.
Mental Health Act Assessment.

Tackling domestic violence – the role of health professionals

Domestic violence is a major health issue for women

About one in four women will experience domestic violence at some time in their lives.

This applies to women in all walks of life, across all ages, ethnic groups and socio-economic classes. Research has documented numerous significant health impacts on both adults and children who have experienced abusive relationships; these include short and longer-term health effects, in terms of physical, mental and sexual health.

Domestic violence is not restricted to physical violence; it may include psychological, emotional, sexual and economic abuse, and these may occur together or separately within the same relationship. To reinforce the fact that domestic violence does not necessarily involve physical violence, some prefer the terms domestic abuse or partner abuse.

What needs to be done by the Health Service?

Three types of action are needed:

- ▣ improving availability of information on domestic violence and services for those who experience it;
- ▣ providing/acquiring appropriate training for health professionals; and
- ▣ instituting systems of enquiry about domestic violence.

These are explained in the sections below.

Recognising that responding to domestic violence is a *process* rather than an *act*, health professionals need to work with other agencies in supporting, and providing options

for, survivors of domestic violence. The health service *alone* cannot meet all the needs of women experiencing domestic violence. But it is uniquely placed to help change public attitudes to domestic violence, and ensure that women experiencing domestic violence can access services to help them change their situation.

Possible signs/symptoms of domestic violence

This list is not exhaustive; women may demonstrate a variety of signs/symptoms or none at all. These should act as a trigger for direct enquiry.

Physical

- ▣ stress-related ailments – headaches, irritable bowel syndrome;
- ▣ STDs, vaginal infections or other frequent gynaecological problems;
- ▣ miscarriages / history of miscarriages;
- ▣ repeated terminations of pregnancy / still births;
- ▣ premature labour;
- ▣ low birth weight babies;
- ▣ fractures to the foetus;
- ▣ forced removal of sutures;
- ▣ bruises on the body, particularly on the breasts and abdomen;
- ▣ injuries to face, head or neck;
- ▣ multiple injuries in different stages of healing;
- ▣ burns – cigarette burns, rope burns;

- ▣ hair loss – consistent with hair pulling;
- ▣ bilateral injuries;
- ▣ unexplained injuries or those inconsistent with explanations; and
- ▣ unexplained “accidents” to children.

Behavioural

- ▣ frequent A & E visits:
- ▣ appears fearful, evasive, ashamed, embarrassed;
- ▣ partner answers questions directed to woman;
- ▣ use of alcohol and drugs (e.g., use of tranquillisers);
- ▣ eating disorders;
- ▣ frequent use of pain medication; and presents with vague symptoms and conditions.

Psychological/emotional

- ▣ depression / anxiety / panic attacks;
- ▣ self-harm; and
- ▣ attempted suicide.

Resources and further information

Sources of advice for advocates and professionals

Department of Health

www.doh.gov.uk/pdfs/domestic.pdf

Domestic violence: a resource manual for health care professionals. London: DoH, 2000.

Home Office

Useful links to other organisations working in the field of violence against women and domestic violence.

www.crimereduction.gov.uk/dv04.htm

Government policy on Domestic Violence
www.crimereduction.gov.uk/dv01.htm

Domestic Violence publications

www.homeoffice.gov.uk/crime/domestic-violence/publications/index.html#4
www.homeoffice.gov.uk/rds/violence-women.html

National Domestic Violence Health Practice Forum (NDVHPF)

This organisation aims to influence and promote sustainable development in good practice within the NHS, as part of a national domestic violence strategy, through:

- ▣ sharing, collating and evaluating current initiatives;
- ▣ the development of policies, training, guidance, protocols and research; and
- ▣ liaising and lobbying at international, national and regional level.

Contact: Dawn Harvey, Health and Social Care Project Worker, Leeds Inter-Agency Project Unity Business Centre, 26 Roundhay Road, Leeds LS7 1AB
 Tel: 0113-2349090
 Email: dawn.harvey@leeds.gov.uk

Refuge

www.refuge.org.uk/

Refuge is the UK’s single largest independent provider of specialist accommodation and support to women and children escaping domestic violence, currently managing refuges around the country in both urban and rural areas. Also runs community-based floating support projects. Manages safe house specifically set up for African Caribbean and Asian women. Trained staff help women and children access the services they need e.g., local social services, doctors, schools and solicitors.

Women's Aid Federation

www.womensaid.org.uk

The website contains a wide variety of useful information including:

- ❑ a directory of multi-agency fora as well as contact numbers for refuges and a list of useful organisations
www.womensaid.org.uk/network/index.htm
- ❑ a factsheet on health and domestic violence
www.womensaid.org.uk/dv/dvfacts2.htm

The website has information in languages other than English.

www.womensaid.org.uk/lingual/main.htm

Training and resource packs

Wakefield

(contact Rachel Payling, Domestic Violence Health Initiative, Eastern Wakefield Primary Care Trust, 01977-605500)

Hammersmith & Fulham Standing Together Health Project

(email: admin@standingtogether.org.uk)

Suffolk Tools for Practitioners Project

(contact Gaynor Farthing, 01473 275267 or gaynor.farthing@1hp.nhs.uk)

Camden:

www.camden.gov.uk/camden/links/equalities/dm_health.htm

Leeds Interagency Project

(0113 2349090 or admin@liap.demon.co.uk)

Redbridge and Waltham Forest Domestic Violence Health Project:

www.dvhp.org

Sources of support and advice for women who have experienced DV

24-hour National Domestic Violence Helpline (a 24-hour information service run in partnership by Women's Aid and Refuge, that provides support, help and information to

women suffering domestic violence)

Freephone: 0808 2000 247 (minicom available)

BAWSO (Welsh organisation for Black women who are victims of domestic violence)

Tel: 029 2043 7390

Broken Rainbow (Pan-London Lesbian, Gay, Bisexual And Transgender Domestic Violence Forum)

Tel: 0781 2644914

www.lgbt-dv.org/html/rainbow.htm

Careline (Counselling services)

Tel: 020 8514 1177

Community Legal Service Directory Line

Tel: 0845 608 1122

www.justask.org.uk/index.jsp

Foreign & Commonwealth Office

(advice on forced marriage)

Tel: 020 7008 0135/0230

Language Line –

Translations: 0800 917 6564

Face-to-face interpreting: 0845 310 9900

National Child Protection Helpline (NSPCC)

Tel: 0800 800 500

www.nspcc.org.uk/nspcc/helpline

Refuge

(operates a network of safe houses and provides outreach services for women from minority ethnic groups)

Tel: 020 7395 7700

www.refuge.org.uk/

Shelterline –

National 24-hour Housing Helpline

Tel: 0808 800 4444

www.shelter.org.uk/housingadvice/shelterline/index.asp

Southall Black Sisters

(advice and support for women from Black and minority ethnic communities)

Tel: 020 8571 9595

The Samaritans

Tel: 0345 90 90 90

www.samaritans.org/



Survivors UK
(organisation that supports and provides
resources for men who have experienced any
form of sexual violence)
Tel: 0845 1221201
www.survivorsuk.org.uk

Victim Support
Tel: 0845 30 30 900
www.victimsupport.org.uk/

Women's Aid
Tel: 0117 944 4411
Tel: 0808 2000 247 (Freephone – National
Domestic Violence Helpline)
www.womensaid.org.uk

Welsh Women's Aid
Tel: 029 20 39 0874
Tel: 0808 80 10 800 (Wales Domestic Abuse
Confidential helpline)
www.welshwomensaid.org/

It is a good idea to remind women that they
need to be cautious about accessing any of the
above websites from a computer that their
abuser has access to. The Women's Aid
website contains information on action that
women can take to minimise the chance of an
abuser detecting that they have accessed the
site.

Useful Websites

The following are websites which you might find useful for obtaining mental health, health and professional development information.

Note: All website address are prefixed by the following <http://>

Audit commission

www.audit-commission.gov.uk

The website has details of national reports, performance indicators, technical releases and information about the Audit Commission.

British Medical Association (BMA)

www.bma.org.uk

The BMA website has information on news, careers, conferences, education, ethics, publications and the BMA library. There is a link to Medline which can be accessed by members of the BMA.

Centre for evidence-based medicine

www.psychiatry.ox.ac.uk/cebmh/frames.html

www.cebmh.com

This contains resources to promote and support the teaching and practice of evidence-based mental health care. The site includes links to evidence-based mental health websites, teaching resources, Evidence-Based Mental Health journal information, and details on workshops and conferences.

Centre for health service research

www.ncl.ac.uk/~ncenthsr

This website has information about the Centre's research, publications, conference papers, courses and the Health Service Research Advisory Scheme.

Cochrane database of systematic reviews

www.cochrane.org/cochrane/revabstr/mainindex.htm

This website contains a database of the abstracts of reviews and the titles of protocols ordered by subject or by Cochrane Review Group. The full reviews and protocols are available by subscription.

Department of Health

www.doh.gov.uk

The Dept of Health site contains press release, COIN (a database of Dept of Health circulars) and POINT (a database of Dept of Health publications). It also has sections on health and social care and public health, statistics and surveys, links to NHSE pages, research and development information and links to other organisations.

Doctors Net

www.doctors.org.uk

Doctors.net.uk is a peer-led Internet resource for the UK medical profession. It provides a free e-mail account, free access to professional discussion groups, full use of information resources (including Medline) and an exclusive members bookshop for members.

Membership is free but GMC details are required. Non-members can view press information.

Guideline

www.his.ox.au.uk/guidelines/index.html

Guideline is a database of critically appraised guidelines.

Health Centre UK

www.healthcentre.org.uk/hc/clinic/support.htm

Health Centre UK includes guidance notes, links, health providers, on-line manuals, disease and drug information, directory, self-help and support, health news and consultations.

Mental Health Foundation

www.mentalhealth.org.uk

This site includes news related to mental health issues, advice, programs, publications, conferences and training, campaigns and policy, information on the Foundation's activities and links to other organisations.

Mind

www.mind.org.uk

Mind offers many services such as helplines, counselling and advocacy. The website contains news and press releases, publications, local MIND addresses, information on government policy changes, conferences and training.

NHS Centre for Reviews and Dissemination

www.york.ac.uk/inst/crd

The Centre's website has databases (DARE, NHS EED, HTA), publications reviews (both

completed and in progress), search strategies, training, information on dissemination, a free information enquiry service, health economics, the Cochrane Library training and user group and links.

NHS Direct online

www.nhsdirect.nhs.uk

A companion to the NHS Direct telephone service, this site has articles, a guide for treating common symptoms, links and audio clips.

Norfolk Mental Health Care NHS Trust

www.nmhc.co.uk

Site which describes the wide range of mental health drugs and their affects. Patient handouts able to be downloaded and distributed.

Nursing standard online

www.nursing-standard.co.uk

News, abstracts, articles and links are available online.

Patient UK

www.patient.org.uk

Patient UK is a directory of psychology websites but also has articles, newsgroups, chat rooms, jobs and events diary.

Royal College of Nursing (RCN)

www.rcn.org.uk

Contains information on RCN's work, events and membership benefits, resources for student nurses, library services, the Nursing Standard and links to branch websites and the RCN Institute.

Sainsbury Centre for Mental Health

www.sainsburycentre.org.uk

This website is divided in 3 sections – Research and Evaluation, Communication and Publications and Development and Training. These contain information on current and forthcoming work, events, publications, press releases, fact sheets and briefing papers.

UK Drug Information Pharmacist's Group (UKDIPG)

www.ukdipg.org.uk

Has information on new drugs in research, a discussion group, the UK Drug Information conference, the UKDI manual, training, the UKDI Procedure manual, drug information centres, an internet guide for pharmacists and links to other sites.

World Health Organisation

www.who.int

This website contains information on the work of the WHO, disease information, health policies and statistics and health technology. There is also information on press material, publications and reports.

Taken from Clinical Governance Support Service: Website Directory for Mental Health by Kirsty MacLean Steel. The Royal College of Psychiatrists' Research Unit, London July 2000.

Patient fact sheets

1 Stress vulnerability model

Stress is a difficult subject to define precisely because it is a complex concept. Stress can be imposed by external demands, but can also be generated from within ourselves, by our hopes, fears, expectations and beliefs. Therefore, what is experienced as stress by one person may be a refreshing challenge to another depending on their perception of the situation and perception of their own ability to cope with the situation.

When an individual becomes stressed, their stress response is mobilised only if the person thinks that they cannot cope with the situation, either by themselves or with the help of others.

There are 4 components that determine whether a situation will be stressful or not:

1 External demands

Stresses caused by external pressures, eg work, mortgage, new baby.

2 Internal needs and values

Stresses generated by our attitudes and expectations.

3. Personal coping resources

Ways we have developed to deal with stress.

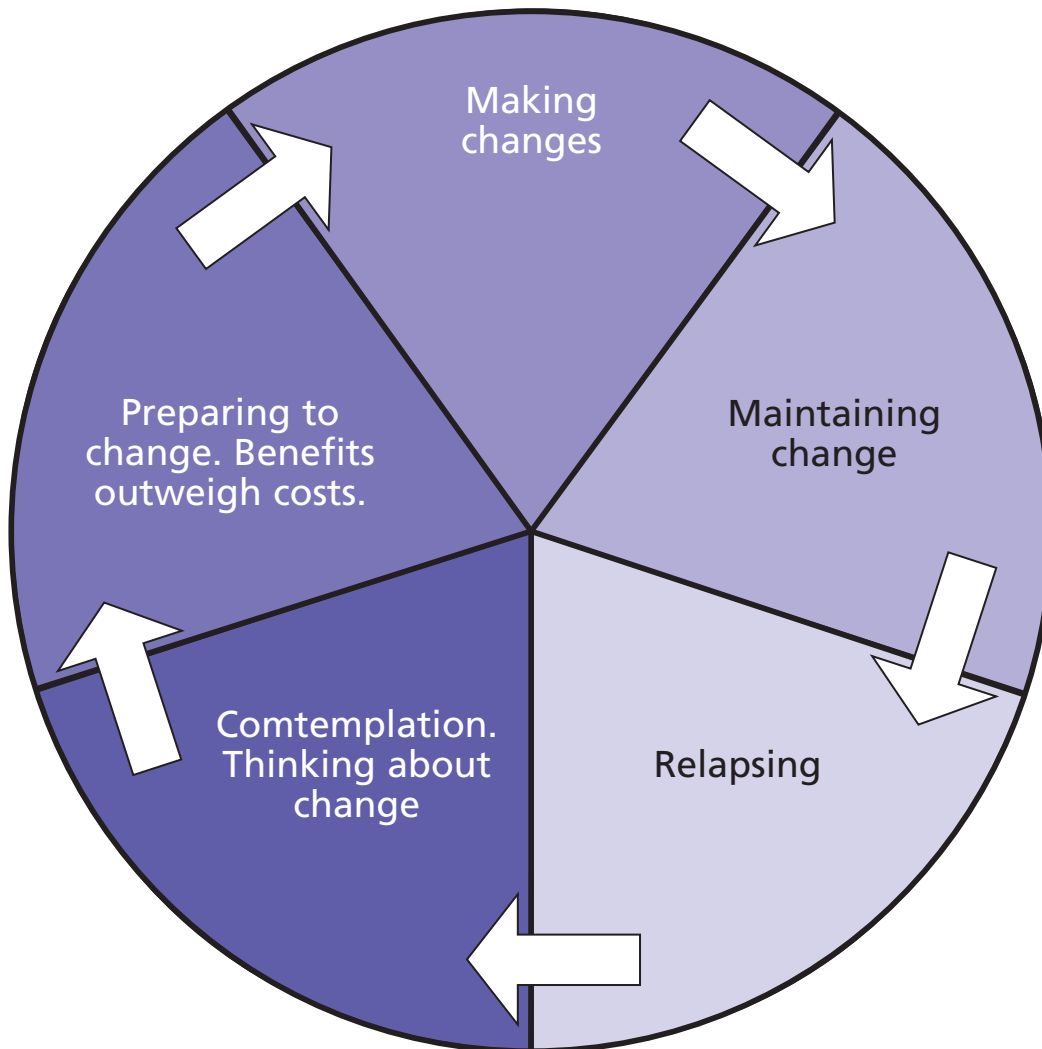
4. External resources

The people and support systems available to help us cope with stress.

A balance of these 4 components determines whether a situation will be experienced as stressful or not.



2 Cycle of change



- ❑ Pre-contemplation: a stage where the individual is not aware that they have a problem, and therefore do not think about change.
- ❑ Contemplation: a stage where the individual begins to weigh up the pros and cons of their current lifestyle.
- ❑ Decision: a point is reached where a decision is made to do something.
- ❑ Action: the process or stage of doing something.

- ❑ Maintenance: the task is to maintain the gains that have been made in order to avoid relapse.
- ❑ Relapse: a return to previous patterns of behaviour at either contemplative or pre-contemplative stage. It is not a failure.

NOTE: Diagram adapted from Prochaska & DiClemente (1986)

3 Ideas for enjoyable things to do

Things to do to pamper yourself

Have (or give yourself) a facial
Have a massage
Try different perfumes in a dept store. Paint your fingernails
Have a bubble bath
Try out new hairstyles
Have a haircut or get your hair coloured
Hug your favourite person
Eat your favourite food
Buy yourself a bunch of flowers
Buy yourself a new piece of clothing or another special gift

Things to do around the house

Do some gardening
Do some handywork around the house
Do some sewing
Listen to music
Dance to some music
Watch television
Play with your pets
Sit in the sun
Do some cookery

Things to do on your own

Write a letter to a friend
Write a short story or poem
Play a computer game
Learn or practise a musical instrument
Paint, Draw, Do some pottery
Sing
Knit
Do some woodwork
Do a jigsaw puzzle
Read a good novel
Read an interesting non-fiction book
Read your favourite magazine
Read the newspaper
Buy or make a present for someone
Look through your favourite photo album
Play a card game (eg Patience)

Social activities

Phone a friend
Visit a friend or a neighbour
Prepare a special meal for friends or family
See a play, ballet, or opera
See your favourite band
Go to your favourite restaurant
Play with your children
Invite friends over for a video & popcorn
Ask yourself over to a friend's place
Hold a Trivial Pursuit, Pictionary, or Charades evening

Active things

Go for a stroll or brisk walk
Go jogging
Go rollerskating
Hire a bike
Hire a tandem bike
Do some aerobics
Do some weight lifting
Arrange a game of tennis or squash
Kick a ball around
Play Table tennis
Have a game of golf
Go for a swim
Fly a kite
Walk the dog
Go fishing

Things to do away from home

Take a Walk
Go to the beach
Go to a film
Visit the zoo
Go to a local car boot market
Go shopping
Go to the library
Visit a bookshop
Visit the art gallery
Visit the museum
Go to a poetry reading
Watch a game of football or soccer

Ideas for enjoyable things to do is reprinted, with permission, from Andrews G and Jenkins R, 1999, Management of Mental Disorders, (UK Edition) Sydney, World Health Organization Collaborating Centre for Mental Health and Substance Abuse.



4 Mental ill health and claiming benefits fact sheet

People with mental health difficulties have the highest rate of unemployment compared to other groups of disabled people. However, recent studies of the uptake of welfare benefits by mental health service users show that more than half do not claim their full benefit entitlement.

The majority of people with long-standing mental health problems look to the benefits system for their income. This is due to their lack of opportunity to get income any other way – a history of mental health difficulties can result in discrimination (from current and/or potential employers) or cause symptoms that make it difficult to manage paid work.

Disability benefits are paid to help people cope with the additional costs of long term sickness or disability – regardless of whether you have an obvious health problem or not, if you feel you may be entitled to benefit, you have the right to make a claim.

Claiming disability benefits is difficult – benefit entitlement forms are complex and the onus is on the claimant to know how to fill in the forms correctly. Most people (mental health workers, some advice workers, and claimants) do not know how to fill in claim forms comprehensively. Also Benefits Agency staff may not assess claims correctly. On top of this, there are ongoing changes to the benefits system, e.g. at the time of writing this, means testing of Incapacity Benefit is being introduced.

If you need to complete a benefit entitlement form try to get an advice worker who knows the benefits system and who understands the impact of mental ill health to help you fill it in – that will give you the best chance of

receiving all the benefits you may be entitled to.

Which benefits?

There are three main benefits to think about, and if you go to see an advice worker ensure that you are assessed for your entitlement to:

- ▣ Incapacity Benefit (IB)
- ▣ Disability Living Allowance (DLA)
- ▣ Income Support

Incapacity Benefit (IB)

This is for people who cannot work because of illness or disability. However, you must have paid enough National Insurance contributions to qualify for it (and the Benefits Agency will assess this for you).

You should claim IB if you can't get statutory sick pay (e.g. if you can't get any more sick pay from your employer, or if you've been signing on and looking for work but have become ill). At present IB is not 'means tested'. This means that you can have other income, or if you have a partner, they can be working while you claim.

Once you start receiving IB, there are a number of stages which effect how much you receive:

- ▣ first 28 weeks short term IB at the lower rate
- ▣ after 28 weeks short term IB at the higher rate
- ▣ after 52 weeks long term IB

If you've worked recently, your incapacity for work is assessed under the 'own occupation'

test for the first 28 weeks. This looks at your ability to do your usual job. If you haven't worked, or have been claiming IB for more than 28 weeks, you will be assessed under the 'All Work Test' unless you qualify for an exemption.

The 'All Work Test' assesses if you are incapable of all work. Most of the activities you are assessed for are physical and sensory activities such as walking, sitting, hearing, and vision. Mental health is also looked at through daily living, coping with pressure, and interacting with other people.

In terms of mental ill health you should be exempt from the 'All Work Test' if:

- ❑ you are suffering a 'severe mental illness' – this might include schizophrenia, manic depression, psychotic illness or dementia
- ❑ if you go for day care at least one day a week to a place where qualified mental health staff work (e.g. to a day centre or mental health resource centre)
- ❑ if you receive care at home from a qualified mental health worker at least once a week as well as long term anti-psychotic medication
- ❑ if you are in receipt of the highest rate care component of Disability Living Allowance (see later for an explanation of this)

Your GP will, at the start of your claim, be asked for information to help determine the severity of your mental health difficulties. The Benefits Agency should request this from your GP (and you should not be charged for this). The information given by your doctor will be used to assess whether your mental health problems are severe or mild-to-moderate.

If your mental health problem is assessed as severe you are then exempt from Incapacity Benefit the 'All Work Test' (see above). If your mental health difficulties are assessed as mild-to-moderate you will be asked to fill in form IB50. This form concentrates on physical

disabilities, but don't be put off, there is a section at the back for information about mental health problems. The information you give is then 'scored' by the Benefits Agency using a points system.

It is very likely that you will then be asked to attend a medical examination with a Doctor from the Benefits Agency's Medical Service – you should get at least 7 days notice of this. The report from this examination will be sent to the Benefits Agency for a decision to be made about your incapacity to return to work. If you are found unfit for work, a review date for your claim will be fixed and you will be asked to repeat this process later (e.g. in 6, 18, or 24 months time).

Remember:

- ❑ if you are called for a medical, and have a 'severe' mental health problem such as schizophrenia or manic depression, it is worth asking the Benefits Agency why you are not exempt from the 'All Work Test'
- ❑ if you are called for a medical, it is important that you go otherwise your benefit may be stopped. If you find on the day that you really can't face going, let the Benefits Agency know. You will have to go at some point though, so try to think of strategies to help you cope with the process
- ❑ when you go to the medical, don't put a brave face on things. You might be questioned about things you can do (eg taking the dog out for a walk), but try to think about how you might cope in a day to day work situation (eg could you go out every day to a busy workplace)
- ❑ you might find the medical distressing, so think about your support needs and try to plan what you might do afterwards
- ❑ if you are found capable of work you can appeal within one month of the decision being made – it is best to get advice with this. Whilst waiting for the appeal hearing

you can sign on unemployed (Jobseekers Allowance) and this will protect your National Insurance contributions or you can claim Income Support (at a reduced rate).

Disability Living Allowance (DLA)

Disability Living Allowance is paid on top of other benefits and income so it can mean extra money. Also, its available to everyone whether you have paid National Insurance contributions or not. You can claim DLA whether or not you're working or a student. You can still get DLA if you are a carer and/or if you have children - DLA looks at your own personal needs, not your ability to care for someone else.

In order to qualify for DLA, you must be under 65 years when you claim, have had the health problem you are describing for at least 3 months prior to your claim, and expect to have it for at least 6 months after you claim. Many people with mental health problems think that DLA does not apply to them because they are not 'disabled', and the questions asked do seem to focus on physical difficulties. However, DLA does most definitely apply to mental health difficulties as well as physical disability or sensory impairment.

However, ploughing through a DLA form can be a depressing experience (and some people actually decide not to go through with their claim as it's too upsetting to fill in the form). Again, get advice or support and help to complete the claim if you can.

There are two different 'components' to DLA, the Care Component and the Mobility Component. You can claim for both components if they seem to apply, or for just the one that seems most relevant to you. The Care Component is split into three categories:

1 **Higher** – this is given if you need supervision or need someone to attend to

your bodily functions during the day and night.

2 **Middle** – this is given if you need supervision or need someone to attend to your bodily functions during either the day or the night.

3 **Lower** – this is given if you need supervision or someone to attend to your bodily functions for part of the day, or if you cannot prepare a proper cooked main meal for yourself.

What is preparing a proper cooked main meal? This is more than opening tins or heating up a ready made dinner – no beans on toast! It involves preparing a meal for yourself from scratch with basic ingredients. You could qualify if, for example, you hear voices or get so anxious that you lack concentration and often leave things to burn badly, or of you are so depressed you lack the motivation to cook for yourself.

What is 'supervision'? This basically means if you need to have someone around to prevent risk to yourself or other people. The supervision doesn't have to be constant, but it does have to be on hand, be ongoing, and must be needed. For example, you may hear voices that tell you to harm or kill yourself. At times you may have actually felt like doing, or may have tried to do this.

What are 'bodily functions'? This could be having someone to prompt you to get up at a reasonable time in the morning, to get dressed, to change into clean clothing, to brush your teeth, to encourage you not to go to bed during the day, to encourage you to get ready and washed for bed and to go to bed at a reasonable time. It could also mean needing to have someone encourage or remind you to take medication, to cope with panic attacks, or to help you communicate with other people. This attention must be for several times in the day throughout the day (or more than twice at night for over 20 minutes each time). An example might be if you have chronic

depression and don't get up in the day, keep the same clothes on for days at a time, and lack the motivation to look after your own personal hygiene.

The Mobility Component is split into two categories:

- 1 **Higher** – this is given if you have severe physical walking problems or if you have severe learning disabilities with severe behavioural problems and high care needs. At present, people who claim solely on the basis of a mental health problem do not qualify for this.
- 2 **Lower** – this is given if you need guidance with walking outdoors in unfamiliar places. In terms of mental health examples include if you experience anxiety or agoraphobia and need someone to accompany you when you leave your home, if you hear voices and need someone to encourage you and make you feel safe enough to leave home.

Income Support

This is a complex benefit and these are basic guidelines. Income Support is not based on National Insurance contributions and is 'means tested'. That means entitlement to it depends on the income coming into your household (eg your partner's wages, or an occupational pension) and the amount of savings you have (for a single person, deductions are made if you have £3,000 or more of savings). If you don't have enough National Insurance contributions to claim Incapacity Benefit, you can get Income Support. When you first make a claim for benefit, always ask to be assessed for entitlement to Income Support. Also, if your circumstances change, e.g. you are awarded any rate of DLA, again make a claim for Income Support.

Where to get further help

- ❑ Some Citizens Advice Bureaux have welfare advice workers who specialise in making mental health claims.
- ❑ Some local MIND groups or local associations for mental health have advice or advocacy workers. Telephone MIND on 08457 660 163 for details of your nearest MIND or the UK Advocacy Network on 0114 272 8171 for details of your nearest advocacy group.
- ❑ Some Local Authorities have welfare rights officers who specialise in mental health claims. Look under 'Local Authority' in your local telephone directory.

Potential difficulties in making and maintaining claims

There are three common situations where claimants may face difficulties:

- ❑ Admission to hospital
- ❑ Starting work or study
- ❑ If your benefit is a Time Limited Award

Admission to Hospital: DLA, Incapacity Benefit, Income Support (and Housing and Council Tax Benefits) are all affected differently if you are admitted to hospital for long stays (eg over 4 weeks). The onus is on you to inform the Benefits Agency of your admission - if you do not do this and continue to receive benefits you will be required to pay them back. Try to get help and advice from a benefit advisor or the hospital Social Work Department.

Returning to Work or Study: If you are receiving DLA this only changes if your care needs or mobility problems are changed. Allow yourself a few weeks in your new job to see how things go before assessing whether your care or mobility needs have changed. You have to tell the DLA unit if your care or mobility needs have changed. With Incapacity

Benefit, you can return to your original rate of benefit within 52 weeks of starting work if you cannot continue working because of your mental health problem. Income Support (as with other means tested benefits) will be dependent on the amount you earn.

You may have heard of 'therapeutic earnings'. This means that you can do some paid work if it helps to improve your mental health problem, or helps to stop it getting worse. You can only start work if your doctor confirms that it is therapeutic and if the Benefits Agency agree.

If your Benefit is a Time Limited Award: Most people claiming DLA and Incapacity Benefit on the grounds of a mental health problem will receive time limited awards - this means that every year or two years you will have to renew your claim. In reality this may mean you find yourself on a 'benefits treadmill' – for instance, it can take up to six months to process some DLA claims so if you receive a one year award it may only just be sorted out before you have to start applying for the next one.

One last point, when, making a claim for benefit (especially DLA), it is worthwhile

making and keeping a copy of your claim to help you if you need to make a future claim for the same benefit.

Amendments to factsheet as at December 2001:

The Women and Mental Health Infoline is open:

Monday: 10 am to 12pm and 2pm to 4.30pm

Tuesday: 2 Pm to 4-30 pm.

Wednesday: 10 am to 12 pm and 2 pm to 4.30

pm Thursday: 2 pm to 4.30 pm

24 hour answerphone outside of these open hours

The 'All Work Test' is now known as the 'Personal Capability Assessment'

The 'Benefits Agency' is now called the 'Department for Work and Pensions'.

With kind permission from Threshold Women and Mental Health Initiative 1999, revised in August 2001. Whilst every effort has been made to ensure the accuracy and reliability of the information in this factsheet is intended as a guide only. Threshold cannot accept liability for errors or omissions.

Please also refer to the Carers Section within this Toolkit

5 Self-harm fact sheet

Self-harm is a lot more common than is probably realized. The term 'self harm' (self injury, self mutilation) is used to describe a certain behaviour where people of various ages, sex, religion and race, inflict injuries on themselves. Self-harm is a sign that a person is in real distress. It is about despair, sadness, hurt, pain and isolation. Every person who self harms will have his or her own reasons for doing it. Self-harm can take many forms the most common is cutting. Other forms of self-harm may be burning, scratching, pulling out hair, taking overdoses. Because the self-harm is often hidden the true extent of the problem is not known.

Is self-harm common?

Self-harm is more common in women than in men, and it is thought that this is the case, as women tend to express their emotions differently to men. Men are more likely to be outwardly violent. About 1 in 10 women between the ages of 15 and 35 are thought to hurt themselves. 10% of admissions to medical wards in the UK are for the results of self-harm. Most admissions or treatment of self-harm are due to drug overdoses. About 10% is for treatment of self-inflicted wounds.

Why do people hurt themselves?

Self-harm can stem from negative childhood experiences, or from distressing adult experiences. This often results in feelings of low self-esteem; feelings of being out of control and self-hate. Self-harm may be a way of managing feelings and feeling numb and empty.

Facts about self-harm

Self-harm isn't necessarily about suicide.

Sometimes people harm themselves because they want to die. But often it's more about staying alive. People may hurt themselves to help them get through a bad time. It's a way to cope.

People self-harm in different ways. Some cut their arms or legs, others bang or bruise their bodies. Self-harm also includes burning, scratching, hair-pulling, scrubbing, or anything that causes injury to the body. Some people take tablets, perhaps not a big overdose, but enough to blot things out for a while.

It doesn't mean you're off your head. All sorts of people self-harm. Even people in high-powered jobs. It's a sign that something is bothering and upsetting you, not that you are mad.

Lots of people self-harm. You may not have met anyone else who self-harms and may even think you are the only one who does it. There's a lot of secrecy about self-harm. But many thousands of people cope in this way for a while.

It's not attention seeking. People self-harm because they are in pain and trying to cope. They could also be trying to show that something is wrong. They need to be taken seriously.

It can happen once or many times. Some people attempt suicide or hurt themselves just once or twice. Other people use self-harm to cope over a long time. They might hurt themselves quite often during a bad patch.

People do stop self-harming. Many people stop self-harming – when they're ready. They sort their problems out and find other ways of dealing with their feelings. It might take a long time and they might need help. But things can get better.

Other things can be seen as self-harm too.

Things like starving, overeating, drinking too much, risk-taking, smoking and many others are also types of 'self-harm'. Some coping methods (like burying yourself in work) may be more acceptable, but can still be harmful.

What can you do?

If you are worried about self-harm you can get help. Self-harm is often a way of coping with painful experiences. These might include being abused or neglected, losing someone important to you, being bullied, harassed or assaulted, or being very lonely and isolated. It helps to tell someone supportive about painful things that have happened to you and the ways these have made you feel.

Emergencies

If you have harmed yourself to the extent of needing medical attention, take yourself to the nearest A&E department. Tell staff what you have done. They should understand. If they are not that is their problem not yours. Remember you are there to get help and it is part of their job to respect you whatever your problem is.

If you have taken an overdose ring 999 (UK), for an ambulance immediately. Do not leave it for a while as you may collapse or become very ill in other ways. The hospital will be used to people having taken overdoses and will know how to deal with it properly. Try to keep calm and if you are feeling very unwell contact a neighbour or keep your door open/unlocked.

If you are feeling suicidal, please contact someone, whether it is a friend, family member, support worker, doctor or anyone else you can trust. You could contact your local psychiatric emergency team who are probably based at your nearest psychiatric hospital. Hopefully they will arrange for you to be seen as soon as possible. You could also

contact your nearest accident and emergency department. They should be able to help.

Also the Samaritans are a well-established organization. The staff are more than willing to help as much as they can, even if it is just to listen to what you have to say. UK Samaritans telephone number is 08457 90 90 90. You could visit their website where you can email them. But please be aware it may take a while for a reply.

Emergencies are scary situations. But you will get through it. Everything changes.

Emergency first aid

Information provided by the Scottish Ambulance Service

Wounds and bleeding

- ▶ **Small cuts:** Wash and apply a sterile dressing
- ▶ **Large wounds:** Examine wound for embedded objects, apply a sterile dressing and direct pressure. Elevate the injured area if possible. If bleeding is serious dial 999 (or your country's emergency number) and request medical assistance. Always wear sterile gloves if you have them available.
- ▶ **DO NOT** remove embedded objects.
- ▶ **DO NOT** remove dressings once applied. If bleeding persists, apply additional dressings on top of the initial one.
- ▶ **DO NOT** use antiseptic creams or lotions.

Burns and scalds

- ▶ Place the injured part under running cold water for at least 10 minutes.
- ▶ Dress the area with a clean sterile non-fluffy material.
- ▶ Seek medical help. **DO NOT** apply lotions, creams or ointments.

- ❑ **DO NOT** use adhesive dressings or cotton wool
- ❑ **DO NOT** break any blisters

Poisoning

- ❑ If you are the casualty, call for help immediately. Notify a relative or friend
- ❑ Place the casualty in the recovery position of appropriate. Keep the casualty still and call for help. Monitor airway (by removing obvious obstructions), breathing (gently tilt head back, check breathing), and circulation (check for pulse)
- ❑ It is appropriate on occasions to induce vomiting if in doubt contact A&E

How can I help prevent myself from harming myself?

Talking to someone that you can trust and feel safe talking to.

Using **distraction** techniques watching television.

Writing letters, poetry, stories to enable you to express your feelings on paper.

Avoiding keeping sharp objects in the house.

Looking at why do you want to self-harm? This can be helpful as what's going on inside your head and could prevent you from harming yourself.

Try to **make connections** with other people and see how they manage to prevent their self-harm.

Exercise, walking running, swimming, cycling dance, etc. Low impact exercise helps to release emotions, tensions and energy, it is difficult to self-harm whilst undertaking most forms of exercise.

Physical means of expression this could be hitting, smashing, kicking or screaming, crying. Relaxation, a warm bath, aromatherapy, yoga, relaxation tapes or gentle music.

Self-nurturing, creating a warm safe place, the use of affirmations (written by yourself or others); enjoyable and nurturing activities. Do activities that you enjoy.

Choose a new response: What action, if any, do you want to take to feel better in the present? For example, a flashback may indicate that a person is once again in a situation that is in some way unsafe. If this is the case, self-protective actions should be taken to alter the current situation. On the other hand, a flashback may simply mean that an old memory has been triggered by an inconsequential resemblance to the past such as a certain color or smell. In such cases, corrective messages of reassurance and comfort need to be given to the self to counteract the old traumatic memories.

Grounding Skills are interventions that assist in keeping a person in the present. They help to re-orient a person to reality and the immediate here-and-now. Grounding skills are useful in many ways. However, they can be used to help re-orient oneself when experiencing intense and overwhelming feelings and intense anxiety. They help to regain one's mental focus. These skills usually occur within two specific modalities:

- 1 Sensory awareness
- 2 Cognitive awareness

Sensory awareness grounding skills

- ❑ Keep your eyes open, look around the room, notice your surroundings, notice details.
- ❑ Hold a pillow, stuffed animal or a ball.
- ❑ Place a cool cloth on your face, or hold something cool such as a can of soda.
- ❑ Listen to soothing music.
- ❑ Put your feet firmly on the ground.
- ❑ **FOCUS** on someone's voice or a neutral conversation.

Cognitive grounding skills

Re-orient yourself in place and time by asking yourself some or all of these questions:

- 1 Where am I?
 - 2 What is today?
 - 3 What is the date?
 - 4 What is the month?
 - 5 What is the year?
 - 6 How old am I?
 - 7 What season is it?
 - 8 Who is the Prime Minister?
- ▣ List as many Grounding skills as you can.
 - ▣ Practice several grounding skills every day.
 - ▣ Construct a list of those which are most helpful and effective.

Goals when using grounding techniques

- 1 To keep myself safe and free from injury
- 2 To reorient myself to reality and the here and now.
- 3 To identify what I attempted to do to prevent the dissociative experience.
- 4 To identify skills that I can use in the future to help myself remain grounded.
- 5 Choose a new response: What action, if any, do you want to take to feel better in the present? For example, a flashback may indicate that a person is once again in a situation that is in some way unsafe. If this is the case, self-protective actions should be taken to alter the current situation. On the other hand, a flashback may simply mean that an old memory has been triggered by an inconsequential resemblance to the past such as a certain color or smell. In such cases, corrective messages of reassurance and comfort need to be given to the self to counteract the old traumatic memories.

6 Self-harm fact sheet 2: For relatives, friends carers or teachers

The Royal College of Psychiatrists

Mental health and growing up, second edition deliberate self- harm in young people

Deliberate self-harm is a term used when someone intentionally injures or harms themselves. Common examples include 'overdosing' (self-poisoning), hitting, cutting or burning oneself, pulling hair or picking skin, and self-strangulation. It can also include taking illegal drugs and excessive amounts of alcohol. Self-harm is always a sign of something being seriously wrong.

How often does it happen?

It's hard to say exactly, because most people keep their self-harm very private. Some say as many as 1 teenager in 10 could be affected. Health professionals probably see only the tip of the iceberg, and certainly nothing like this number. The problem mainly affects girls and is rare in boys (7:1 female:male ratio). It is very much more common than suicide.

Why do young people harm themselves?

Self-injury is a way of dealing with very difficult feelings that build up inside. People say different things about why they do it. Some say that they have been feeling desperate about a problem and don't know where to turn for help. They feel trapped and helpless. Self-injury helps them to feel more in control. Others talk of feelings of anger or tension that get bottled up inside until they feel like

exploding. Self-injuring relieves this tension. Feelings of guilt or shame may also become unbearable. Self-harm is way of punishing oneself. Some people try to cope with very upsetting experiences like trauma or abuse by convincing themselves that the upsetting event(s) never happened. These people sometimes suffer from feelings of numbness or deadness. They say that they feel detached from the world and their bodies, and that self-injury is a way of feeling more connected and alive.

Self-injury is always a sign of great upset. Sometimes people can end up killing themselves accidentally. The difficult feelings that lead to self-harm can be caused by a number of things. Young people who are depressed or have an eating disorder are at risk. So are people who take illegal drugs or excessive amounts of alcohol. In fact, eating disorders and drug or alcohol misuse are a kind of self-harm in themselves. The commonest trigger is an argument with a parent or close friend. When family life involves a lot of abuse, neglect or rejection, people are more likely to harm themselves. 'Copy cat' self-harm sometimes happens in a group. It can have tragic results.

Why they need help

Anyone who is harming themselves is struggling to cope and needs help. If people don't get help when they need it, problems are likely to continue. Problems may also get a lot worse and the effects may 'snowball'. Some people will continue to harm themselves more and more seriously. They may even end up killing themselves.

What can you do to help?

A person who is thinking of killing themselves often tries to let someone else know how upset they are. They are most likely to share their upset feelings with friends of their own age or adults they know well. But self-injury is different and is often kept secret – even from friends or family. The person feels so ashamed, guilty or bad that they can't face talking about it. There may be clues, such as refusing to wear short sleeves or take off jumpers for games.

If you are a parent or teacher, you can help by

- ▣ recognising signs of distress and finding some way of talking with the young person about how they are feeling.
- ▣ listening to their worries and problems and taking them seriously.
- ▣ offering empathy and understanding.
- ▣ helping with solving problems.
- ▣ staying calm and constructive – however upset you feel about the self-harm.
- ▣ being clear about the risks of self-harm – making sure they know that, with help, it will be possible to stop once the underlying problems have been sorted out.
- ▣ making sure that they get the right kind of help as soon as possible.

It's important to make sure that the young person feels that they have someone they can talk to and get support from when they need it. If they can't get it when they need it, there is a risk they will harm themselves instead. It's important to ask whether parents and family will be able to give the support that's needed. This may be difficult if there are a lot of problems or arguments at home. As a parent, you may be too upset or angry to be able to give the help that is needed. If so, you should seek advice from your family doctor.

If you are a teacher, it is important to encourage students to let you know if one of their group is in trouble, upset or shows signs of harming themselves. Because friends often worry about betraying a confidence, you may need to explain that self-harm can be dangerous to life. For this reason it should never be kept secret. It's better to get help than to suffer in silence.

Not everyone can help someone who self-harms as it can be a very stressful thing to do. Do not feel guilt about this. You can give what you've got, that's just as important. If you feel you are able to help then here are some helpful suggestions.

- ▣ It is important to remember that people who self-harm are deeply distressed. Don't try to ignore the person. Try to be respectful and the same person they knew beforehand.
- ▣ Help them find other sources of support, such as support groups or a therapist.
- ▣ Try to make it clear that it is safe to talk about their self-harm and their problems with you.
- ▣ It is important for them to feel comfortable within your relationship. You could try asking questions as well as just letting them talk. Doing this shows that you are not just there to listen to her problems. It shows that you are interested in helping them.
- ▣ Try to encourage them to recognize the urge to self-harm, what has caused it and to find other ways to cope for example exercise, talking, small distractions like watching TV or playing on the computer.
- ▣ Acknowledge that stopping self-harm instantly could be very hard, if not impossible. It is also not the best way to go about it. Self-harm may worsen while exploring feelings and worries, as doing this can be frightening and unsettling. But do not lose hope if this happens.

- ❑ Remember that sometimes people simply aren't ready to stop their self-harm. Having become a way to survive. To take it away instantly could be very, very unhelpful. Try helping them to set small, achievable goals, e.g.: 'why not try to get through the next week, or even next day without self harming'

Specialist help available

If you feel that more professional help is needed, the family doctor should be able to advise. They will be able to tell you what help is available locally and make a referral to your local child and adolescent mental health service. Here the team includes child psychiatrists, psychologists, social workers, psychotherapists and specialist nurses who can offer expert help.

Many young people who harm themselves do need specialist help. Everyone who has taken an overdose needs an urgent assessment by a doctor as soon as possible, even if they look OK. The harmful effects can sometimes be delayed. Even relatively small amounts of some medications sold without prescription as paracetamol can be fatal.

All young people who need hospital treatment for self-harm should have a specialist mental

health assessment. Often, this will be done by a child and adolescent psychiatrist in a community clinic or hospital. The aim is to discover the causes of the problems and to prevent repetition. It is very helpful when parents or carers can take part. This makes it easier to understand the background to what has happened, and to work out what sort of help is needed after the young person leaves hospital.

Psychological treatment can make all the difference. There are different approaches, depending on what is causing the problem. It often involves both individual and family work. Individuals will need help with how to cope with the very difficult feelings that cause self-harm. Families often need help in working out how to make sure that the dangerous behaviour doesn't happen again, and how to give the support that is needed. If depression or anxiety are part of the problem, medication may be helpful. Occasionally, intensive help may be needed. Sometimes recovery from very damaging or traumatic experiences happens slowly. Then specialist help is needed over a longer period of time.

Adapted from the Royal College of Psychiatrists Self Harm Factsheet

7 Useful contacts

Borderline U.K.

Po box 42, Cockermouth,
Cumbria CA 13 0WB
website: www.borderlineuk.co.uk

Childline

Freepost 1111, London N1 0BR
Tel No: 0800 1111
Website: www.childline.org.uk/

National Self-Harm Network

C/o Survivors Speak Out,
34 Osnaburgh Street, London NW1
Survivor-led campaigning organisation.
Leaflets.

SASH (Survivors of Abuse and Self-Harming)

20 Lackmore Road, Enfield,
Middlesex EN1 4PB

The Young Minds Parent Information Service

102–108 Clerkenwell Rd, London EC1M
5SA. Telephone 0800 018 2138

Provides information and advice on child
mental health issues.

The Young People & Self-Harm Information Resource

website: www.ncb.org.uk/selfharm

Youth Access

19 Taylor's Yard, 67 Alderbrook Road,
London SW12 8AB.

Telephone 020 8772 9900.

Offers information, advice and counselling
throughout the UK.

Shout

C/o PO Box 654, Bristol BS991XH
A newsletter for women who self-injure.

The Basement Project

82 Colston Street, Bristol BS1 5BB.
Tel No: 0117 9225801
Training, workshops and publications.

MIND

Granta House, 15-19 Broadway, Stratford,
London E15 4BQ
Survivor-led campaign organisation. Leaflets.

42nd Street

2nd Floor, Swan Buildings, 20 Swan Street,
Manchester M4 5JW
Tel No: 0161 832 0169
Services for young people who self-harm and
other innovative services, 15-25.

Self Harm Alliance

P.O. Box 61, Cheltenham Gloucestershire.
GL51 8YB
Telephone 01242 578820 Wed–Sun 7–8pm
selfharmalliance@aol.com
www.selfharmalliance.org.uk
National survivor-led voluntary group which
support people effected by self-harm.

Samaritans

Tel No: 0345 90 90 90

Taken from Royal College of Psychiatrists

Suggested Reading

- ❑ **The Mental Health and Growing Up series** contains 36 factsheets on a range of common mental health problems. To order the pack, contact Book Sales at the Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG. Telephone 020 7235 2351, ext. 146; fax 020 7245 1231; e-mail booksales@rcpsych.ac.uk
- ❑ **A Bright Red Scream:** Marlee Strong, Virago, London ISBN 1-86049-754-3
- ❑ **Cutting: Understanding and Overcoming Self-Mutilation:** Steven Levenkron ISBN 0-393-31938-5
- ❑ **Making Sense of Self-Harm:** Lois Arnold and Anne Magill (The Basement Project) ISBN 1-901335-03-8
- ❑ **The Language of Injury: Comprehending Self-Mutilation:** Babiker G. and Arnold L., Leicester; British Psychological Society
- ❑ **Who's Hurting Who?:** Helen Spandler, Handsell Publishing, Gloucester ISBN 1 90078200-6
- ❑ **Women Who Hurt Themselves: A Book of Hope and Understanding,** Basic Books, New York.
- ❑ **Working with Self Harm:** Mike Smith, Handsell Publishing, Gloucester ISBN 1-903199-02-6

8 Managing your anger fact sheet

Anger is a normal, usually healthy emotion. It is a natural human response to perceived attack, injury, violation or frustration which we all experience. It is designed to be a positive aid to our survival by providing us with the physical and emotional energy we need to protect ourselves from danger.

Coping with anger can be difficult because from an early age we are often taught that getting angry is wrong. As a consequence we learn to deal with anger by bottling it up and not expressing it openly. However bottled-up emotions do not disappear, they tend to fester making us feel tense or anxious. This makes it more likely that anger is expressed inappropriately, or that we may feel angry all the time. We may shout at our partners, family or friends unnecessarily, damaging our valued relationships over the long term.

If we constantly bottle up anger it can boil over into rage and uncontrolled behaviours. Under these circumstances anger can be damaging and can harm our relationships and our own self esteem and confidence. Remember that losing your temper is never a good solution. It may provide temporary relief, but often leads to undesirable consequences.

Anger needs to be expressed calmly in a controlled manner, not aggressively.

We often do not recognise anger until it is getting out of hand, at which stage it is very difficult to control. It is useful to think of anger as a crescendo of feelings, with mild irritation or annoyance at one end, building through anger to fury and extreme rage at its most intense.

One knack to managing anger is to recognise it at an early stage, and take appropriate action

before the crescendo builds up to a point where it explodes.

Physical effects of anger

Anger can have physical effects on:

- ▣ **Digestion** – causing heartburn, ulcers, colitis or irritable bowel syndrome.
- ▣ **The muscles** – causing feelings of tension, aches and pains including headaches.
- ▣ **The immune system** – making us more likely to pick up infections, such as ‘flu, or making us less able to recover from operations and illnesses.
- ▣ **Respiration** – causing increased rate of breathing which can lead to hyperventilation or panic attacks.
- ▣ **The heart and circulatory system** – causing blocked arteries and circulation or heart problems.

People who are constantly angry are 6 times more likely to suffer from heart disease.

Emotional effects of anger

Being angry can:

- ▣ Make us more likely to be depressed.
- ▣ Reduce patience.
- ▣ Increase anxiety and agitation.
- ▣ Cause feelings of being victimised.
- ▣ Increase the desire for addictive substances – alcohol, nicotine or drugs.

Effects of anger on behaviour:

Being angry is more likely to cause:

- ❑ Aggressive behaviour, either physical and/or verbal.
- ❑ Violence.
- ❑ Dominating or controlling behaviour towards others such as bullying.
- ❑ Self isolating behaviours like sulking or withdrawing from people.
- ❑ Erratic behaviours including bingeing on food or excessive dieting.
- ❑ Unhelpful lifestyle choices such as not taking enough exercise or eating a healthy diet, or not getting enough sleep or overworking.

Effects of anger on our thinking

When we are constantly angry we are more likely to:

- ❑ Act first and think later.
- ❑ Think with “Hot thoughts” or thoughts that are more likely to inflame the situation.
- ❑ Have a low opinion of ourselves.
- ❑ Lack confidence and self-esteem.

Understanding anger better

How we think and how we feel and behave are closely related. By being able to control one we can influence the others.

In order to control anger better it is important to recognise how our thoughts are influencing our patterns of anger. Identify any “Hot thoughts” (unhelpful thoughts) and balance these with “Cool thoughts” (helpful thoughts).

“**Hot thoughts**” are thoughts which are usually unhelpful, critical, lacking compassion, do not consider a different point of view or look at

the bigger picture. “Hot thoughts” usually make the situation worse. For example “Hot thoughts” might be: “she is a fool” or “I can’t stand this a moment more”.

“**Cool thoughts**” are more rational, helpful thoughts that look for a less damaging explanation. They also try to see things from the other person’s angle and recognise that not everything needs to be taken personally. Examples of “Cool thoughts” might be: “She has a lot on her mind, so perhaps that is why she was late” or “I can cope with this, it is not all that bad”.

It is also useful to be able to distinguish the difference between being angry and being aggressive, people often confuse the two. Anger is an emotion which is normal and usually, fine provided it is expressed in a manner that does not hurt others or oneself. It is the way we express anger that is important. Anger expressed in an assertive manner, considering the rights and needs of all involved, might be a positive experience. However anger often gets expressed aggressively which often has destructive or negative consequences.

Steps to managing anger

Recognise anger

- ❑ It is healthier to recognise when we are feeling angry at an early stage and to express it assertively, by being open and calm, using words which will not hurt or offend, not aggressively or with violent actions such as shouting or gesturing.

Prepare for difficult situations

- ❑ Think about situations beforehand and prepare what to do and say.
- ❑ Do not blame everything on other people.
- ❑ Own feelings and responsibilities. It is easier to deal with things that belong to you.



Manage the situation

- ▣ Take time, count to 10.
- ▣ Think first before rushing into words.
- ▣ Use relaxation and breathing techniques to calm down.
- ▣ Recognise any “Hot thoughts” and think of “Cool” alternatives.
- ▣ Listen to the other person’s point of view.
- ▣ Try not to jump to conclusions or take it personally.

Look after yourself

- ▣ Look after your general health, especially your diet as too much or too little of certain nutrients can make us feel irritable or lacking energy.
- ▣ Ensure you take sufficient exercise which is a healthy way of releasing physical energy and prevents tension building up in the body.
- ▣ Make sure you have enough sleep and rest.
- ▣ Learn relaxation and breathing techniques.
- ▣ Be kind to yourself and make sure you include things in your life that you really enjoy.

Here is a checklist of points to bear in mind when coping with anger:

Rules of anger management

- C Count to 10, take time and look at the bigger picture.
- O Own your anger; blaming other people will not help you to cope.
- N Negotiate – look for win win situations – respect the other person’s point of view.
- T Try not to take it personally.
- R Remember your relationships are important and Relax.

- O O.K. to have a different opinion – we don’t all have to think the same.
- L Listen actively – try to understand the other person’s feelings.

Finally – if you are too angry to manage a situation, walk away. Say you need time to think and calm down. Return to the situation when you are ready to do so calmly and constructively.

Benefits of managing anger better

Learning to manage your anger has many benefits:

- ▣ Improving your relationships.
- ▣ Communication will improve.
- ▣ Boosts your self esteem and confidence.
- ▣ Helps you to feel in charge of yourself in a positive way.
- ▣ Helps you to make friends.
- ▣ Prevents others being hurt emotionally or physically.
- ▣ Keeps you out of trouble.
- ▣ People need not be frightened of you and will respect you for yourself.

Here are some tips to learning how to express your anger in an assertive rather than aggressive way

Assertiveness training

Read all you can on assertiveness and anger, most book shops have a selfhelp/personal development section. Find an assertiveness training course, your local college is a good place to start or ask your local GP, most libraries advertise personal development classes as well. Counselling can also provide assertiveness and anger management training.

How to communicate your anger assertively and effectively

- ❑ Get it clear in your head what it is you want to say. What are your rights and what are you entitled to? Be realistic. What are the likely consequences of telling the person you are angry?
- ❑ Set the scene – choose a time and place that suits you and where the other person is more likely to listen and hear what you have to say.
- ❑ Protect the meeting, ask others not to interrupt you for a set time.
- ❑ Choose a setting that makes you both feel equal and that you both matter, eg, sit in chairs the same height, both sit or both stand. Make sure there are no physical barriers between you, such as a pile of papers, a desk, etc.
- ❑ When talking to the person keep your body language assertive and non-threatening, make eye contact and be alert and relaxed.
- ❑ Keep breathing slowly! This will help you remain calm.
- ❑ Be specific, eg, ‘I am angry because...’ ‘This situation makes me angry because...’ This avoids blaming and shows you are taking responsibility for your feelings. The other person is also less likely to feel attacked.
- ❑ Listen to the other person’s response and try to understand their feelings and point of view.
- ❑ Treat the other person with the same courtesy and attention that you want from them.
- ❑ Ask for more time if you cannot resolve the conflict in the time set.
- ❑ Finish by thanking the other person for their time and attention.

- ❑ Give yourself a pat on the back for handling your anger assertively!

For further information on relaxation and breathing, please refer to the fact sheets in the Anxiety Section entitled “Controlling overbreathing” and “Learning to relax”.

Useful Books

- ❑ *Managing Anger* by Gael Lindenfield, Thorsons, 2000.
- ❑ *Developing Assertiveness* by Anni Townend, Routledge, 1991.
- ❑ *The Anger Workbook: A 13 step interactive plan to help you* by Les Carter & Frank Minirth, Thomas Nelson Publishers, 1993.
- ❑ *Anger: How to live with it and without it* by Albet Ellis, Carol Publishing, 1990.
- ❑ *The Angry Book* by Theodore Isaac Rubin, Collier Macmillan, 1969.
- ❑ *Freedom from Anger* by Roger Dalrup & Dodie Gust, Pocket Books, 1990.
- ❑ *Talk it Out* by Danial Dana, Kogan Page, 1990.
- ❑ *Stress* by Jo Macdonald-Wallace, The Crowood Press, 1988.
- ❑ *Overcoming Irritability and Anger* by Will Davies, Robinson, 2000.



9 Social Services information sheets

If you would like information about the services offered by Social Services, please tick the boxes next to the information sheets you would like to receive.

Send the whole form to: Guide, FREEPOST SWC4299, Gloucester GL1 2ZZ.

Or phone Guide on 0800 521640.

S1 Community Services in Gloucestershire

Services for adults

- A1 Adults at risk
- A2 Blue (orange) parking badges
- A3 Community meals provided by Social Services
- A4 Day care services provided by Social Services
- A5 Help in your own home
- A6 Leaving hospital
- A7 Moving into a home?
- A8 Occupational therapy, adaptations and equipment for your home
- A9 Respite care-short breaks for carers
- A10 Standards for mental health assessment and admissions to hospital
- A11 The Disabled Persons Act 1986 (for young people leaving school)
- A12 Transport for people using Social Services
- A13 Adult Protection Services
- A14 Helping people to stay independent

Services for children

- C1 Adoption in Gloucestershire
- C2 Becoming a foster parent

- C3 Who is eligible for assistance-children
- C4 Childminders (Standards for registration)
- C5 Child Protection
- C6 Children looked after away from home-information for children
- C7 Choosing a childminder
- C8 Choosing a day nursery
- C9 Short term breaks for children with disabilities C10 Services for children under 8 (early years)
- C11 Services for children with disabilities
- C12 Youth Offending Team

Health information

- He1 Who to contact to provide the health services you need
- He2 Gloucestershire health standards Housing information
- Ho1 Home Energy Efficiency Scheme
- Ho2 Housing services for young people
- Ho3 Repairs and improvements
- Ho4 The housing register

Information for different groups of people

- P1 Social Services – the services we provide
- P2 Services for children and families
- P3 Services for deaf and hard of hearing people
- P3a Practical ways of helping
- P4 Services for older people
- P5 Services for people looking after someone (carers)
- P6 Services for people with learning difficulties

- P7 Services for people with mental health problems
- P8 Services for people with physical disabilities
- P9 Services for visually impaired people
- P9a More information for visually impaired people

Information about rights

- R1 Advocacy schemes
- R2 Benefits and financial help
- R3 Charges for services
- R4 Complaints (for people with learning disabilities)
- R5 Direct payments – cash to buy your own care services
- R6 Making a comment, suggestion, or complaint about Social Services
- R7 How well Social Services is doing its job (performance information)
- R8 Who is eligible for assistance
- R9 Working out your needs
- R10 Your right to see your files
- R11 Our key standards (Social Services)

If you would like information in another format please tick the boxes below. Please ask Guide which titles are available.

- Braille
- Large print
- Audio tape
- Computer disc
- Bengali
- Chinese
- Gujarati
- Urdu

Your Name and Address:
