Information for carers of people receiving care from SECONDARY Community Mental Health Services
It can be a difficult experience to know that someone you love and care about has a mental health condition. You will need both information and support to be able to assist the person you care for to return to their everyday life in the community especially after discharge from hospital. To achieve this staff will work in partnership with you. The staff value carers’ commitment, expertise and experience and will work with you to achieve the best results.

This booklet explains how care is delivered, how carers are included and how staff will work with carers and support them. More detailed information about the specific team your relative is involved with can be found in the team’s information leaflet. The information here should be useful to a carer of a person with a mental health condition. If there are any questions please speak to a member of staff and they should be able to help. The following information completed by your relative’s/ friend’s Care Coordinator/ Case Manager should be useful:

The Team’s name/ address is:

Telephone number:

The Team Manager is:

Telephone number:

The Care Coordinator/ Case manager for the person you care for is:

Telephone number:

The Consultant is:

Telephone number:

The Crisis Team telephone number is:

Other useful contact numbers such as those for Carer support organisations and the Mental Health Helpline can be found on the back page of this booklet.
**Who Is a Carer?**
In this booklet a carer is described as someone who provides practical and emotional support to a person with a mental health condition. This could be a condition such as depression, or one of the more severe and enduring mental illnesses such as schizophrenia or bipolar disorder.
It is important to remember that there is plenty of room for hope and optimism. Having a diagnosis of a mental illness does not mean that people have to give up the life they are used to and the aim is always to enable each individual to achieve the best possible recovery.

**The Teams**
Secondary Care Mental Health Teams support people who have complex needs and require multi-disciplinary (see glossary) support. The teams comprise of health staff from LCFT and social care staff employed by the local authority. Mental Health care in these teams is usually carried out according to the CPA (Care Programme Approach). Mental health services will assess an individual’s needs, develop a ‘care plan’ to meet these needs with the service user, and check that the plan is working by regular contact and reviews (at least every 12 months) with the person and their carers. ‘Needs’ can mean anything which will help the individual concerned and can include personal circumstances including family and dependants, psychiatric and psychological treatments, physical health and well-being, diet, social life, housing and domestic tasks, finances, occupation and activities, employment and training, risks and safety, drug and alcohol use, culture and ethnicity, gender and sexuality, spiritual needs, hopes and strengths. The full needs assessment forms the basis of the care plan, which should be developed in conjunction with the person and (where appropriate) their carer and the person and their carer should receive a copy of this. If everyone agrees there is no longer a need for LCFT services, they may be transferred back to their GP. In preparations for this the person will be involved in developing a care plan that describes what happens when the person becomes unwell and how to get help if they need it in the future.

**Recovery**
The approach to mental health care is focused on recovery. This might not necessarily mean a complete cure, but rather a personal process of tackling the adverse impact of mental health problems. It involves personal development and change, a sense of involvement and control over one’s life, cultivating hope and using the support available from others. An important factor in this is the collaboration between the person, the carer and the professionals. The person and the carer are key figures and usually best-placed to evaluate how effective
the care is. If a person or the carer feels that there are aspects which could be improved on they should not hesitate to say so.

**How You Work With The Community Mental Health Service.**
You are the person who really knows your friend/relative best and your input is needed and valued by staff. Any questions or concerns should be raised with the Care Coordinator or Case Manager.

You should be able to attend any meeting about the person you care for if that person agrees. You can also have someone, either a friend or advocate, to support you if you feel this would help. Where possible meetings should primarily be arranged to suit the individual and the carer.

If the person is ill or distressed they may say they do not want you to be involved in their care. If this happens you can request a private meeting with any of the relevant professionals, including the Consultant, to put forward your concerns. You may also find it easier to discuss matters on the phone or by letter before the meeting takes place. Staff cannot always tell you everything because of rules about patient confidentiality, but they must listen to your perception of the current situation and if necessary take appropriate action. If the person you care for is living with you, or if you provide regular support for them in their own home, staff must take this into account when making a decision about what to tell you. They must ensure you are informed of anything which has implications for your own situation. Other family members including children must also be an important consideration.

At times staff may need to pass on information you have given about yourself and/or your relative - for example where information sharing agreements are in place with other Statutory Bodies (see glossary) or if there are concerns about someone’s health and wellbeing. Your own confidentiality will be respected unless there are very strong reasons to do otherwise and this will be discussed with you beforehand.

You have the right to say ‘no’. Make sure it’s clear what you are unwilling or unable to do certain tasks for your relative and ask for this to be reviewed whenever the situation changes. It is often difficult for a carer to say ‘no’ but staff will support you if you need to do this.

Another important right is the right to have your views taken into consideration when the Care Coordinator is assessing the needs of the person you care for. Your relative may not want you to be involved in this, but if you play an essential
part in looking after someone then the law requires that your knowledge and opinions are recorded as part of the important information-gathering process which is the first step of the assessment. Until this is done no decision can be made about which needs will be met, and no care plan can be put together. You can ask for a copy of the care plan describing the person’s needs if your relative agrees to this and if you feel it is incomplete you should write in with your concerns.

**Meetings**

A meeting can be called a ‘review meeting’, a ‘CPA meeting’, or a ‘multidisciplinary meeting’ (see glossary). Meetings are held to plan the care for the individual concerned and should be attended by anyone involved in this.

You should ensure you feel comfortable enough to express your views at the meetings; please speak to the staff if this is not the case. If you need to say things that are likely to upset the person you care for, then you can speak to staff, especially the Care Coordinator, privately, or write in with your concerns.

**Carer Assessment**

It is a legal requirement for carers to be offered an assessment at least once a year and the Trust is committed to this. This does not mean that someone is judging how good you are at looking after the person you care for. It is simply a way of making sure that your own needs are discussed. The assessment examines ways to reduce the stress, worry and demanding workloads that many carers experience. It can be a very useful way of improving the difficult aspects of caring and of addressing any questions relating to confidentiality.

If you are not offered a Carer Assessment please speak to your relative’s Care Coordinator who is responsible for making sure your carer assessment is completed and – most importantly – producing a ‘carer care plan’ for yourself which should spell out specific actions to help you in your caring role. You can also speak to your Carers Centre or Welfare Rights Service, who can do a ‘Benefits check’ about the benefits you are entitled to.

**Carers Centres and Groups**

There is a network of registered charities that provide support to Carers from
across Lancashire. They provide a range of services which Carers can tailor to their own individual caring role, preferences and requirements, plus dedicated ‘Carers Development Workers’ who can work with Carers to provide them with individual specialist support including those who face language or cultural barriers. These services are free and confidential. Carers find them invaluable.

**Respite**
Many Carers find they need a short break, often referred to as ‘respite care’. In order to do this, it is often necessary for them to source alternative care for the person they care for. Finding this care can sometimes seem like a challenge, your local Carers Centre can help you with this.

**Self Directed Support**
Self-Directed Support is another way of providing social care. It offers more choice, flexibility and control over the support a person needs in order that they can live the life they choose. Under Self Directed Support most people assessed as needing social care services will be allocated a Personal Budget. A Personal Budget is an amount of money that is agreed to meet a person’s social care support needs. Following an assessment of needs, the assessor will give the person an indication of how much money may be available to allow them to begin to plan support. The person may choose to manage their support entirely by themselves, or ask others such as a carer, family or friends to help them. The person may also choose to have their support managed by a provider agency on their behalf. The person will have a support plan that details how they want support to be provided. To request an assessment for Self Directed Support ask your Care Coordinator.

**Medication**
Carers of a person living in the community can have an important role in ensuring adherence to medication so it is important that you understand what medication is being prescribed, what it is for, and what the side effects might be. You can ask for leaflets about this or obtain information from the Care Coordinator / case manager or team pharmacist (where available). Most psychiatric medications are obtained on prescription from a person’s GP, following advice from the Consultant Psychiatrist, and are supplied by a local chemist and can be done on a ‘repeat prescription’ basis in blister packs labelled for each day. Some medications can only be prescribed by Consultant Psychiatrists or may be in injection form. The care co-coordinator or case manager will be able to assist with more information on this or if there are any concerns. The carer is often the first person to notice signs that someone has not been taking medication regularly.
Physical Health

It is really important that Carers look after their own health and wellbeing. Carers should register with their GP that they are a Carer. It is also important that people with mental health problems look after their physical health as well as their mental health as this can promote recovery. Your relative will be asked if they would like to complete a physical health check questionnaire with either their care co-ordinator, case manager or an STRW who specialises in this area. As a result of this health check the staff member may advise the person to attend their GP surgery for further advice or treatment. The staff will support the person with this if they need help. They may also signpost the person to other services in the community i.e. smoking cessation clinics. The results of the physical health care check are shared with the persons GP.
Who are some of the professionals you will meet?

**Advocate**
An Advocate is independent of the NHS and Social Services. They can listen to a carer and their relative/friend in confidence. They can speak up for you and the person you care for if you are unhappy with the services you are receiving. Advocates can also put you in touch with people who are able to help and give you support at meetings.

**Approved Mental Health Professional (AMHP)**
Created in 2007, this role replaced the Approved Social Worker. Approved Mental Health Professionals can be social workers, community psychiatric nurses, occupational therapists or psychologists. They have had additional training to allow them to carry out duties under the Mental Health Act, for example making an application for someone to be detained in hospital under a section of the Mental Health Act 1983.

**Care Coordinator/Case Manager** - this can be a Community Mental Health Nurse / Community Psychiatric Nurse (CMHN/CPN) or a Social Worker (S/W), Psychologist or occupational therapist. As part of the Care Programme Approach (CPA), individuals receiving Community Care in Step 4 are assigned a Care Coordinator (if they aren’t under CPA the person will be called a Case Manager). The role of the Care Coordinator is to be the link between those using mental health services and the care team helping them. The Care Coordinator can be any member of the care team. They are the main point of contact if you have any questions or concerns. Care Coordinators also have responsibility for ensuring the involvement of carers.

If the persons care coordinator or case manager is off and there is a problem a ‘duty worker’ is available in Secondary Care Mental Health Teams to give help, support and advice.

**Consultant Psychiatrist**
A Consultant Psychiatrist is a trained and very experienced doctor who specialises in diagnosing and treating people with mental health problems. A psychiatrist will examine the different factors that may have contributed to a mental health problem. Each team has a dedicated Psychiatrist who is linked to each GP in a person’s locality. If a person goes into hospital then for the time they are an inpatient they will have a different dedicated in-patient psychiatrist. The Consultant Psychiatrist may have other grade doctors working as part of their team. These Doctors report
to the Consultant and may see the person on behalf of the Psychiatrist.

**STR (Support Time and Recovery) Worker**
These are unqualified staff who are usually very experienced and will provide practical help and support to the person. This care will be directed and planned by the qualified staff.

**Psychologists/ Psychological Therapists /Occupational Therapists /Team Pharmacists**
These are specialist professionals and are available in Secondary Care Mental Health Teams. The person’s Care Co coordinator will discuss with the person if they feel it would be useful for one of these professionals to be involved and if agreed will arrange for the professional to meet the person and where appropriate carer. The involvement of these professionals and their role will be in the care plan.

**Other Community Teams**
You may come into contact with other teams, such as Crisis Resolution and Home Treatment Teams, Early Intervention Teams, A and E Liaison Teams and Substance Misuse Services. The Care Co-coordinator or Case Manager’s role is to facilitate contact and communication between these teams.

**Community Restart**
This service has the ethos of social inclusion at its core, that is, the belief that a person’s recovery is more profound when they interact more effectively with other people and the places in which they live. The service helps people to create and sustain new partnerships with a variety of organisations, groups and services. Staff are familiar with local communities in order to support individuals to get involved in activities that are of interest and value to them. Examples include activities related to sports and leisure, arts and culture, faith, education, volunteering and environment of activities. Where the local community does not offer a particular activity, the service can support people to establish their own group in order to pursue that activity.

The service also offers specialist advice and support to help people to regain or retain paid employment. Similarly the service can support people to regain or retain safe and secure accommodation.
Glossary

Care Programme Approach (CPA)
The Care Programme Approach is a standardised way of planning a person’s care. It is a multidisciplinary (see definition) approach that includes the service user, and, where appropriate, their carer, to develop an appropriate package of care that is acceptable to mental health professionals, the individual and their carer.

Local Authority
This an organisation that is officially responsible for all the public services and facilities in a particular area – often called ‘the council’ the ‘county council’ ‘the borough council’

Multi-disciplinary
Multi-disciplinary denotes an approach to care that involves more than one discipline. Typically this will mean that doctors, nurses, psychologists and occupational therapists are involved.

Psychological Therapies
A broad range of treatments, (including cognitive behavioural therapy, psychotherapy, arts therapy, counselling) which aim to reduce distress, symptoms, risk of harm to self and others, improve quality of life and social or occupational functioning by assisting the individual to develop a psychological understanding and learn new skills to manage their mental health

Statutory Bodies
Organisations that have been created by Parliament, such as the NHS, the Local Authority, the Primary Care Trust
Sources of help and information

**Carers Lancashire** are an invaluable source of help and information. Phone 0345 688 7113 to be put in touch with your local Carers Centre.

**The Mental Health Helpline** provides an information and listening service for people in Lancashire. It is available between 7:00pm and 11:00pm Mondays to Fridays and from 12:00 noon until 12:00 midnight on Saturdays and Sundays. Freephone: 0300 222 5931.

**Rethink Mental Illness Advice and Information Service** gives specialist advice on any aspect of care for people with a mental illness and those who care for them. Phone 0300 5000 927 weekdays between 10 am and 2pm, email advice@rethink.org. www.rethink.org

**Welfare Rights** provides specialist advice about benefits and entitlement telephone 0845 05300 for advice weekdays between 9am and 5pm.

**nCompass** who offer carer support on 0300 303 8700 or email mhcarers@ncompassnorthwest.co.uk
Other sources of information:

The Wellbeing and Mental Health Helpline
This provides an information and listening service for people in Lancashire. It is available between 7:00pm and 11:00pm Mondays to Fridays and from 12:00 noon until 12:00 midnight on Saturdays and Sundays.
**Freephone 0300 222 5931.**

Customer Care
If you wish to pay a compliment about the Trust’s services, make a comment, raise a concern or complaint, please contact the Customer Care Department on **01772 695315, freephone 0808 144 1010** or email **customer.care@lancashirecare.nhs.uk**

Data Protection
Lancashire Care NHS Foundation Trust adheres to The Data Protection Act 1998. The Trust will endeavour to ensure that your information remains secure and confidential at all times. For further information regarding data protection please visit the Trust’s website or ask a member of staff for a copy of our leaflet entitled “Sharing Information With Us”.

Copies of this leaflet are available from:

**Lancashire Care NHS Foundation Trust,**
**Sceptre Point, Sceptre Way,**
**Walton Summit, Preston PR5 6AW**

Tel: **01772 695300**
Email: **communications@lancashirecare.nhs.uk**
Website: **www.lancashirecare.nhs.uk**