

**BETTER
SERVICES FOR
PEOPLE WHO
SELF-HARM**

**USER
HANDBOOK**

WELCOME!

It's great that you are getting involved in the 'Better Services for People who Self-harm' Project.

This handbook offers information and resources which we hope you will find helpful. You will also have a copy of the Project Management Pack which gives more detailed information about the Project.

This is the first edition of a user handbook for the project. We'd like to improve it as time goes on, and would welcome your ideas and feedback, which can be incorporated in updates as the project progresses.

Looking forward to working with you.

Compiled by Helen Blackwell, October 2005

Available online at: <http://www.rcpsych.ac.uk/cru/auditSelfHarm.htm>

To request further copies, or to suggest changes to this document, please contact selfharmproject@cru.rcpsych.ac.uk, Telephone 020 7977 6643

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'BETTER SERVICES FOR PEOPLE WHO SELF-HARM' INTRODUCTION TO THE PROJECT

The Issue

Self-harm is one of the top five causes of admissions to emergency departments in the UK (68,716 admissions in 2001/2002). The quality of care for those who self-harm depends on the quality of working between emergency departments and mental health service and this appears to vary across the UK.

Although there are, of course, areas of good practice, many people who attend an emergency department as a result of self-harm find the experience unpleasant. This finding greatly influenced the recently published the guideline developed by the National Institute of Clinical Excellence and the National Collaborating Centre for Mental Health for the short-term management of people who self-harm (available at www.nice.org.uk). The guideline concluded that improving staff knowledge and attitudes is the key to better services and reducing levels of self-harm, levels of distress to service users, and deaths resulting from self-harm

Through scrutinising local practices, using a quality improvement framework, teams may be able to confirm commonly held assumptions about 'what is happening'. They may, however, be surprised by some of the things that are revealed.

Some of the improvements identified through the quality improvement processes will relate to the behaviour of individual practitioners, others to the structure of the services within which they practice. Teams may be able to act on some of the findings immediately e.g. by introducing a new risk assessment tool. Others will require medium-term solutions e.g. increasing access to liaison psychiatry services during evenings and weekends. Others still may need long-term plans e.g. re-designing the emergency department to provide more private space. Clearly, not all changes will be welcomed and some may be resisted.

What is the 'Better Services for People who Self-Harm' Programme?

Local teams have been established throughout the UK comprising of service users, senior practitioners and managers from emergency departments, their associated mental health services, and local ambulance services. Local teams have been grouped with neighbouring teams to form 6 regional collaboratives spread throughout the UK. The collaboratives will work together to firstly review their services against good practice standards, and then take forward incremental changes aimed at improving the services being delivered. The programme of work runs for about 18 months and will take participating teams through a number of discrete stages:

Data collection	<p>Local Data Collection Data will be collected covering such areas as (for example) service user experiences, staff training, triage, health records and assessments, department facilities, and patient information. Individual responses will remain anonymous.</p>
	<p>Peer-review visits Members of teams within the same regional collaborative will conduct visits to each other's services to explore key themes and support local action planning.</p>
Reports	<p>Local reports These will detail compliance against each of the standards.</p>
	<p>Regional and national reports These will allow teams to compare their performance against regional and national averages (note: services will not be named unless to highlight good practice).</p>
Learning Event 2: Regional Feedback and Action Planning	<p>Local collaboratives will come together to discuss their findings relative to the regional and national findings, and to begin action planning using the PDSA cycle (<i>see page 4</i>).</p>

Action Period	During Action Periods, local teams will work within their organisations towards measurable and achievable service improvement, however incremental.
Learning Event 3: National Feedback and Evaluation	Members will come together to discuss their findings relative to the regional and national findings, review their overall progress, and celebrate their successes.

For more details, please refer to the Project Management Pack (issued at introductory events and available from the local team lead, or the central project team (CPT))

WHO'S WHO IN THE CENTRAL PROJECT TEAM (CPT)

CENTRAL PROJECT TEAM

Lucy Palmer	Project Manager
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Kayleigh Caesar
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LOCAL PROJECT TEAM

Ambulance

Name
Phone
e-mail
Preferred method of contact.....

Name
Phone
e-mail
Preferred method of contact.....

A & E

Name
Phone
e-mail
Preferred method of contact.....

Name
Phone
e-mail
Preferred method of contact.....

Mental Health

Name
Phone
e-mail
Preferred method of contact.....

Name
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Service users

Name
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e-mail
Preferred method of contact.....

Name
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Name
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e-mail
Preferred method of contact.....

Voluntary Sector

Name
Phone
e-mail
Preferred method of contact.....

Name
Phone
e-mail
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Other

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Preferred method of contact.....

Name
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e-mail
Preferred method of contact.....

SERVICE USER ROLE DESCRIPTION

We anticipate that the involvement for service users will be 9 to 13 days over a period of 18 months. Some time will be spent:

- Attending full day events, with some travel involved
- Attending shorter meetings
- Consulting with other service users
- Preparing for events (by reading)

We have suggested to Local Project Teams that a minimum of two service users are recruited to the team, but preferably three. If there are two users in the team, it is important to recruit a deputy who can stand in if one of you cannot attend an event. It's good practice to have two service users at each meeting or event for support and debriefing.

You will be involved in all aspects of the project. This is likely to include:

- Meetings of the LPT, which will design and implement the project locally. The LPT will collect information about services, interpret the information, plan actions to improve services and communicate the results of the project.
- Regional events – to share learning with other LPTs in your Collaborative
- Peer Review Visits – visiting, and receiving a visit from, another LPT to discuss progress.
- User consultation and feedback – gathering views from service users in your area and keeping them informed as the project develops

As a service user member of the LPT you will have a key role in consulting other service users and contributing views and ideas based on experience of using services, but your other skills are valuable too. You might for example, be good at analysing information, or facilitating groups, or bring knowledge of the local area, and numerous other things.

The table on page 13 gives a possible outline of how service user time might be allocated, ***but this is really a starting point for discussion***. The 'Optional Activities' are *optional for the LPT as a whole* – as an equal member of your LPT you should be invited to take part in anything which the LPT does.

USER MEMBER OF LOCAL PROJECT TEAM PERSON SPECIFICATION

This has been prepared to provide an outline of the different elements of the role and associated skills and experience.

Essential criteria

- Recent experience of using mental health services
- Recent experience of using emergency department services for treatment of self-harm*
- Understanding of user empowerment and user involvement
- Ability to work in groups
- Ability to represent the views of people who self-harm
- Experience of liaison with user and voluntary sector networks, or, the ability to develop links with these networks
- Available to devote 12 to 15 days to the project over the course of the project (18 months), including meetings held during the day
- Confidence in communicating with a range of people including service users, carers, mental health professionals, medical staff and service managers

Desirable criteria

- Experience of research or service evaluation
- Experience of working in committees or working groups
- Understanding of issues facing service users from diverse communities and minority groups

Note

At least one of the service user representatives should have personal experience of self-harm and use of emergency department services. However, it is recognised that other service users may have particular expertise to bring, for example membership of emergency department liaison committee, experience of group advocacy, user consultation etc., and one user representative could be someone with this experience

GUIDE TO TIME COMMITMENT FOR SERVICE USER MEMBERS OF LOCAL PLANNING TEAM

Many local teams have asked us for advice about how much input we expect from service user representatives on the local project team. This guide adheres to some of the key elements of 'good practice' indicated in the project management pack, i.e.:

- service users representatives can share some aspects of the role between them, but should not be expected to serve as sole representative in any professional forum;
- to minimise the risk of this happening, three service users should ideally be recruited to provide supports to your local project team. If you can only recruit two service users, you should ask them to ensure that they can nominate a deputy to stand in for them if they are unable to attend a meeting (this will not cost you any extra money because you would only pay for the person who attends)
- It is essential that service users are fully involved in every stage. They will play a vital role and must be invited to all meetings and events connected to the project and have an equal say in all aspects of decision making.

The guide below indicates 'minimum' and 'maximum' levels of involvement. The list of possible activities is illustrative, not comprehensive.

SERVICE USER TIME COMMITMENT – Outline for discussion

	2 service users in team - total 'person days'	3 service users in team - total 'person days'
ESSENTIAL ACTIVITIES		
Attend introductory event in the local region (Nov 05)	2 (people) x 1 (day)	3 (people) x 1 (day)
Data Collection/contact with other networks (Feb – April 06)	1 x 7	2 x 7
Meet with project team to discuss results of audit (April –May 06)	2 x ½	3 x ½
Prepare for peer-reviews (May 06)	2 x ½	3 x ½
Attend a peer-review (with the rest of the project team) within the local region (June/July 06)	2 x 1	3 x 1
Receive (with the rest of the project team) a peer-review visit (June/July 06)	2 x 1	3 x 1
Attend a feedback workshop in the local region (Sept 06)	2 x 1	3 x 1
Contribute to follow-up report (Dec 06 – Jan 07)	1 x 2	3 x ½
SUB-TOTAL (ESSENTIAL ACTIVITIES)	19	30.5
OPTIONAL ACTIVITIES (but see note 3 above)		
Meet with project team to prepare for project (Jan 06)	2 x ½	3 x ½
Attend the National Event (March 07)	2 x 1	3 x 1
Contribute to the Self-Harm newsletter	2 x ½	3 x ½
Contribute to service user focus group	2 x 1	3 x 1
Attend additional project team meetings	2 x 1½	3 x 1½
SUB-TOTAL (OPTIONAL ACTIVITIES)	7.5	10.5

2 service users = between 19 and 26.5 days *in total*

3 service users = between 30.5 and 41 days *in total*

Between 9 and 13 days for each service user over 18 months

INVOLVING SERVICE USERS – A CHECKLIST

Recruiting service user members

- Invite a minimum of two (ideally three) service users to join the local project team. This helps to achieve balance between clinicians, researchers and users in the team and ensures that users have peer support. It allows for the fact that individual users may be absent at times because of fluctuating health.
- Consult with people who use services and their organisations to identify the most appropriate people to join the local project team. Ensure that the people you involve have links with networks of other service users or are able to develop links.
- Make links with more than one local user organisation or service. (Even if service users on the local project team come from just one organisation, it will be important to consult and inform as wide a group of users as possible during the course of the project.)
- Look for people who have experience working in committees or are interested in being trained to do so.
- Provide a job description and person specification for the role. (See Appendix 2)
- Consider the implications of including workers and users who are, or have been, in an ongoing clinical relationship with other members of the organisation. Discuss carefully with the workers and users concerned.
- Involve service users from the beginning. It is hard to influence work when decisions have already been made.

Working collaboratively

- Make the purpose and remit of the local project team clear.
- Be prepared to relinquish some power and adapt ways of working. But be honest about any areas of decision making which users cannot influence.
- Do not assume there are areas where service users are not competent to take part. Consider service users for all roles in the team, for example Chair, Vice-Chair.

- Be prepared for the work to take longer e.g. because of the need for greater discussion
- Be clear to staff and service users that no-one will be victimised in their use of services for taking part in consultation and representation: this fear can sometimes prevent open criticism by users.
- Let individuals and groups know that you appreciate their input.

Access

- Be aware that users might belong to more than one marginalised or stigmatised group, for example as an older person, as a lesbian or gay man, or as a member of an ethnic minority. Try to ensure that non-user members of the group are drawn from diverse communities.
- Ask service users (and other members of the team) about access needs – don't wait for them to raise the issue. Examples might be:
 - Use of a personal assistant or support worker
 - Access to taxis or other forms of transport
 - Wheelchair accessible venues
 - Hearing induction loop
 - British Sign Language interpreters
 - Community language interpreters
 - Written material in large print, in Braille or on audiotape
 - Reminders before meetings
 - Specific dietary requirements
 - Provision of childcare
- Hold meetings in user-friendly and public transport accessible places: ask people about this.
- Hold some meetings on users' 'home territory', e.g. at the premises of a user or voluntary sector organisation
- Ask about the best time of day for meetings. Early mornings may be difficult for some service users because of the effects of medication.

Organising Meetings

- Ask if service users would like pre-meetings with the Chair - to go through the agenda, ask for background information, and highlight issues they want to raise.
- Invite service user items for the agenda; don't place them near the end.

- Allow enough time between meetings for service users to consult user networks. Plan ahead to allow for use of existing communication networks e.g. monthly newsletters, regular user forum meetings.
- Consult service users on the structure of the meeting – e.g. length of meeting, number of breaks. Check if breaks need to allow time for people to go outside to smoke.
- Consider different formats for meetings to facilitate participation, e.g. small group discussion with feedback.
- Provide plenty of drinks – some psychotropic medication dries your mouth.

At the meeting

- It is the Chair's role to ensure that all members of the group have the chance to participate.
- Ask team members for suggestions for ground rules for meetings.
- Establish a ground rule that any personal information or experience shared is confidential to the group.
- Be clear which elements of the agenda can be discussed outside the meeting and which cannot.
- Use specialist language only where necessary. Consider asking members of the group to prepare 'front sheets' summarising academic papers, if academic papers are being discussed.
- Encourage all members of the team to ask for clarification when terms are not understood.
- Be prepared for meetings to take longer sometimes.
- Be prepared for strong emotions at times – most service users will bring some painful experiences of services - anger and hurt are normal responses!

Study Related Support

- If possible, facilitate access to training e.g. in committee skills, introduction to research methods, focus group facilitation
- If possible, provide a mentor e.g. an experienced member of the research team chosen by the service user

Practical Support

- Provide an induction pack (This will be made available to teams at the Introductory event)
- Produce papers, including the agenda, soon after the meeting so that representatives can consult other people.
- Find out what support the service users need to feed back issues from the meeting to other users, and to consult with them.
- Ensure that user representatives have access to computer facilities, phone, email, photocopier, stationery if required.

Emotional Support

- Facilitate time and space for service user representatives to get together after meetings for mutual support and debriefing.
- Ensure that service users have access to someone outside the local project team to talk through personal issues raised by involvement in the project - discussions about services can trigger difficult memories and feelings.

Payment and expenses

- Service users should be offered a fair rate of payment for their time and expertise. Payment should cover time spent carrying out all aspects of the role: meetings and events, reading papers, research, consulting service users, liaison with other user members of the core team etc.
- Do not assume that service users are on benefits and set rates of payment which are artificially low. However, it is important to inform people that if they are on benefit it is their responsibility to check out the effect of any earnings on their benefit. For detailed guidance on payments to service users see Appendix . It may also be useful to contact other teams within your region to discuss local policy on payment for service users.
- Travel expenses should be reimbursed in cash on the day of the meeting where possible.
- If the service user's session fee does not match the rate of professional consultancy fees then the pay should be sufficient to cover any childcare costs plus payment for time.

With acknowledgements to :

Changing Practice: Mental Health Nursing and User Empowerment. Peter Campbell and Vivien Lindow, 1997, Royal College of Nursing and Mind Publications

Involving Marginalised and Vulnerable People in Research : A Consultation Document, Roger Steele, 2004, INVOLVE

Guidance for Good Practice :Service User Involvement in the UK Mental Health Research Network, Alison Faulkner, 2005, SURGE

Involving the public in NHS, public health, and social research: Briefing notes for researchers, Hanley B et al, 2003, INVOLVE

EXAMPLES OF PAYMENT FOR SERVICE USERS

- **The NHS Health Technology Assessment programme (HTA)** pay £111.18 or £138.71 (if there is preparation) a day for attending panel meetings including any induction/development days if the person is self-employed, not in paid employment or will lose a day's pay by virtue of attending a meeting. Travel, subsistence and carer costs are also paid. They also offer a fixed fee of £200 for peer reviews where the document is more than 200 pages long (2003). For each role HTA have a 'job description' and person specification.
- **The Department of Health** guidance on best practice for national R&D programmes says of payments for peer reviewers who are members of the public, or people who use services (as defined by INVOLVE), and who are being asked to provide a consumer perspective to a review (2003):
 - Lower level* £50
For reviews of short documents such as research briefs and vignettes or lay summaries of reports
 - Middle level* £100
For reviews of larger amounts of information. For example reviewing several grant applications, or medium length reports (50 - 200 pages)
 - Higher level* £200
For reviews of large reports or documents. For example reviewing long reports (over 200 pages)
- **The Joseph Rowntree Foundation** offer a fee of £75 per meeting to service users who are members of their advisory groups if they are unwaged, plus additional payments for preparation time. They will also pay for a support worker as necessary (2002).
- **The National Institute of Clinical Excellence (NICE)** pay £200 a day (2002) for some activities.
- **The National Nursing and Midwifery Council** pay £268 per day to all who attend, both professionals and service users (2002).
- **Devon Social Services** pay £50 for attending a meeting at full day rate and £25 for half day (2002).

- A paper published by **West Midlands MIND**, 'Partnerships in Mental Health' McHarron & Nettle, 1999 recommend that for attendance and participation at work groups/committees /meetings/ recruitment panels etc. a minimum payment of £5.00 per hour or £15 flat rate sessional fee plus travel expenses and any necessary and reasonable subsistence costs.
- **The National Lottery Charities Board** pays user assessors of social and medical research proposals a fee of £125 plus expenses, the same in fact as other assessors (2002).
- **Gedling Primary Care Trust (PCT)** pay £95 per day to lay members participating in meetings (2002).
- **The Department of Health Strategic Review of NHS R&D in Mental Health** agreed to pay £350 a day to the employer organisation (a national charity) to recruit a service user to join the Advisory Group on a consultancy basis. The Mental Health Strategic Review also paid £150 to the members of a specially convened User Panel for their attendance at the meeting, plus expenses (2002).
- **MIND in Dacorum** recommend paying service users £10 per hour, £30 half-day, £65 full day for attendance at a meeting/panel/event for consultation, recruitment and selection, and auditing services (2003).

Taken from: 'A guide to paying members of the public who are actively involved in research' INVOLVE, October 2003.

The full guidelines can be downloaded from the INVOLVE website www.invo.org.uk

TEN WAYS FOR MENTAL HEALTH WORKERS TO IMPEDE USER PARTICIPATION IN PLANNING AND MANAGING MENTAL HEALTH SERVICES

By Vivien Lindow

Introduction

I am introducing this subject in a contrary way. I am going to tell workers how to stop us from getting involved in service planning and management. All these things have happened to me in trying to take part in psychiatric service planning, as someone who has used the services. At the same time, I must acknowledge the very great help that professional people have given to me and other service users in helping us to be involved in trying to improve services.

1. Do not give resources

If you want to prevent user involvement, never give service users the money they need to meet and discuss policy matters. Do not offer money for training in committee skills. After all, you do not want them to get the hang of how the power system works.

2. Take charge

Secondly, take charge. When asked to be treasurer or chairperson by a user group where the members lack confidence, feel flattered, accept the job and wonder why the users will not take responsibility.

3. Sow doubts

The third way you can prevent user participation is to express doubt about the group's ability to be autonomous. Ask: "What if the chairperson becomes manic"? What happens when any chairperson is unable to fulfil that function? User groups are no different.

4. Not representative

Suggest to colleagues that the service users who are making representations are not representative because they are articulate. "Real" psychiatric patients are not articulate. If they were, they would have been given drugs to stop them speaking out. How representative are you?

5. Choose someone compliant

Invite a service user of your choice on to your committee rather than inviting a user group to send representatives. Then you can be sure to hear what you want to hear, not what psychiatric patients have to say.

6. Tokenism: outnumber them

My next two points are about tokenism. Invite just one service user representative on to a committee comprised of professionals. The user will probably not be confident enough to present other users' views unsupported. If the person is confident, he or she will be so heavily outnumbered that you will not have to change anything.

7. Tokenism: ignore them

The next form of tokenism is to consult widely, but exclude service users from the decision-making structures of your organisation. Then you can say that you have asked the service users, but will not have to act on what they have told you.

8. Embarrass them

The eighth idea to exclude service users is to embarrass them. For example, if a service user representative starts by making remarks that do not conform to your agenda, ensure that an awkward silence is followed by ignoring the content of what is said.

9. Exploit them

Never pay service users. Expect them to attend regularly as the only unpaid people in the roomful of salaried people. Then they will stop embarrassing you with their presence, and you'll have satisfied your conscience by inviting them.

10. Suggest that you are as powerless as service users

The tenth way to exclude psychiatric patients is to suggest that you are as powerless as they are. Mental health workers have the power to recommend children being taken away, to order compulsory admission to hospital, to remove access to desired services, to release grants of money and give access to housing of various sorts. You have a salary and probably a secure home. You do not carry a diagnosis that invalidates what you say.

<p>The ideas in this paper have been published in "Just Lip-Service" by Viv Lindow in the Nursing Times (UK), 2 December, 1992.</p>

MANAGING YOUR OWN HEALTH AS A USER/SURVIVOR WORKER

Be clear what you are taking on

It's important to have a clear idea of what you are committing yourself to, both in terms of time and what is involved. The section 'Service User Role Description' (page 10) gives an outline and the project management pack gives more information, but please feel free to ask about anything which is not clear. The role is not set in stone: there is room for negotiation.

Make use of support systems

We are suggesting that each service user has a mentor within the LPT and you have a say in who that is. It's up to you how you use time with them, but a few examples spring to mind. If you're not familiar with structures in NHS services, the mentor could help with information. If you want to talk about the way the LPT is working, the mentor might be a good person to talk it through with first of all. If there are ideas you'd like to test out before broaching them with the team, this could be a place to do it. If you need access to resources to carry out your role effectively, the mentor could negotiate this for you.

We're also suggesting that you have access to someone outside the LPT, perhaps for emotional support. This could be someone in a user group or Mind or other organisation you are involved with. Or it could be someone within the NHS trust who has skills to offer. This is something to negotiate with the LPT lead or your mentor in the LPT.

Another useful approach is for the service user team members to meet with the LPT chair for half an hour before LPT meetings to clarify anything which is not clear about the agenda, and to make sure the Chair allows time for things you want to raise in the meeting. It's helpful to debrief after the meeting or event as well – which could be with the other service users involved, or with your mentor, whatever you find most useful.

Plan ahead

A lot of people say that they get a buzz during events, but crash afterwards. It might be useful to think in advance about what you need in that case – whether it's being with a friend or having an easy day the following day.

Let the team know what you need

It is the team's responsibility as a whole to make sure the team works in a way which takes on board the needs of all its members, but please do voice you needs. This could be access needs such as written material in large print, or a lift to meetings. It could be that one time of day is better than another for meetings, or that you need to bring a support worker to meetings – whatever is necessary to enable you to be fully involved.

Think about how much of your own experience you want to disclose

Some people want to give examples of situations they have experienced, other don't. There's no right and wrong in this. What is most important is that your views and ideas are *informed by* your experience and that of other people. It's often helpful to negotiate with the team at the beginning whether you'd be happy for them to refer to your personal stories outside the meetings, for example when explaining to staff what the issues are, or whether examples you give are confidential to the LPT. Also would you want examples to be attributed to you or referred to anonymously.

Using A & E services

If you need to use A & E services during the time the project is running, do you feel OK about using the A & E department where the project is based, or would you prefer to go elsewhere. This is something you could talk through with your mentor in the team.

Getting other people involved

You'll probably be consulting service users in local organisations. Can people in those organisations help you organise things?

You might want to think about having someone who can deputise for you at meetings and events if you're going through a difficult time. It's important though that anyone standing in for you is well briefed.

Setting limits

This is the sort of project in which one could probably do an infinite amount, and it's tempting as we're all involved because of a commitment to improve services. But do set realistic limits.

Please let us have your suggestions!

GLOSSARY

Action Research

Research designed to explore a practical situation or service, with the aim of implementing findings as they are discovered and bringing about positive change. Typically the research will follow a cycle of investigation – findings – action (implementation) – investigation – findings and so on. (See PDSA)

Audit

An investigation to measure the range and quality of a service against agreed standards.

Collaborative

In the 'Better Services for People Who Self-harm Project': a group of Local Project Teams which meet to share learning, good practice and action planning. In the 'Better Services' project there are six collaboratives in the UK, each with five or six Local Project Teams.

Collaborative research

The term 'collaborative research' is also used to describe an active partnership between researchers and service users to carry out a research project. Collaborative research can also refer to any partnership to carry out research, such as that between researchers and health service practitioners.

Commissioning research

This is the process of selecting someone to undertake a particular research project. It will typically involve advertising the research topic, selecting a shortlist of the best proposals from those submitted, and reaching a decision about which one to fund. The final decision may be informed by peer review, i.e. engaging other independent researchers and experts to read and comment on the shortlisted proposals.

Consumer

The term 'consumer' refers to anyone who is a consumer of the service, including patients, carers, long-term users of services, organisations that represent consumers' interests and members of the public who are the potential recipients of health promotion programmes. The intention is to distinguish between consumers and health or research professionals.

CRTU

The College Research and Training Unit of the Royal College of Psychiatrists

Data

Information collected as part of the research project

Dissemination

The process of ensuring that the results or findings of a research project reach a wide and relevant audience. This might involve giving talks at conferences, speaking on the radio, writing articles in newsletters or journals and giving talks at events arranged for people for whom the project is relevant.

Empowerment

Empowerment is what happens when someone gains a greater voice in situations where they have little power or say over what happens to them; or when someone gains greater control over their life through learning the skills or finding the opportunities in which to express themselves.

Epistemology

The theory or science of the method or grounds of knowledge.

Ethics (see also RECs below)

In research terms, ethics are the principles underlying the practice of research that will ensure, as a minimum, that no harm or abuse will be done to research participants. Examples include informed consent and maintaining confidentiality. Ethics can also include other values held dear to researchers and service users, such as the importance of respect, clarity and transparency, diversity and accessibility. (Note: 'Better Services for people who Self-harm is an audit project, rather than a research project, and does not need approval from Research Ethics Committees).

Evaluation

An evaluation seeks to assess how well a service or project is doing against its aims and objectives, and against some specified standards or level of quality. It is likely to use both qualitative and quantitative methods and to gain the views of service users, staff and other 'stakeholders' of the service.

Focus group

A focus group - or group discussion - is a small group of people brought together to discuss and respond to research questions. It is a good method to use when a researcher needs to gain people's views about a service or ideas about a new or ideal service.

Implementation

The process of acting on the findings of research to bring about positive change.

Informed consent

Ethically, a researcher needs to gain 'informed consent' from a research participant before they can proceed to include them in the research. It means that the participant must be fully informed and understand about the research and what involvement will entail before they agree to take part.

INVOLVE

(formerly Consumers in NHS Research) The Involve Support Unit provides advice and information on public involvement in research. There is a website and they produce a range of useful publications. www.invo.org.uk

Local Project Team (LPT)

In the 'Better Services for People Who Self-harm Project': The team co-ordinating the project in the local area. Each LPT is made up of representatives from the Ambulance Service, A & E Services, the Mental Health Trust and service users.

Methodology

A system of methods or ways of going about undertaking research.

NCCMH

National Collaborating Centre for Mental Health. One of seven collaborating centres established and funded by NICE to develop clinical guidelines on their behalf. The NCCMH develops the majority of the guidelines relating to mental health. It is a joint partnership between the Royal College of Psychiatrists and the British Psychological Society.

NICE

National Institute of Clinical Excellence. NICE is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health. (NB Since the production of the NICE Self-harm guideline NICE has become the National Institute for Health and Clinical Excellence.)

NICE Guidelines

NICE guidelines are recommendations for good practice for the treatment and management of specific health conditions. They are developed by a group of health workers, people who have the health condition themselves, carers and scientists. The recommendations are based on research evidence or, where no research evidence is available, on agreed recommendations of the guideline development group.

NICE Self-harm Guideline

Good practice recommendations developed by NICE for the physical and psychological management of self-harm in the first 48 hours after a person self-harms.

NIMHE

National Institute of Mental Health, England

Outcome/outcome measure

An outcome may be the result or effect of a treatment on a patient, e.g. a change in the level of depression caused by the use of anti-depressant medication. The outcome measure is what is used to measure the effect of the treatment on the patient. In this case, a questionnaire may be used before and after the use of the medication to assess whether it has brought about any change.

Peer review

The process by which a team of likeminded peers visit another team to review the service. For the self-harm project, a group made up of healthcare professionals and service user experts will spend a day visiting a local team, to find out about their service and help them make plans to improve. Unlike some 'inspections' by outside bodies, peer-reviews build on the fact that reviewers have a real understanding of the issues because they either work in, or are users of, similar services. The peers can therefore be supportive, encouraging and offer ideas for improvement based on their own experience.

PDSA

The Plan–Do–Study–Act cycle

The PDSA is an approach to quality improvement that encourages teams to plan changes, test their effectiveness over time, and then continue to make improvements on an ongoing basis. For the Self-Harm project, once initial data has been collected, teams will look at the findings and decide where improvements are needed. Teams then attempt to make the changes and then re-evaluate some time later to see if improvements have been made, and if the changes were lasting. Teams are encouraged to work on small changes first, and then build on their success over time.

Qualitative research

This is research that endeavours to gain understanding about personal experience and the meanings behind actions or beliefs. It is usually obtained through in-depth interview and seeks themes and issues rather than facts and figures. As it produces rich and detailed information, there will be few participants and analysis may not be applicable to the general population.

Quantitative research

This is research that aims to understand the world through measurement, facts and figures: data that can be readily analysed through statistical methods and widely generalisable.

REC

Research Ethics Committee. Local RECs have the responsibility of giving approval for research projects to go ahead. They are concerned with good practice in relation to the treatment of patients and clients in research as well as with high quality standards in research.

Research Governance

Research Governance refers to the process by which broad principles are set for good and ethical practice in research; it seeks to promote high quality scientific and ethical standards, encourage innovative research, and prevent poor performance and adverse incidents. The Research Governance Framework for health and social care was published in April 2001.

Self-harm

The NICE guideline defines self-harm as 'self-poisoning or self injury, irrespective of the apparent purpose of the act'. The guideline recognises that there are many culturally acceptable actions which result in self-inflicted physical or psychological harm, such as smoking, excessive drinking, over-eating or dieting, or that self-harm may form part of an accepted religious practice, social protest or be done as body enhancement. However, the NICE guideline and the 'Better Services for People Who Self-harm Project', focus on acts of self-harm which are an expression of personal distress and where the person directly intends to injure her/himself. (Note 1)

Self-injury

The term 'self-injury' is used to describe a wide range of actions including cutting, burning, hanging, stabbing, swallowing objects, inserting objects into the body, shooting, and jumping from a height or in front of vehicles

Self-poisoning

'Self-poisoning' includes overdosing on prescribed or over-the-counter medication. It could also include poisoning oneself in some other way, such as taking a dangerous amount of a street drug or drinking a harmful substance.

Self-harm Support Group

A group, open to people who self-harm, which meets to offer mutual support. It may be facilitated by service users or by mental health workers.

‘Service user’ and ‘Survivor’

These terms can be used rather differently by different people. The term ‘service user’ is usually used where the people to be involved in a project are using or have used services, i.e. they are or have been patients or clients. Very often, in the context of research, this means they have used the service being explored within the research project.

The term ‘survivor’ is often intended as a more broad term to include people who have experienced mental or emotional distress, whether or not they have used mental health services. However, ‘survivor’ is also used politically to refer to people who have survived mental health services and/or treatments; in this sense it is shorthand for ‘psychiatric system survivor’.

Stakeholders

These are people or organisations who have a recognisable ‘stake’ or interest in the service or project in question.

TOXBASE

The National Information Poison Service’s computerised database, which is available via the internet to healthcare professionals. This database is the primary toxicology information source in the UK for the management of poisoning

User controlled / user-led research

This is research where service users lead or control the research: design, undertake and disseminate the results of a research project. There may be a distinction between the two: user controlled research may be more comprehensively under the control of service users, whereas user-led research may be funded from within an organisation where some control is retained but is led by service users. There is a project currently funded by Involve to scope this area, and to arrive at agreed definitions.

User group

A group or organisation made up entirely of users or ex-users of services. The term ‘user group’ often refers to a local group of people who have used mental health services. Groups are involved in a range of activities, which may include: mutual support, representing user views on statutory committees, consulting on and auditing local services, campaigning on local and national issues, running Patients’ Councils and user forums, providing user-led mental health services etc.

Voluntary sector organisation

A charity or not-for-profit organisation. In the field of mental health some leading voluntary sector organisations are Mind, Rethink, Sane, and Richmond Fellowship - plus many other national and local charities.

Note 1

NICE Guideline page 16: 'It is important also to acknowledge that for some people, especially for those who have been abused as children, acts of self-harm occur seemingly out of the person's control or even awareness, during 'trance-like' or disassociative states. The guideline therefore uses the term 'self-harm' rather than 'deliberate self-harm.'

With thanks to

SURGE: 'Guidance for Good Practice: Service User Involvement in the UK Mental Health Research Network', Faulkner, A.,2005.

INVOLVE publication: 'Getting involved in research: a Guide for Consumers' Royle et al, 2001.

NCCMH: Self-harm, the short-term physical and psychological management secondary prevention of self-harm in primary and secondary care, Gaskell and BPS, 2004

😊 16 WAYS TO MAINTAIN A HEALTHY LEVEL OF INSANITY 😊

- At lunch time sit in your parked car with sunglasses on and point your hair dryer at passing cars. See if they slow down.
- Page yourself over the intercom. Don't disguise your voice.
- Every time someone asks you to do something ask them if they want fries with that.
- Put your rubbish bin on your desk and label it 'in-tray'.
- Put decaf in the coffee maker for three weeks. Once everyone has got over their caffeine addictions switch to espresso.
- Don't use any punctuation.
- As often as possible skip rather than walk.
- Specify that your Drive-Through order is 'to take away'
- Sing along at the opera.
- Go to a poetry recital and ask why the poems don't rhyme.
- Put mosquito netting around your work area and play tropical sounds all day.
- Five days in advance tell your friends that they are not in the mood to go to your party.
- When the money comes out of the ATM, scream, 'I won, I won!'
- When leaving the zoo start running towards the car park screaming, 'run for your lives, they're loose.'
- Tell your children over dinner, 'I'm sorry but due to the economy we are going to have to let you go.'
- And the final way to keep a healthy level of insanity.....Send this to someone to make them smileit is called therapy...