

Mental health re-consultation, February-March 2009



**Report for Bradford and Airedale tPCT by
Bradford LINK: June 2009**

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How to read this report

This report has been separated into sections.

Section 1.0 tells you what the report said in two pages so that it is quick to read.

Sections 2.0 to 5.0 tell you about how and why we wrote this report.

Section 6.0 tells you what we have learned from writing the report and how we can do better the next time we write one.

Section 7.0 gives you information about what people said to the questions that we asked. We do this by explaining what people said. We have put the most important things that people said into a box. To show that we are telling the truth, we include what people actually said. This is called a **quote** and has quotation marks “” on either side of it. There is also a piece of writing after the quote which tells you who was speaking.

Section 8.0 brings what people said together into areas, called themes. This makes it easier for you to understand the main things that people said were important to them.

Section 9.0 puts these themes together and says what we think people want the most. Section 10.0 says what we think we need to do next to help people get what they want from adult mental health services.

This report is about adult mental health services. We call people who use these services either mental health service users or people with mental health needs, depending on how this sounds best in the sentence. These are the words we have chosen to use. We think it is best to decide at the beginning and we want to say that we are very sorry if we have hurt anybody's feelings by using the words we have chosen.

The group that asked us to write this report is Bradford and Airedale teaching Primary Care Trust, which is shortened to tPCT. Since this report was written, it has changed its name to NHS Bradford and Airedale. We have chosen to keep using the name that we started with. Although this name has now changed, the people who work for NHS Bradford and Airedale do the same kinds of jobs and so the report is still useful.

List of words and phrases

This report has been written in a plain English and easy read style. This is so that most people will read and understand it. Some of the words used in this report cannot be made easier to understand without changing their meaning. We have listed these and explained what these words mean. We have put these words in **bold** when we first write them in the report and you can look back at this page at any time to check their meaning. We have listed these in the order that they can be found in the report.

Consultation means asking what people think about things

Re-Consultation means asking what people think about something a second time or in a different way

“Communities of interest” are groups of people with a similar background or life experience. This might include people of a similar race or age, for example.

Self-directed care is a way of paying for things that might help with respite and rehabilitation. The money comes from the Government.

People spend time in hospitals to get better and feel better. When they go back home they sometimes need to spend a few days in a hospital or other care centre every now and then, so that they and the people who care for them can stay feeling better – this is called **respite care**.

Sometimes when they are at home, or about to go home, they need to spend time learning how to live better so that they do not need to go to a hospital or care centre again – this is called **rehabilitation**.

The **Third sector** means groups of people who do voluntary and community work

Grounded theory is the kind of research method Bradford LINK used to write this report

Self-directed care is a way of looking after money that might help with respite and rehabilitation.

Paperwork is the way that the people who give out grants check that the money is being spent properly

Carers are people who look after other people. The things that people do to look after other people are called **caring responsibilities**

1.0 Summary

At its board meeting on 27th January 2009, Bradford and Airedale teaching Primary Care Trust (**the tPCT**) invited the Bradford LINK to ask people about adult mental health services. This was because it had just finished asking people questions (called a **consultation**) and that this was not completely successful.

Bradford LINK did a **re-consultation**. This means asking what people think about something a second time or in a different way. We talked to 100 adult mental health service users and their carers, using interviews and questionnaires. Our research exercise showed:

1) People's views on hospitals/care centres

People's views are mixed. They said that the best mental health care centres were general hospitals, such as the Bradford Royal Infirmary. Moor Lane was seen as the best mental health care hospital. However, there is a move away from hospital treatment towards care within the home. People also go to a mixture of "communities of interest" organisations for help. Some of these organisations focused on mental health, some did not.

2) Views on home care

Many people said that they preferred home care, although they needed hospitals and care centres when they began treatment or when they had a crisis. Carers liked home care the most, and people without a permanent home to visit (vulnerably housed) liked it the least. Most people agreed that hospital and care centre staff were likely to know more about mental health conditions, but that home visitor staff would learn more if they helped the same people for a long time.

3) Themes

Many of the mental health users that we spoke to came from "**communities of interest**" groups. By this, we mean people with a similar background or life experience and includes people of a similar race or age. These people felt that they got help from special organisations and contacts that had their needs at heart. This was particularly important for lesbian, gay and bisexual people and former refugees and asylum seekers. They felt that they were able to "be themselves" and talk openly about their experiences in these groups because people would not judge them or say that they did not believe them. South Asian people preferred to be with others who had the same culture and spoke the same language.

Some people also talked about giving each other emotional and practical support. Long-term carers also said that they needed a break from their day-to-day caring duties.

4) Self-directed care

Self-directed care is a way of paying for things that might help with respite and rehabilitation. The money comes from the Government.

Mental health service users said that they wanted to take part in making decisions about their **rehabilitation** and **respite care** with help. However, they did not want to have to deal with the money to pay for this care. These findings are backed up by the original tPCT consultation report, which says:

“On a personal level, service users were concerned that they would have to source their own care...[they] felt they would need support to help plan respite.”

(Bradford and Airedale Teaching Primary Care Trust: Meeting of the board of directors on 27 January 2009: Appendix D - Proposed changed to adult psychiatric inpatient respite and rehabilitation services)

However, our research also showed that over half of the people we asked, would like their “community of interest” group or organisation to be paid to provide more services for them. Other people wanted either more practical help (food, clothes, items for the home) or holidays/short breaks.

From what we have learned, we think that this should happen:

- 1) Rehabilitation and respite mental health care should continue to focus on providing home care, but people should still be able to go to hospitals and care centres when they begin treatment or have a crisis.
- 2) Long-term carers of mental health service users should have more support and respite care.
- 3) We need to find and list organisations that help people with mental health needs who are from a “community of interest” to find out what services they are being given. We also need to ask the organisations what more they need to give extra help to people. We also think these organisations need professional help from the tPCT to work effectively.

More information about these recommendations and the next steps need to take this forward are included in the last section (on page 47) of this report.

2.0 Why this report is needed

Bradford LINK (Local Involvement Network) was set up on April 1st 2008. It followed on from the Public Patient Involvement (PPI) forums, and before this, the Community Health Councils (CHCs). Bradford LINK is a network that gives a voice to people who use health and social care. The organisation is run by a development group of participants that decide what work the Bradford LINK will do. Four members of paid staff do this work: a project manager, communications officer, research officer and an outreach officer.

On the 30th May 2009, the tPCT published [A strategic review of adult mental health services in Bradford and Airedale 2008](#). This report proposed changes to mental health care from 2008-2012. This report took account of the

principles set out in Our NHS, Our Future (The Darzi Report), published October 2007. This review said that more consultation would be needed: **“involving all stakeholders, including users, carers and the wider public.”**

The Strategic Review was accepted by the tPCT Board on July 22nd 2008 and by Bradford Council on October 14th 2008. It showed that Bradford spends a large amount of its money on inpatient care. Despite new investment in community care, less money is spent on these services. The report gave some interesting suggestions about better ways of using the services from voluntary and community organisations, sometimes called the **“third sector.”**

“The voluntary and 3rd Sector provision is too fragmented to be fully involved. In many instances it is staffed by skilled, highly motivated culturally sensitive individuals but at times it feels ignored. The current short term funding arrangements result in too much of its time and resources being devoted to its own annual survival rather than to service delivery. Additionally, some people felt there should be an increase in the overall third Sector spend.”

(p.9 Strategic review of adult mental health services in Bradford and Airedale 2008)

For more information on how the third sector can help to provide better services for mental health users and their carers, please see Sections 9.0 10.0 (pages 45 and 47)

Between 16th October 2008 and 11th January 2009, the tPCT had six consultation events on adult mental health respite care and rehabilitation services. The consultation document showed three proposals for the future of the service for people to choose from.

This consultation was carried out following the research we have already talked about. The National Clinical Advisory Team (NCAT) also looked at these proposals from a medical point of view and gave advice on how these services could be delivered. The report for the meeting of the tPCT’s board of directors on 27th January 2009 backs up these proposals:

“It has long been recognised that for rehabilitation to be most effective, the appropriate interventions need to be carried out in the settings where the patient is expected to live and this has been a significant clinical driver of the development of early intervention, assertive outreach and crisis and home treatment mental health services.

As a consequence of more patients being successfully treated in the community, the case mix of inpatient rehabilitation services is increasingly focused on people with challenging behaviours and complex needs. Earlier ‘buildings-based’ models of rehabilitation are being replaced by tailored psycho-social interventions delivered as far as possible in community settings and there is a movement to give

patients and carers greater choice of personal services through, for example, voucher schemes and direct payments, a scheme whereby patients can purchase their own personalised package of social care using funding allocated via an assessment process.”

(Bradford and Airedale Teaching Primary Care Trust: Meeting of the board of directors on 27 January 2009: Appendix A - Proposed changed to adult psychiatric inpatient respite and rehabilitation services p.4)

2.1 Why the tPCT consultation could have been better

The tPCT was disappointed because only 75 people responded to the consultation, even though 1.600 documents were circulated. A lot of the people who answered the questions in the consultation were mainly worried about the possible closure of one mental health care centre, Moor Lane. According to the 24th February meeting of the board of directors, this closure was proposed to take place on 31st March 2009.

According to the people who had taken part in the consultation, these are some of the reasons why it did not work well:

1) Not enough consultation events

The tPCT held only six consultation events. These were not held at convenient times or places. Some of the events were in areas mostly likely to be affected if Moor Lane closed. This meant that the tPCT did not get a wide enough range of people's views:

“Only three service users and one carer attended this meeting and it was clear that the distance (inaccessible isolated location) and time of day (it was dark at this time in November) put people off. People would have felt vulnerable walking there and it was not on a bus route.”

(Notes taken by Lynn Leadbeatter attending tPCT consultation meeting held at Keighley Cougars Rugby League Club, 17/11/2008)

“She [the caller] wishes to attend the Moor Lane consultation but transport could be an issue - her walking frame is not collapsible and will not fit in a small car. I suggested that the PCT should pay for her transport costs if the consultation were to be truly open but she said that she felt that she would be told to pay the taxi fare out of her living allowance, which would be difficult... She feels that BDCT and BA tPCT should be asked to produce evidence of the effort undertaken to ensure that a representative sample of service users could respond to the consultation, including hard-to-reach people including those with low literacy skills and mild learning difficulties, housebound people and agoraphobics.”

(Anonymous caller to Lynn Leadbeatter.06/01/2008)

“The consultation sessions closed with many attenders expressing a lack of belief that the consultation findings would accurately reflect service user opinion”

(Notes taken by Sarah Harrison, Research and Information Officer, North Yorkshire LINK attending tPCT Consultation meeting held at Moor Lane Centre, 08/01/2009)

2) Not enough choice

The tPCT did not give many choices for respite care and rehabilitation services, and this meant that people could not say what they really wanted. During the meetings, people who had to talk about the closure of Moor Lane sometimes stopped other people talking about their needs:

“Mohammed Shabbir [Sharing Voices] suggested that there should be a smaller focus group for people affected by Moor Lane closure.”

(Notes taken by Lynn Leadbeatter attending tPCT consultation meeting held at Bradford library 25/11/08)

Some people thought that they were not being listened to and that their views would not be taken into account:

“There was a good deal of concern that alternative service models were not adequately described in the consultation process and this made it difficult for people to envisage how the needs of patients and carers could be met in the future should current arrangements change.”

(Bradford and Airedale Teaching Primary Care Trust: Meeting of the board of directors on 27 January 2009: Appendix A - Proposed changes to adult psychiatric inpatient respite and rehabilitation services p. 7)

“Choices taken away - not clear what is offered in return.”

(Notes taken by Lynn Leadbeatter attending tPCT consultation meeting held at Bradford library 25/11/08)

3) Decisions already made

Because people believed their views were not being listened to, they felt that decisions on the future of adult mental health services had already been made before the consultation events:

“No point in saying anything – they’ve lied from the start.”

(Quote noted by Lynn Leadbeatter from the 6th consultation event, Moor Lane 08/01/2009)

“...as the meeting wore on, it became more and more apparent that the decision...had already been made.”

(Quote from letter to Ilkley Gazette 04//12/2008 re: consultation events)

Our information and communications officer, saw that hardly any notes were being taken at one of the two breakout groups at the 06/01/2009 consultation:

“The new research officer from York and North Yorkshire LINK also took notes - a good job because [anonymous] hardly wrote anything down....

which goes back to the issue of minute taking at other meetings raised by [anonymous]

(Email from Lynn Leadbeater, 09/01/2009)

4) Not enough publicity

There was not enough publicity about the consultation exercise, so there were not many responses:

“I feel so strongly about this closure and fear powers that be might not be publicising meetings as they should.”

(Anonymous email to Lynn Leadbeater re: consultation meetings 16/12/2008)

“The whole consultation appears to be a paper exercise with a lack of publicity.”

(Quote from letter to Ilkley Gazette 04/12/2008 re: consultation events)

There were also clashes with dates at least once, which stopped some people from attending:

“...why is the the tPCT Mental Health consultation and the Care Trust Foundation Status [meeting] taking place at the same time?”

(Anonymous email to Lynn Leadbeater re: consultation meetings 20/11/2008)

2.2 What people at the Bradford LINK development group meeting said

After the Bradford LINK development group meeting on 12th February 2009, we decided to help find out some of the information that was missing from the tPCT's report.

The Bradford LINK development group was worried that:

- 1) Most mental health service users cannot pay for respite care using direct payments.
- 2) There is not much information about respite care. Most of this is provided by the voluntary and community sector, and written information mainly comes from Making Space workers and staff at the Moor Lane centre.
- 3) Respite care is not always included in carers' assessments and care plans.
- 4) Planned breaks were all the same. They also did not use centres in and around Bradford, which would support the local economy.
- 5) People did not know about the home sitting service and the Shared Lives scheme, and what kind of help these services can give.

The Bradford LINK development group also said that:

- The questions should be more general and wide-ranging, asking about people's opinions of rehabilitation and respite care services in hospitals and health care centres or at home.
- The Bradford LINK team staff should ask questions in a face-to-face or group interview with people at events or meeting places used by their community of interest.

We wrote a summary of intent document and sent it to the tPCT on 27th February, showing the dates when the interviews would be finished (13th March) and the first draft of the report would be ready (31st March). The summary of intent document is shown at Appendix B.

Because of a small delay in answers from Making Space, the carers' support group, the deadline was put back from the 13th to 28th March.

3.0 What information was already there?

When we began planning this research, we looked at two other research reports, which helped us choose which questions to ask in our own report.

The Shepherd Taylor Partnership carried out the final report of its Carers Review, for Bradford and Airedale tPCT in October 2008.

The Carers Review: Final Report, commissioned in 2008 was partly about mental care services. The report gave a list of needs to the tPCT, including:

- 1) Making a single information access point for all carers' services.
- 2) Making and keeping information on the condition and needs of all carers.
- 3) Giving small grants to local carers' groups.

Bradford LINK wanted to find out more about voluntary and community (third sector) groups that help mental health service users and their carers. Although we did not ask a special question about voluntary and community service, many Bradford LINK participants thought that people would talk about the help that they got from their community of interest and that this would include help from voluntary and community groups.

Bradford LINK also believes that if the tPCT kept more information on these voluntary and community groups then it would be able to ask them more questions in the future. This would be very useful if the questions were only for one or two groups of people because the list would be big enough for the tPCT to choose the groups that it would be best to talk to.

At the beginning of February, we also found out about a research report which is still being written. This report is called Give us a break: the respite care survey and it is being written by the Bradford and Airedale Mental Health

Advocacy Group (BAMHAG) Link project. This report was begun at the end of 2004 and it is due to be finished by the middle of 2009. The report is asking:

- 1) How carers find out about respite care.
- 2) How much carers use respite care.
- 3) The different kinds of respite care needed by carers and mental health service users.
- 4) How mental health services can be more creative and flexible in providing breaks.

Up to November 2008, 21 carers and 9 mental health service users had completed questionnaires. So far the survey has said that not enough people know about the home sitting service (called Time Out) and the Shared Lives scheme, and what kind of help they can get from using those services. The report also said that people got information about these services at Moor Lane and less people might find out about them if Moor Lane was to close.

We found this report very useful and after reading it we chose to ask questions about respite care and direct payments in our own report.

Bradford and Airedale tPCT created a report called Achieving the best health for all: strategic plan 2008/2013. This report is important because it lists all the things that the tPCT want to do in the next four years.

The report has a “vision” section, which talks about mental health services and says:

“We will aim to include the measurement of service user determined outcomes in all service specifications.”

(Achieving the best health for all: strategic plan 2008/2013, p.8)

Within the “organisational objectives”, the report also says:

“We aim to systematically collect and respond to information that we collect from patients over the quality and experience of services.”

(Ibid, p.10)

This is really important because it shows that the tPCT wants to really listen to what people have to say and give people what they say that they want. Bradford LINK believes that the tPCT will read our report and listen to what people said to us about mental health services. By doing this, the tPCT will be able to understand what people want them to do better.

4.0 Proposition – what did we do?

Bradford LINK saw how important it was for us to help the tPCT choose how

to work with mental health services and who best to work with. We wanted to try and get as many views as possible from people to help the tPCT but we understood that we would need to keep asking questions in the future to make sure that people could keep telling the tPCT what they wanted if their needs changed.

We decided in February 2009 that the best way to do this was to ask people questions about mental health care a second time. This is called a **re-consultation**. We also decided to ask some different questions to fill in the gaps and the things that people had complained about in the tPCT report.

Just before we started the re-consultation, we held a Bradford LINK development group meeting on 12th February. During this meeting we had a discussion about mental health care. People wanted to be able to say what they really wanted (like keeping Moor Lane open) but understood that if the tPCT wanted mental health care to be better for everyone, then it might have to close Moor Lane. They said that what was important to them was good mental health care and that where that health care was based was not so important to them. This meeting, together with the useful results from the BAMHAG survey, showed us that we were travelling in the right direction by asking different kinds of questions to a wide range of people.

5.0 Methodology – how did we do it?

We saw it as very important to ask people questions who were not asked by the tPCT before. This is why we wrote a new set of questions. We also decided to visit people rather than hold meetings and have them come to us. The questions we asked can be seen in Appendix A. These questions were written for mental health and former mental health service users and their carers to answer. They asked if people preferred to be treated at hospitals and care centres or at home. There were also some questions about direct payments and carers. We wrote the questions so that they would be as simple to answer as possible. We then sent the questions to Nick Farrar and Joan Letotcha who work for Adult Services in Bradford Council for them to check and they told us that they were happy with them.

Finally, although we wanted to ask people and groups questions face-to-face, or by telephone, we thought that we might not have the time to talk to everybody in this way and so we created a written form of questions for people to complete. We made sure there were as few changes as possible to the questions so the answers that we got back would not be different.

To talk to as many people as possible, we looked at the “communities of interest” groups in the Bradford area that we thought would be most interested in answering our questions. Here are the groups that we decided to talk to:

Organisation	Target group/s	Date/s contacted	How they replied	Number of replies
Bradford Equity Partnership & Yorkshire Mesmac	Lesbian, gay and bisexual	19/02-04/03/09	Telephone	11
Bradford Speakout	Homeless or vulnerably housed people	02/2009	A Poster was supplied with details	0
MIND in Bradford	Mental health	04/03/09 13/03/09	Interview (Two separate groups)	13 men 12 women
MIND in Craven	Mental health	09/03/09	Written questions	1
Edmund Street Shelter	Homeless or vulnerably housed people	27/02/09	Interview	10
ISIS Project	Women and their children surviving mental distress	23/02/09	Interview	15
Making Space	Supporting carers	23/03-28/03/09	Interview	7
Out of Hours Project	Self-referral mental health group	02-06/03/09	Written questions	12
Sharing Voices	Former refugees & asylum seekers	25/02/09	Interview	8
South Asian Women's Mental Health Awareness Association (SAWHAA)	Mental health	03/03/09	Interview	2

We asked the Bradford and Airedale Mental Health Advocacy Group (BAMHAG) for advice on what questions to ask. This was very useful because they had helped a lot of people to give their views to the tPCT in the consultation. This meant that they had some good ideas about what had stopped people answering these questions.

We also sent our written questions to the Community Empowerment Network (CNet) and they sent these to people who we were not able to talk to face-to-face or on the telephone.

100 people talked to us and gave us their views.



(Daniel Park meeting Benoit Mussanzi from Sharing Voices)

We spent three weeks collecting the views that people gave us and you can read more about what they said in section 7.0 (page 17)

To make people's views easy to understand, Bradford LINK chose a kind of research method called **Grounded theory**.

Grounded theory is useful because it is based on what people have got to say and is not complicated. Many other people doing health research also use it for the same reason. It works best when asking questions to a small number of people (less than a thousand) because too many answers make it more difficult to understand what people want the most.

We would have liked to talk to more people than we did, but we needed to get the results and write the report quickly. This was because the tPCT was due to close Moor Lane on 31st March and we wanted to give it the results of what we had asked by that time. We also wanted the report that you are reading now to be written as quickly as we could. This would mean that the tPCT could see what we had done and think about how it might ask questions to find out what people want.

6.0 Learning points – what would we do differently?

We learned three things when we were asking people questions that we would like to tell the tPCT about. These will be useful for it to remember when it is finding out what people want:

1) Kinds of questions

We asked questions that did not stop people from answering in any way they chose. Eight of the eleven groups we talked to liked to be asked questions like this. One person from MIND men's group said:

“I want to tell people what I think, not what they think I should think.”

One problem with asking questions that can be answered in any way is that some people talked about other things. This meant that what they said could not be put into the report.

The tPCT asked questions that could only be answered in a few ways. Most people said that they did not like this and some did not answer because they felt they were not being listened to.

The best thing would be to ask questions that gave people more choice in answering than the tPCT had but not so that they could say anything, like we did.

2) Working quickly with “communities of interest”

Because we wanted to write this report quickly, we did not have the time to talk to everyone that we wanted to. We were also not able to talk to two groups of people properly because of this. The Cellar Project put up a poster to tell people about what we were doing, but nobody came back to us from this group. We did not have time to talk to Making Space, the carers' support group, until ten days before we needed to start writing the report. The group was unhappy with the questions we had asked, because they were not written well enough for carers. We put this right by asking questions for carers over the telephone, but this meant that we needed more time to interview people. We hope to get better at this.

3) Medical words in different languages

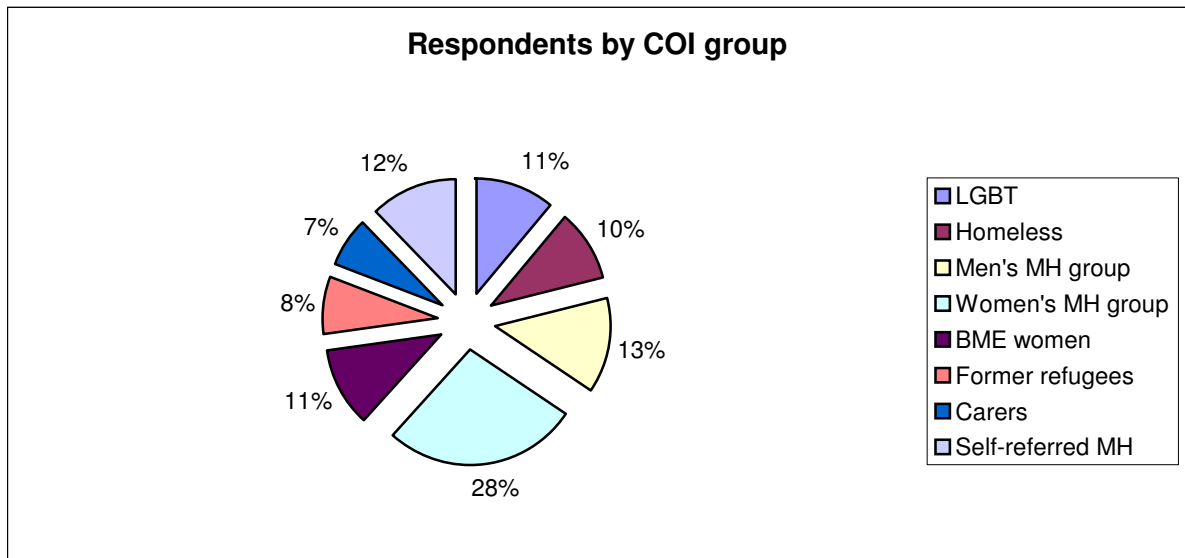
We heard translators saying the words “respite” and “rehabilitation” in English when they were talking to south Asian people in the Urdu language.

One of our translators said that there were similar words to “respite” and “rehabilitation” in Urdu. She did not use these Urdu words because not many south Asian people understood what they meant unless she explained.

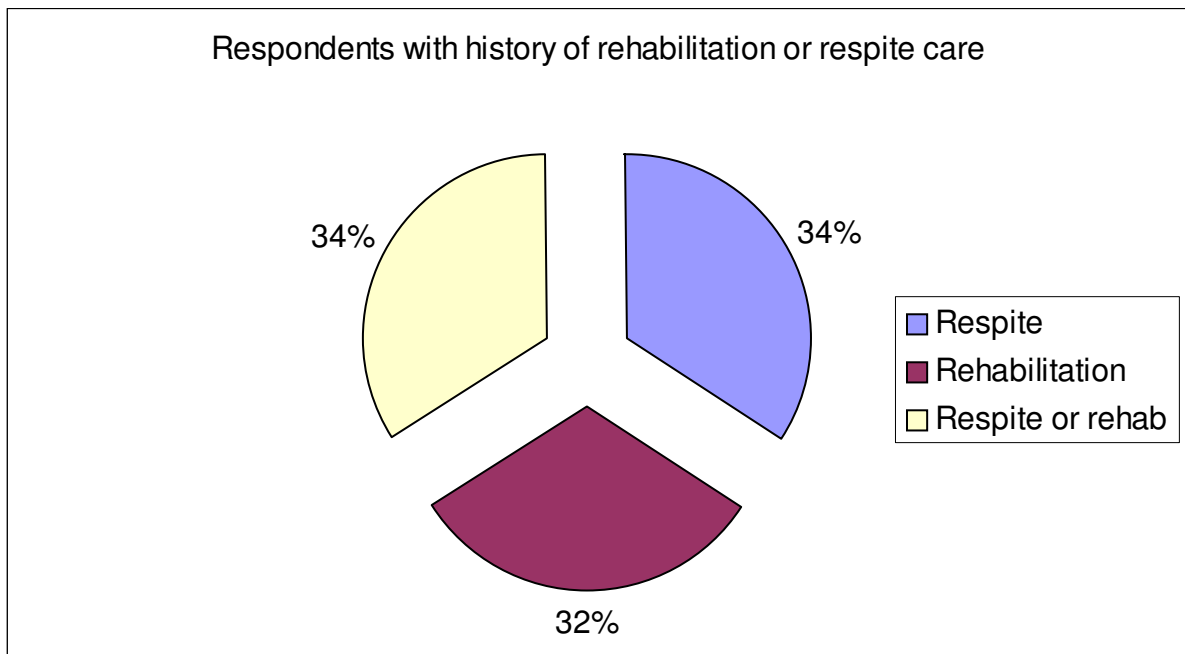
The tPCT might find it easier to learn what people want if it stops using long medical words with people who do not speak English.

7.0 Results: What we found out

This graph shows how many people the Bradford LINK interviewed from each “community of interest”:



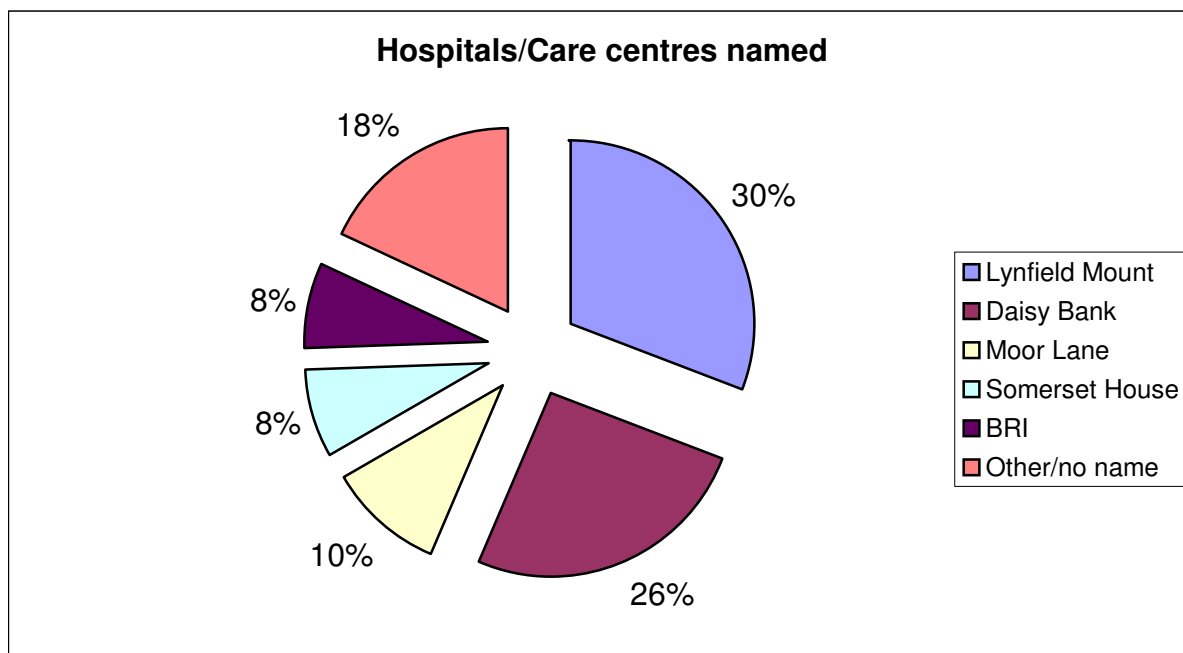
About one in three people had rehabilitation and one in three had respite care. The rest had one or the other.



7.1 Hospitals and care centres

Out of the **100** people asked, **24** people liked hospital and care centre care more and **37** liked home care more, with **21** people saying they did not mind. The rest did not answer.

Hospitals and care centres named during these interviews are shown in the graph below:



Some people thought they were well looked after in hospitals and care centres and others did not think this:

Moor Lane

“Yes, they were really nice – my partner, Cathy, came to see me and they seemed to be okay with that – though I suppose they could have mistaken her for a relative.”

68-year-old woman, self-identified lesbian, low-level dementia/Alzheimer’s (Moor Lane)

“Yes, exceptionally [friendly and supportive staff].”

Respondent from Craven MIND (Moor Lane)

“Yes, it was very nice to me, let me spend plenty of time with my husband [the patient being treated].”

Respondent from Making Space group (Moor Lane)

Lynfield Mount

“They were okay. I felt a bit like I was being processed, but I feel like that in all hospitals anyway, so maybe that’s the nature of being in hospitals, that you’re a product being processed, like cheese. Of course I didn’t talk about why I was poz to them – being poz is one thing, being gay is another.”

46-year-old white man, self-identified as gay, moderate depression and HIV positive “Central Bradford Hospital” (possibly Lynfield Mount or Daisy Bank?)

and Somerset House)

“There were cameras everywhere – you thought people were spying on you all the time, then if something went wrong – like a fight broke out, no-one came to help for a long time.”

Comments from 13 men, age range 31-58, Bradford MIND (Lynfield Mount)

“It just felt like a hospital to me – cold and stark and that’s how the staff were too, stand off-ish.”

33-year-old woman, self-identified lesbian, bipolar disorder (Lynfield Mount and Somerset House)

“It was a bit scary, the atmosphere. The staff were okay.”

20-year-old woman, self-identified as bisexual, depression and history of self-harm. (Lynfield Mount)

“Yes. Out-patients is quite calm, only a few people there at any one time.”

Man, (age undisclosed), vulnerably housed, previous history of drug use, suicidal thoughts and self-harm (Lynfield Mount)

Daisy Bank

“They were okay with me – I didn’t give them any hassle and they didn’t give me any hassle either. Very busy, they left a patient on a landing once, and the place could have done with a good clean.”

40-year-old man, personality disorder, substance abuse, depression, homeless, post-traumatic stress disorder (Lynfield Mount and Daisy Bank)

“It felt all a bit patched together, like they couldn’t treat all of me.”

49-year-old woman, self-identified as lesbian, with history of self harm and eating disorders (Daisy Bank)

“Yes, very nice hospitals, especially BRI.”

30-year-old East-European, homeless man, treated for drug abuse/suicide attempt – English skills not very good (Daisy Bank)

“They were okay. They took you places, like Pizza Hut and playing golf, and those were real treats, I enjoyed those more than the hospital.”

Comments from 13 men, age range 31-58, Bradford MIND (Daisy Bank)

Bradford Royal Infirmary (BRI)

“Yes, and they sent me somewhere else for other stuff too, the physical side – I went to BRI for that. BRI were good too, although they’d diagnosed me as diabetic and then put sugar all over my cornflakes!”

39-year-old man with substance abuse, depression, type 2 diabetic (Daisy Bank and BRI)

“They were sound the last time, really helpful. When I went for the first time after the suicide attempt they sneered at me, they treated me like a leper because I was homeless, but that’s all improved so much now.”

38-year-old, white man, substance abuse, previous history of suicide attempts, recently moved into own bedsit, previously 7 years homeless (Bradford Royal Infirmary)

Other hospitals/care centres mentioned

“It was a horror – people drinking and trying to hit you. Half the people there should have been sectioned and locked up.”

Comments from 13 men, age range 31-58, Bradford MIND (Rookwood Nursing Home)

“It was good as it was like being at home, but having someone to hand to help you if things started getting out of control – it was not like being locked up in a hospital. I felt in control and safe all at the same time.”

Comments from 13 men, age ranges 31-58, Bradford MIND (Block of assisted flats in Wheatley, Halifax)

“I wasn’t treated very well, I didn’t feel safe.”

One of eight former refugees and asylum seekers at the Sharing Voices event speaking of a mental health care hospital in Bradford tPCT

“They treated me like they treated everyone else, like I was on a conveyer belt of care. There was some personal consultations but I didn’t feel comfortable talking about my whole self, my sexuality, cause I thought that would just confuse things for them and maybe line me up for some kind of shit like aversion therapy or else they’d treat me differently – worse I mean. I think people do treat you differently you know, if you’re a lesbo. I mean they call you names in the real world, can you imagine what they’d do to you in the mental hospital?”

47-year-old white woman with psychosis, self-identified as lesbian (did not wish to disclose name of hospital)

“A hospital is an institution and I simply couldn’t handle that sort of impossibly oppressive atmosphere. It would be like being in the army or something, positively impermissible.”

29-year-old white man, self-identified as gay, mild depression (not been to a hospital, an opinion of hospitals)

7.2 Where hospitals and care centres are

We talked to people who had respite or rehabilitation care in hospitals and care centres within the Bradford and Airedale area. **13** thought that they were being treated close enough to home and **2** thought that they were not.

People that were happy:

“It was in the middle of Bradford so that was good.”

(40-year-old man - personality disorder, substance abuse, depression, homeless, post-traumatic stress disorder)

People that were not happy:

“Not really, no. It was difficult for my family to visit.”

(33-year-old woman, self-identified as lesbian, bipolar disorder)

“No, I would have liked to have been closer. I live near Keighley. Somerset House was better in terms of distance.”

(46-year-old white man, self-identified as gay – speaking of the “Central Bradford” hospital he was treated in, moderate depression and HIV positive)

People who were homeless or were former refugees and asylum seekers said that because they did not have a home, they did not mind where they were treated:

“I had to go somewhere, that was as good a place as any.”

(66-year-old south Asian man, homeless, episodes of psychosis)

Some people said that when they were really sick, it did not matter where they were looked after, as long as they were looked after properly:

“At the time I didn’t care where it was, just that it did the job and made me feel better. Location wasn’t the top button in my mind.”

(47-year-old white woman, self-identified as lesbian, psychosis)

“No, but that wasn’t necessarily a bad thing, the hospital [Moor Lane] was in the middle of nowhere, which is how I was feeling at the time.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

“Can’t say I was bothered by where the hospital was. I was in outer space at the time anyways.”

(51-year-old woman, self-identified as bisexual, schizophrenia)

“I wasn’t very close but we had him in that home because my grandma was there and it was a nice home.”

(Respondent from MIND consultation)

Some people also said that they were happy to go to a hospital away from their homes because they did not want other people to know they were in hospital:

“Lynfield Mount wasn’t very close to me – I live in the Bingley area, and I

wish it could have been a bit closer in some ways. But in others I didn't as I didn't want my family knowing about it – I just said that I had to go to hospital, and as I didn't look well they believed me. It was easier to say it was too far for them to travel than to tell them it was a local place and face the shame of them visiting me in a mental hospital.

(43-year-old mixed-race man, self-identified as bisexual, anorexic/bulimic with history of bipolar disorder)

7.3 What it felt like?

We asked people: **“Did the place where you went feel peaceful and calm?”** 20 thought the place where they were looked after was “peaceful and calm” and 12 did not.

People were happiest at Bradford Royal Infirmary, even though this is not a hospital known for looking after people with mental health needs. They were very unhappy at Lynfield Mount hospital. People liked Moor Lane but said that it was old fashioned.

Lots of people had things to say, so to make it easier to read we have listed everything that people said about how they felt by the name of the hospital they stayed in.

Lynfield Mount

“It felt like a prison – bars at the windows, everything.” Respondent from MIND consultation (Lynfield Mount)

“I don't remember, I was so out of it, but it couldn't have been bad, very bad, because if it had been very, very bad. I guess I would have noticed or complained or something. I honestly don't remember. I try not to think about that part of what happened.”

43-year-old mixed-race man, self-identified bisexual. anorexic/bulimic with history of bipolar disorder (Lynfield Mount)

“No, I felt scared being there.”

20-year-old woman, self-identified as bisexual, with depression and history of self-harm (Lynfield Mount)

“It was secure and that was the important thing. It took me a while to get over it when I was really out of it. Later I found that I wanted to get out of the closed-in feeling of a hospital ward.”

51-year-old woman, self-identified as bisexual, schizophrenia (Lynfield Mount)

“Yes. Out-patients is quite calm, only a few people there at any one time.”

Vulnerably housed male (age not disclosed), previous history of drug use, suicidal thoughts and self-harm (Lynfield Mount)

“It was a bit loud, lots of shouting and screaming, so no, not exactly peaceful.”

33-year-old woman, self-identified as lesbian, bipolar disorder (Lynfield Mount and Somerset House)

“Very busy, they left a patient on a landing once, and the place could have done with a good clean.”

40-year-old man, personality disorder, substance abuse, depression, homeless, post traumatic stress disorder (Lynfield Mount and Daisy Bank)

“Not really, it didn’t do much to make me feel like I was getting better. I was glad to get away, quite frankly.”

46-year-old white man, self-identified as gay, moderate depression and HIV positive “Central Bradford Hospital” (possibly Lynfield Mount or Daisy Bank? and Somerset House)

Daisy Bank

“It was busy, but it was a very busy place.”

38-year-old homeless man, substance abuse, depression, type 2 diabetic (Daisy Bank)

“Quite the opposite, it felt hectic at times.”

49-year-old woman, self-identified as lesbian, with history of self-harm and eating disorders (Daisy Bank)

“It was okay, the staff were quite good.” Respondent from MIND (Daisy Bank)

Moor Lane

“It was certainly peaceful and calm, although it felt a bit like a nursing home.”

61-year-old white woman, self-identified as lesbian, bipolar disorder (Moor Lane)

“It was very pleasant, a bit like a really old-fashioned sanatorium.”

68-year-old woman, self-identified as lesbian, with low-level dementia/Alzheimer’s (Moor Lane)

“Yes, very [peaceful and calm].”

Respondent from Craven MIND (Moor Lane)

Bradford Royal Infirmary

“It was very busy, so I can’t call that peaceful. Still they handled the stress very well.”

38-year-old, white man, substance abuse, previous history of suicide attempts, recently moved into own bedsit, previously 7 years homeless (Bradford Royal Infirmary)

“It was nice compared to what I was used to.”

66-year-old South Asian man, homeless, episodes of psychosis (Bradford Royal Infirmary and Lynfield Mount)

“Yes, very nice hospitals, especially BRI.”

30-year-old East European homeless man, treated for drug abuse/suicide attempt – English skills not very good

Other hospitals/care centres mentioned

“I was terrified all the time that I was going to get lamped. I was sharing my room with a wino psychopath.”

Respondent from MIND consultation (Rookwood)

“It felt like bedlam to me – sounded like it too. At night I almost got assaulted by this old bloke in the ward next door. The supervision at night was fing shit. They just sat in the staffroom and talked about soap operas or fell asleep. There were meant to be nurses around all the time – not as if I’d trust them if they were perched on my bed.”***

47-year-old white woman, psychosis, self-identified as lesbian (did not wish to disclose details of hospital/care centre)

7.4 How people felt that they were getting better in hospital

We asked people: “Did the care make you feel better or more able to live better at home?” **79%** of people said **yes**.

Some people who were not happy said that it was because they needed more time in hospital to get better:

“It was a good use of my time, but I could have done with 2 weeks there.”

Respondent from MIND consultation (block of assisted flats in Wheatley, Halifax)

Two people were very unhappy. One person did not name the hospital they were in. The other named Rookwood nursing home. Bradford LINK thinks that the tPCT should look at this care centre to make sure people are being looked after properly there.

Lots of people had things to say, so to make it easier to read we have listed everything that people said about how they felt by the name of the hospital they stayed in.

Lynfield Mount

“I suppose it did – I suppose the hardest bits were treated and I looked better afterwards. They did something about my weight there too and being in a hospital meant you couldn’t hide your food or stuff like that.”

43-year-old mixed-race man, self-identified as bisexual, anorexic/bulimic with history of bipolar disorder (Lynfield Mount)

“Yes I think some of the sessions did help, and the medication did as well. It also made my family take notice after my self-harming.”

20-year-old woman, self-identified as bisexual, depression and history of self-harm (Lynfield Mount)

“I guess it helped for a bit.”

24-year-old woman, homeless, depression, former suicide attempt, substance abuse (Lynfield Mount)

“Maybe some. I think I learned more later though because by the end of my time there I really wasn’t listening, I was trying to block them out instead.”

51-year-old woman, self-identified as bisexual, schizophrenia (Lynfield Mount)

“It was a good place. I liked it there, it made me feel better.”

66-year-old south Asian man, homeless, episodes of psychosis (Bradford Royal Infirmary and Lynfield Mount)

“They were okay – they helped me more than I thought they did when I first came out of there.”

40-year-old man, personality disorder, substance abuse, depression, homeless, post-traumatic stress disorder (Lynfield Mount and Daisy Bank)

“I think it helped but it was like three steps forward, two steps back.”

33-year-old woman, self-identified as lesbian, bipolar disorder (Lynfield Mount and Somerset House)

“Not particularly, I learned a few techniques but they could have put me on a training course to learn all that in a week, instead of a month being pushed around by nurses.”

46-year-old white man, self-identified as gay, moderate depression and HIV positive “Central Bradford Hospital” (possibly Lynfield Mount or Daisy Bank? and Somerset House)

Daisy Bank

“There was some positives that came from it, but what it really taught me was not to get to the point where I’m admitted as an in-patient.”

49-year-old woman, self-identified as lesbian, with history of self-harm and eating disorders (Daisy Bank)

“Gave me some confidence, yeah.” (Respondent from MIND consultation (Daisy Bank)

“Yes, they make me feel better.”

30-year-old East European man, treated for drug abuse/suicide attempt – English skills not very good (Bradford Royal Infirmary and Daisy Bank)

Moor Lane

“Yes, it gave me the chance to recharge my batteries as I was getting very ragged at home.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder (Moor Lane)

“Yes, I was getting very forgetful and upset with myself and they gave me some easy ways to cope, at least for now. I’m scared that I’ll get worse, but it’s a relief to feel better, and it’s a relief for Cathy [carer and partner] too – I’d hate to become a burden to her.”

(68-year-old woman, self-identified as lesbian, with low-level dementia/Alzheimer’s (Moor Lane)

Other hospitals/care centres

“It was a good use of my time, but I could have done with 2 weeks there.” (Respondent from MIND consultation (block of assisted flats in Wheatley, Halifax)

“All I wanted was to get out of there. I didn’t care if I’d healed up or not, I was getting worse in that shithole.” Respondent from MIND consultation (Rookwood nursing home)

“It got me out of the hospital quickly – mostly through me saying what I hoped they’d want me to say so they’d discharge me and let me back home. My carer suggested I went, and she was like really supportive of it. It broke my heart to think things had turned out so badly and I didn’t dare tell her how bad things got, so I just smiled at visiting and concentrated on getting out of that shitty place. I trust my carer so much, that was more or less the only time I ever had to lie to her, about that so-called respite care.”

47-year-old white woman, psychosis, self-identified as lesbian (did not wish to disclose details of hospital/care centre)

“They more or less wrote me off, dismissed me.”

“I had so many fears and problems I couldn’t concentrate on what they said. When English isn’t your first language, you have to try very hard and the constant talking made me give up.”

Two former refugees and asylum seekers (non-English speaking men) from Sharing Voices event (no hospitals stipulated)

7.5 What people thought about mental health staff visiting them at home

Of the **100** people asked, **31** had been visited by mental health staff at home

83% of people thought their home care visitors were friendly and helpful.

Things that were good

There were four things that people really liked about home care visitors.

1) Some people liked to feel in control over the way they were looked after by being at home. People who were gay, lesbian or bisexual were the happiest about this:

“I’d be in charge of my own life, not at the mercy of a hospital with all the timetables and doctors and group meetings where I had to pretend I was one of them.”

(47-year-old white woman, psychosis, self-identified as lesbian)

“It’s your world they’re coming into. I can have books and magazines there and stuff that shows I’m me and not just anybody else, and that’s important to me. Important to me that they recognise who I am, that they appreciate it and they acknowledge it.”

(51-year-old woman, self-identified as bisexual, schizophrenia)

“Home visits put the icing on the cake, but they also made the lettering kind of fancy, they let me talk about sexuality issues a bit more openly. After all, no-one’s going to tell you you’re a dyke in your own home – and if they did, I’d feel strong enough to order them out of my house. I couldn’t do that in a hospital.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

2) Some people felt that it was nice to have family around to help and comfort them at home when the home visitors were there. People who cared for others who were ill were happiest about this:

“I’m there when my husband gets treated – if he gets upset, I can be there for him.”

“Home treatment means we can get on with our lives, do the shopping, see friends, plan the day better.”

“I think the people who visit you at the house are more friendly. I can talk through issues with them either with my daughter, or away from her if I don’t want to get her upset – it’s just so much more a better atmosphere than in a hospital ward.”

(Comments from three individuals from Making Space)

“I feel more at home when I’m at home. My family also know I’m being treated and that makes them calmer.”

(20-year-old woman, self-identified as bisexual, depression and history of self-harm)

“I felt more in control at home, my partner appreciated it too. She could see that I was getting good treatment.”

(Respondent in MIND consultation)

“... because the family is there...help and support. If they can’t express themselves, the family could get involved. There would be more time to talk. You would get more of a one-to-one at home.’

One person did not agree with this view. She said:

“Often people live with extended families. Sometimes privacy isn’t there and if you have children, or you’re bedridden or you’ve got incontinency problems that’s really going to make things a problem. Meetings held in a front room because the patient couldn’t go up and down stairs. Lots of people sit in a front room.”

(South Asian woman in Grange Interlink consultation)

3) Some people thought that being visited at home was more convenient than having to go to a hospital or a care centre:

“...it’s easier for people to come and talk to me and help me at home. It’s like going to the minimart instead of the supermarket, I can get what I want without having to leave the street, but if I needed something really special then I’d need to go further and I’m happy with that choice.”

(43-year-old mixed-race man, self-identified bisexual. anorexic/bulimic with history of bipolar disorder)

4) Finally, one person said that her home visitor was nice and did not use complicated language:

“The people that come visit me are much more touchy-feely, and they don’t use those technical words so much. I think I prefer to be talked to and not talked at.”

(33-year-old woman, self-identified as lesbian, bipolar disorder)

Things that were bad

There were four things that people did not like about home care visitors.

1) Two people said that they were worried their home visitor might change. They did not want to have to talk to another person about their problems and have to say what they had already said to somebody else:

“I’m happy with the way things are going there, but if it could be better, it would be that she can’t be sure if I’ll keep getting her as a visitor or

not and I'm worried I'll have to start over again with someone strange or that I won't like the next person."

(20-year-old woman, self-identified as bisexual, depression and history of self-harm)

"You get fed up of reliving the emotions you are going through to different people."

(Respondent - south Asian women, non-English speakers - from the ISIS consultation group)

2) Some people were unhappy because they could not get regular visits from their home visitor:

"There were some times I wanted to see them and they couldn't make it and other times when they wanted to see me and there were family round but we meet up in the middle."

(43-year-old mixed-race man, self-identified as bisexual. anorexic/bulimic with history of bipolar disorder)

"...it's no good when they call and say they can't come because they're not feeling very well and then you're on your own. Cathy [the interviewee's carer and partner] is okay with them coming, but when they cancel I get upset, so then she gets upset. They can't cancel if you go to a hospital – it's there, it's bricks and mortar, they can't pack it up and go away, they have to deal with you then and there."

(68-year-old woman, self-identified as lesbian, low-level dementia/Alzheimer's)

'I've had no choice. My worker has a bad back so she can't come to me. She was supposed to be coming today but she's poorly. It's no good when you're dependent on people ringing.'

(Respondent - south Asian woman, non-English speakers - from the ISIS consultation group)

"... it took some arranging, they kept giving excuses why they couldn't come to start with."

(Comments from three individuals from Making Space)

3) One person said that he did not get home visits at first because people did not think his mental health needs were important enough:

"I rang the doctor for help and he said it wasn't an emergency and I had to call twice more before anyone would come out. When they came out though, that was fine."

(39-year-old vulnerably housed man, substance abuse, depression, type 2 diabetic)

4) One person did not want home visits because she did not trust people who came to her home:

“People who come to other people’s homes are wanting to pry, people looking for benefit scroungers and shit like that. I wouldn’t let them in my door if I had one.”

(24-year-old woman, homeless, depression, former suicide attempt, substance abuse)

People who did not have a home

Some people said they could not have a home visitor because they did not have a home:

“I don’t live in a permanent home. How could they come visit me?”

(Former refugee and asylum seeker, Sharing Voices consultation)

“I’ve not got a home so visiting me at home would not happen.”

(22-year-old homeless man)

“I think I’d prefer home now, but when I was homeless I’d have had to visit as an out-patient.”

(38-year-old white man, substance abuse, previous history of suicide attempts, recently moved into own bedsit, previously 7 years homeless)

One homeless person who we spoke to at the Edmund Street centre said homeless people might be able to use the centre as a place for home visitors to see them:

“I’m homeless, nowhere for them to visit, unless they used the [Edmund Street] centre somehow.”

(40-year-old man, personality disorder, substance abuse, depression, homeless, post-traumatic stress disorder)

7.6 Cultural views of home visitors

People had different views about health visitors when it came to their culture and background. One person who is a former refugee and asylum seeker did not want a home visitor:

“I share with other people – I would be embarrassed to have doctors in the house.”

Two other former refugee and asylum seekers said that they would choose a home visitor:

“Culturally it can be more acceptable to be treated at home.”

“Hospitals are places for the really sick. My family at home would have a friend to visit instead.”

Three people said that they choose to talk to friends and look after their own health rather than going to a hospital or seeing a health visitor. We will talk more about people getting help from friends from “communities of interest” groups in Section 8.1 (page 38).

“...more likely than not I’ll go see my mates and ask them about it – I believe in taking time and letting illness run its course with things from the chemist and advice from other people who’ve had it.”

(22-year-old homeless man)

“So as far as I’m concerned, I’d rather I wasn’t looked after in any of these settings, I’d rather look after myself with the help of others.”

(46-year-old white man, self-identified as gay, moderate depression and HIV positive)

“I’d rather be in a group of like-minded people in my local group, than in a care setting. I’ve got people who understand me there, and why I’m feeling upset sometimes – people who can have a bit of sympathy... the company of my gay friends keeps my destructive feelings back.”

(38-year-old woman, self-identified as bisexual, borderline depression)

7.7 Care in hospital/care centre vs. home care visits

Although **73%** of people said that hospitals and care centres were “friendly and supportive” and **64%** said they were “peaceful and calm”, a lot of people said that they were not happy with how they were looked after in hospital.

One person said that hospitals and care centres might not be as good as home visitors for looking after some people who were not well:

“Hospital is good when you are really serious but sometimes they keep you longer than necessary and you would be better at home for mild depression or long-term conditions.”

(Notes from interview with nine Asian women, mainly non-English speakers, Roshni Ghar group)

Another two people said that home care was better for some people with mental health needs that are not too bad or if the person needed looking after for a long time.

“I think people visiting at home are better if the condition isn’t serious. If they diagnose worse problems, then you should be taken to the hospital or other treatment centre.”

(Former refugee and asylum seeker, Sharing Voices consultation)

“I preferred the hospital for my respite, but after that it was helpful to have the home visits which I used to get. I don’t get them so much now, my medication keeps me on an even keel.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

Only **36%** of people believed that hospital and care centre staff were “better” than home visitors.

The people who thought hospital and care centre staff were better said it was because they had more medical knowledge than home visitors:

“I think the experts would be in the hospital.”

(22-year-old man, homeless, no history of mental illness)

“I think there’d be more specialists [in a hospital] to help me.”

(40-year-old man, personality disorder, substance abuse, depression, homeless, post-traumatic stress disorder)

“Hospital people have the right drugs and things, visitors just talk.”

(Respondent in MIND consultation)

“I guess they [hospital staff] know about restraint and stuff and tablets at the hospital more”

(51-year-old woman, self-identified as bisexual, schizophrenia)

Some people, who said that hospital and care staff had more medical knowledge, then said that home visitors were more helpful and friendly.

“I’d say a person in a hospital would know more because they’ve got all the qualifications, but the person visiting would be friendlier.”

(38-year-old, white man, substance abuse, previous history of suicide attempts, recently moved into own bedsit, previously 7 years homeless)

“[A home visitor would] Know you better; know your moods and you are in your own environment.”

(Man, (no age given) vulnerably housed, previous experience of using mental health services)

“I guess they know different aspects of me. The hospitals know more about drugs and treatments, the home visitors know more about talking and sympathy”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

Two people did not like the way hospital staff talked to them. They said hospital staff made them feel stupid or not important to them:

“I think I trust my home visitors more, but respect them less...[they] know all the technical terms for things, all the medical phrases, and they

talk like that as well – they talk over you like you’re not even there. You get the feeling they know what they’re doing but they don’t care if you like it or not. When they ask questions of you it sounds really patronising.”

(33-year-old woman, self-identified as lesbian, bipolar disorder)

“I think hospital doctors treat lots of people at once at a kind of distance and they speak all stuck-up, like – home visitors are more personal and make time for you, and I like that.”

Respondent from Making Space group (Moor Lane)

64% of people said that they would like to be visited at home and not at a hospital or care centre for rehabilitation or respite care. **83%** of people who had been looked after by home care staff said that they were “friendly and helpful”.

Many people said that having home visitors made them feel comfortable and in control of how they were looked after:

“[I prefer home visits] Because I’d be in charge of my own life, not at the mercy of a hospital with all the timetables and doctors and group meetings.”

(47-year-old white woman, self-identified as lesbian, psychosis)

“I felt more in control at home, my partner appreciated it too. She could see that I was getting good treatment.”

(Respondent in MIND consultation)

“...it’s good to get treated here where you’re comfortable.”

(22-year-old man, homeless, no history of mental illness)

“I feel more at home when I’m at home. My family also know I’m being treated and that makes them calmer...I’d rather I was visited at home, to stop me getting to the point where I have to go to hospital again.”

(20-year-old woman, self-identified as bisexual, depression and history of self-harm)

People who looked after others said that that home care was better for the people they cared for:

“A hospital isn’t a break for them or for me, as I’m going to have to visit them and I’ll be worried sick about them when I’m not – if you’re going to give me a break, give me a break with home visitors doing the caring for me.”

“A home visitor can talk to my daughter for an hour and I can get a good break that way. I also take her to a centre that I trust where she gets looked after whilst I’m taking care of things in the house or time out for me.”

(Respondents from Making Space group)

One person said that other people might not want to be treated at home. He said it might be better for them to get treated away from their home, but not in a hospital:

“I prefer home [care] myself, but I can understand if you can’t stay at home, if your family or parents are at home, then you need a home-like place away from your home. I’m not sure what that would look like though – it wouldn’t be a hospital.”

(43-year-old mixed-race man, self-identified as bisexual. anorexic/bulimic with history of bipolar disorder)

Three people did not want to go to a hospital because they had bad experiences of them:

“I think I’d only want to go into hospital for a medical complaint. Mental hospitals conjure up images of madhouses.”

(29-year-old white man, self-identified as gay, mild depression)

“It’s shaming to be taken away to a hospital.”

(Respondent in MIND consultation)

“I don’t trust hospitals. I had bad experiences of hospitals in my country.”

(Former refugee and asylum seeker, Sharing Voices consultation)

Two people said that being looked after at home was better because home visitors could see what was wrong with them in the place where they lived:

“I often feel at my worst in these four walls so it feels more practical them helping me where I’m stuck.”

(49-year-old woman, self-identified as lesbian, with history of self-harm and eating disorders)

“I think it would be helpful for professionals to see my home environment and would prefer to be seen at home....”

(Man (no age given), vulnerably housed, previous history of drug use, suicidal thoughts and self-harm)

One person was very upset about being looked after in hospital because she was afraid that her children would be taken away from her:

‘If they put me in hospital and take me away from my kids, I’ll take my life.’

(Woman, from the ISIS consultation group)

67% of people said that it was easy to talk to people at home.

85% of the people who did **not** say it was easy to talk to people at home were south Asian women.

We will talk more about this in Section 8.2 – “Problems for people from different “communities of interest”, on page 41

7.8 How home care might be made better

People had less to say about this than other things we asked. Former refugee and asylum seekers and carers said the most.



(Daniel Park and Kerefalla Sidebay (volunteer and respondent) at Sharing Voices consultation event)

Most of the former refugees and asylum seekers talked about problems with translation, because they only speak French. They did not want to have to talk to other home visitors about their problems if they had already talked to somebody else. They also thought that some home visitors did not believe what they said:

“It was all smiling and nodding. I asked for help because I didn’t understand English very well but I didn’t get anyone to help me and they didn’t come back.”

“Someone came and I told them all my problems. Then a different person came and I thought, I don’t want to be doing that all over again, it’s just making it worse like watching the horror over and over. I can’t get it out of my head, why should I make it worse by repeating it over and over to different people?”

“I told them that I never got any help. That I came here to be safe, but all I got was ignorant people who disbelieved me. Why did God put me in

this place? Why am I here and lonely and that I wanted to kill myself and they listened but they didn't offer me any of the help I needed.

(Former refugee and asylum seekers, Sharing Voices consultation)

A homeless person also said that home visitors did not always believe him:

"The health visitors could believe me the first time when I have a problem instead of telling me it's not important to them."

(39-year-old man, homeless, substance abuse, depression, type 2 diabetic)

Lesbian, gay and bisexual people were worried about having to repeat things to different home visitors as well. They were worried that they could not trust home visitors they did not know to understand their issues:

"I don't think there's anything else they could do – but they keep changing the people who come and see me. That can be good sometimes, but there are other times you don't like the look of who they've sent – they look a bit kinda dodgy or something and you ask for ID and then they look at you like you've done a big shit on their shoe [laughter] and they're all standoffish and shit when they're talking to you, especially the women – ugh!"

(47-year-old white woman, self-identified as lesbian, psychosis)

Some lesbian, gay and bisexual people said that mental health visitors did not know enough about their "community of interest" We will talk more about this in Section 8.2 – Use of "communities of interest" groups which is on page 41.

People said that they might not be able to see home visitors when they needed them:

"It would be good if I could talk to them over the phone sometimes instead of just face to face. There are times when there's family weddings and funerals and things and I can't see them and I get under a lot of pressure so it would be good to talk to them then. Sometimes it feels that the family stop me from seeing them when I need them the most, you know."

(43-year-old mixed-race man, self-identified as bisexual. anorexic/bulimic with history of bipolar disorder)

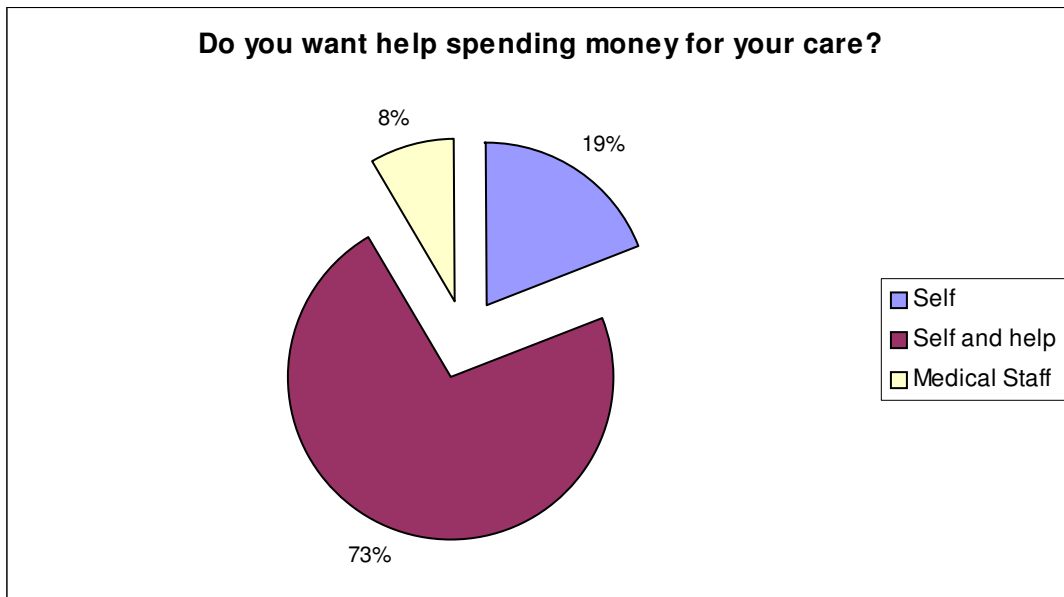
"I think I need them back for a while, I'm feeling a bit on edge at the moment. I think it's all this bad news on the TV, it gets you upset for other people, and then for yourself"

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

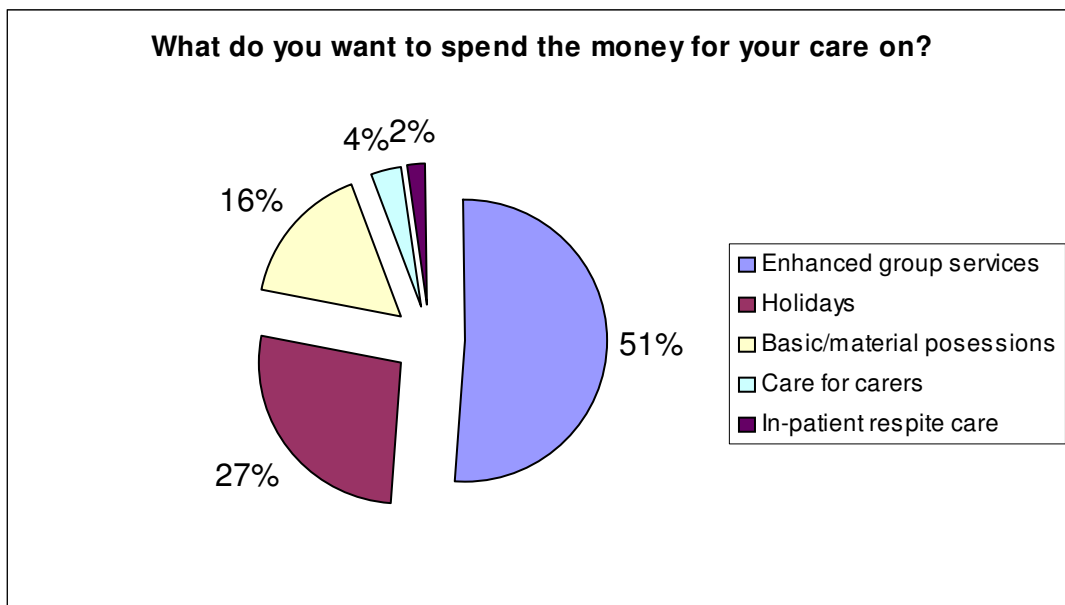
7.9 Self-directed care

The last questions we asked were about how to manage money that might help with respite and rehabilitation. **This is called self-directed care. 73%** of people talked to us about this.

Only **14** people thought they would be able to choose what to do with their money by themselves. **53** people said that they would like help from friendly people to make these choices. The **53** people included **6** out of the **7** people who were carers, who said they would like to choose what to do with the money that belonged to the person they looked after.



Half the people we talked to (**50%**) wanted to spend some of their care money on the places where people from their “communities of interest” go to enjoy themselves.



Most other people said they wanted to spend their money on things that they need to live on or holidays:

“...a place to stay, warm clothes, better food, so I look respectable and people give me some respect.”

(40-year-old man, personality disorder, substance abuse, depression, homeless, post-traumatic stress disorder)

“Yes I’d like to go on holiday very much. I’ve not had a holiday since Alice [carer and partner] died.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

Two carers wanted some rest for themselves. We talk more about this in section 8.3, page 43

Just one person (who uses Moor Lane) wanted to spend her money on respite care in a hospital.

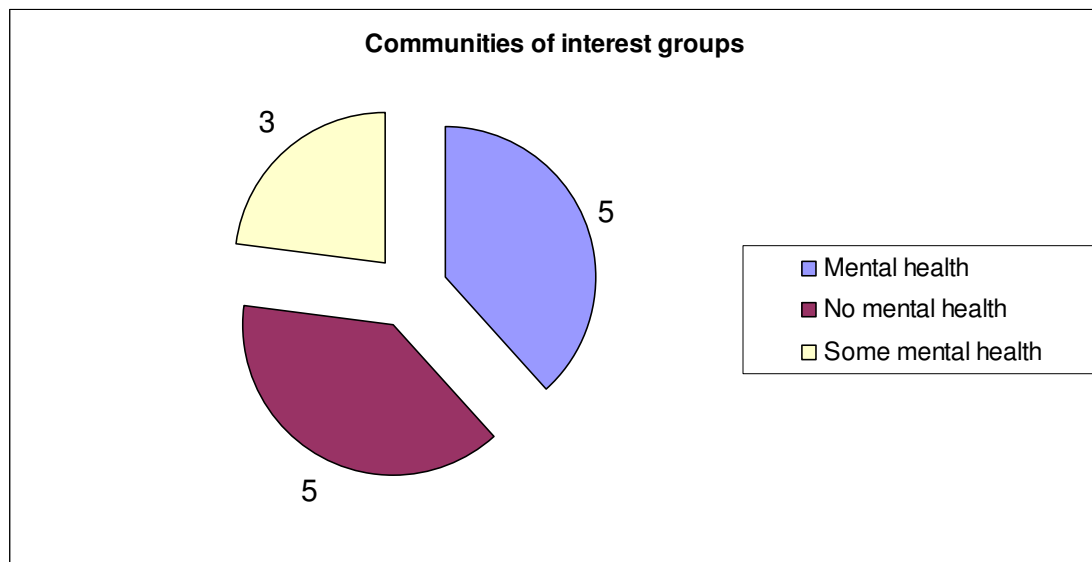
8.0 Themes

8.1 Use of “communities of interest” Groups

A lot of people told us how important voluntary, community and self-help groups for their “community of interest” were to them.

Voluntary and community groups are sometimes called the **third sector**.

Bradford LINK tried to talk to “communities of interest” groups that were set up to help people with mental health needs. Five of the groups we talked to were like this, but another five were not, and three worked for people with mental health needs sometimes, but were open to everybody:



We found that people did not care why the group had been set up. They were more interested in the help they got from the group and many people said that were very happy with this help.

People talking about help they got from groups for people with mental health needs:

“I prefer to talk to social groups like Sharing Voices, that’s better than any medicine.”

“I got a lot of advice from the ethnic minority lady worker here [Bradford MIND] who was really excellent – really good for helping me out and I’m on an even keel now.” (MIND women’s group)

“It’d be better if drop-in centres like this [Bradford MIND, Tradeforce building] were open more. People say we just sit around and talk, but it’s the best way to keep sane. I don’t think hospital people realise how good it is to spend time here.” (MIND men’s group)

People talking about help they got from groups that are not for people with mental health needs

“You support each other when you are here [Grange Interlink]. It’s about socialising, having a chat, a laugh and a moan. It’s a form of respite community home... It’s about social contact and it’s a form of improving people’s mental wellbeing before it’s got to that stage of total bizarre.”

“I come here [Edmund Street centre] to feel better.”

Lesbian, gay and bisexual people were the happiest with the help they got from “Communities of interest” groups:

“I’d rather be in a group of like-minded people in my local (LGB) group, than in a care setting. I’ve got people who understand me there, and why I’m feeling upset sometimes – people who can have a bit of sympathy. I guess if I got really bad, I’d need stronger stuff, but the company of my gay friends keeps my destructive feelings back. Home visits would feel isolating, as if it was just me who had the problem.”

(38-year-old woman, self-identified as bisexual, borderline depression)

“I prefer being visited at home, but I also like the LGB group I go to for my friends, that’s healing for me too.”

(33-year-old woman, self-identified as lesbian, bipolar disorder)

“I also go to social groups for other gay and bi people in the area, and I find that they’re supportive in ways the mental staff can’t be. Queers have their own family.”

(51-year-old woman, self-identified as bisexual, schizophrenia)

“...once my meds were balanced it tended to become more that I went places to socialise with other poz [HIV positive] guys...”

(46-year-old white man, self-identified as gay, moderate depression and HIV positive)

Lesbian, gay and bisexual people also said that hospitals and care centres needed to take more notice of their needs:

“Perhaps a supportive care centre would be okay, but it would have to be somewhere gay-friendly, based in the Equity Partnership or a similar help centre environment.”

(29-year-old white man, self-identified as gay, mild depression)

“Hospitals are alien places. A comfortable care centre would be okay, but I’d prefer to go to my local LGB group.”

(38-year-old woman, self-identified as bisexual, borderline depression,)

“It took me a long time to come out and in a way it’s a bit irritating that no one suggests some kind of older LGB group I could go to with Cathy, it’d be fun.”

(68-year-old woman, self-identified as lesbian)

“It would have been good if they’d known about groups and centres for poz people in the area. That would have added to the gen I already had from the HIV clinic, but they didn’t seem to know that kind of stuff at all.”

(46-year-old white man, self-identified as gay, moderate depression and HIV positive)

Many people who belonged to a “communities of interest” group that helped them asked for more help and money to be given to that group. This was so the group could open for longer and give people different kinds of help:

“The only problem is, this place is women only Friday to Sunday so the weekends are really isolating. Nothing happens anywhere on Sundays and I’m stuck on my own, that’s when I start self-harming. I think they didn’t realise that when I was isolated, and there was nowhere to go to at the weekends, I would self-medicate on booze and drugs. I told them that, but it didn’t sink in that I had nowhere to go. I mean there’s the public libraries in Shipley and Bradford, and Bradford Community College, but they’re not special drop-in centres like here.”

“We need this place to be open more, and to people, both men and women, all the time, and we need to have the staff here as well. This place is somewhere I feel safe and it’s got to be cheaper than us being in hospitals and things. I think we should all club together and use some of the money to buy the centre a minibus for the centre so we could go on outings together.”

(MIND men’s group)

“Group would like more funding to Roshni Ghar to pay for reflexology, massage, physiotherapy, cooking, socialising and trips and outings.”

(Notes from interview with nine Asian women, mainly non-English speakers)

“More social events for people like us held by Sharing Voices. More money to hold these. Music, dance, time to chat about where we came from, our experiences, people with the same culture.”

(Comment from interview with nine non-English speaking former refugees and asylum seekers, Sharing Voices event)

One person said that she got some money to help run a group but had problems dealing with the **paperwork**. Paperwork is the way that the people who give out grants check that the money is being spent properly. It is important for everyone to understand that if groups get more money then it must be easier for the people who run these groups to know how to deal with the paperwork:

“I got a small grant but I couldn’t cope with the paperwork. We have a right good time but I’ve been without funding now for nearly two years but I couldn’t cope with all the receipts. It was a packet of biscuits here and cheese slices there. You’re supposed to keep the receipts but I can’t keep my own receipts.” (MIND women’s group talking about Monday Night Group at Walker House).

8.2 Problems for people from different “communities of interest”

People who came from a “community of interest” with a different culture or background sometimes said that it was difficult for them to use home carers:

“I don’t think people are going understand my culture if they don’t have any background. They can’t speak my language, how could they know anything else about me? There’s a training need there.”

(Respondent, non-English speaker from Roshni Ghar, Asian women’s group)

People said that if home carers did not understand how they were different, then they would not be able to make them better:

“They could be more responsive to my needs – I don’t feel comfortable even now talking about my sex differences and they’re kind of key to some of my problems. “

(49-year-old woman, self-identified as lesbian, with history of self harm and eating disorders)

People also said that coming from a “community of interest” sometimes made it more difficult getting to a hospital or a care centre:

“[I would prefer to be treated] At home because at hospital you have to sit and wait and that can be frustrating. A lot of people like us won’t go particularly if they are suffering. They won’t make that initial step unless there is transport available.”

(Grange Interlink respondent, south Asian woman, English speaker)

People from two “communities of interest” groups said that they might not be listened to by the people in hospitals or by home visitors. They worried that people who were in charge would not believe what they said:

“The health visitors could believe me the first time when I have a problem instead of telling me it’s not important to them.”

(39-year-old man, homeless, substance abuse, depression, type 2 diabetic)

“...the doctors and nurses often didn’t believe me because I was African and didn’t speak their language well enough. They didn’t think I had a problem because it wasn’t a physical problem.”

“They just didn’t believe me. They didn’t want to believe me.”

“I don’t trust my solicitor [either] and I see him on an individual basis. They all think we [people from Africa] are liars.”

(Two former refugees and asylum seekers (non-English speaking men) from Sharing Voices event)

One person said that coming from a different culture made it difficult for her to find a place to talk to a home visitor without other people listening:

“Often people live with extended families. Sometimes privacy isn’t there and if you have children, or you’re bedridden or you’ve got incontinency problems, that’s really going to make things a problem. Meetings held in a front room because the patient couldn’t go up and down stairs. Lots of people sit in a front room.”

(Grange Interlink respondent, south Asian woman, English speaker)

Another person from a different “community of interest” group said that she was happy being visited at home. This shows that different groups have different needs:

“The people that come visit me are much more touchy-feely, and they don’t use those technical words so much. I think I prefer to be talked to and not talked at.”

(33-year-old woman, self-identified as lesbian, bipolar disorder)

There were a lot of people from “communities of interest” who said they could be themselves with a home visitor more than they could at a hospital. Here are two people talking about good things that happened with home visitors:

“Now I trust one of them enough to tell them about my family and that they want me to marry and stuff and the problems I have with that. He understands more about it and although I’m not sure he can do anything about it – I mean it’s the family after all – it’s great to be able to talk to someone who understands me completely after all this time.”

(43-year-old mixed-race man, self-identified as bisexual, anorexic/bulimic with history of bipolar disorder)

“...they let me talk about sexuality issues a bit more openly. After all, no one’s going to tell you you’re a dyke in your own home – and if they did I’d feel strong enough to order them out of my house. I couldn’t do that in a hospital.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

Here are two people talking about bad things that happened with people in hospital:

“I held things back from them, I didn’t talk about my feelings fully. I didn’t want to disclose my sexuality to them, there were other people in the rehab groups talking and it was embarrassing talking about sex stuff. There was this obsession about talking about it, I thought – I was biting my tongue.”

(51-year-old woman, self-identified as bisexual, schizophrenia, speaking of treatment at Lynfield Mount Hospital)

“One staff member – I think she was in the kitchens - said something about being HIV positive being a punishment from God, and I thought, “I’m glad I didn’t say I was gay too, or they’d have got out the burning crosses.” I was really scared she’d find out and I’d get a dodgy sausage or something worse.”

(46-year-old white man, self-identified as gay, moderate depression and HIV positive, no hospital clearly identified, but references given to Somerset House)

People with different religions said that it was important their needs were taken care of in hospitals and care centres:

“Hospitals/care centres would have to have single-sex facilities, right food and prayer rooms, workers that understand the culture.”

(Grange Interlink respondent, south Asian woman, English speaker)

Some people from “communities of interest” were happy that they were better looked after in hospitals than they used to be:

“They were sound the last time [I was admitted to hospital], really helpful. When I went for the first time after the suicide attempt they sneered at me, they treated me like a leper because I was homeless, but that’s all improved so much now.”

(38-year-old white man, substance abuse, previous history of suicide attempts, recently moved into own bedsit, previously 7 years homeless)

8.3 Caring responsibilities

We asked some questions about people who looked after other people. These people are called **carers**. We wanted to know if carers wanted the people they looked after to stay at home or go to hospital when they felt bad:

Of the 7 carers we asked, only 1 wanted the person he cared for to go to a hospital or care centre.

Two people said that going to a hospital would make it difficult for people to visit :

“I live with mum and dad, they’re not my carers as such. They prefer me to be at home though because it was a long way they had to drive to visit me and the parking wasn’t good. It’s not a good start when you’re really feeling manic to hear your mum and dad grumbling about finding a parking space before they even ask how you are.”

(33-year-old woman, self-identified as lesbian, bipolar disorder)

“I wouldn’t want to be separated from my daughter.”

(Comments from 13 men, age range 31-58, Bradford MIND)

Most people said that being treated at home would be much easier for them and for the people who looked after them:

“My mum and dad prefer me to be visited at home, they don’t like to see me in a hospital. I was at my worst when I was in the hospital and it upset me and them to be there, to see me there.”

(20-year-old woman, self-identified as bisexual, with depression and history of self-harm)

“When I had my suicide attempt at 18 I had my mum and dad and I think it was better to be in hospital then as I was really ill and they had to pump all the drugs out of me and everything.”

(38-year-old, white man, substance abuse, previous history of suicide attempts, recently moved into own bedsit, previously 7 years homeless)

“My carer is in a relationship with me – off and on. Sometimes when things get bad it would be good to have a break, but not in a hospital. I’d want to go somewhere else to treat myself, or send her somewhere else to treat her – hospital isn’t good for either of us, I’ve found out.”

(47-year-old white woman, self-identified as lesbian, psychosis)

Some people said that when they were really feeling bad, being looked after in a hospital or a care centre was better for them and their carer. They said that once they were feeling better they wanted to be treated at home again:

“...when I’m really bad it’s best we take a break from each other and go to Moor Lane. Most of the time though I’m perfectly well enough to be seen to at home.”

(68-year-old woman, self-identified as lesbian, with low-level dementia/Alzheimer’s)

“My carer died four years ago, she was my partner. She needed the break when I was really bad and needed to go into respite in Moor Lane, but once I’d had the course of treatments she was really happy that I was back home and that there were home visitors there. She used to say

“If you can’t talk to me about your special problems, then at least you’ve got someone who comes once a week who does understand” and I think between them – my partner and my visitors – I really had the best of both worlds.”

(61-year-old white woman, self-identified as lesbian, bipolar disorder)

The MIND women’s group and Making Space, the carers’ support group, were happy to talk more about looking after other people.

The women from MIND said that they looked after their friends from their “community of interest” like they were a family:

‘I’m in supported housing but I’ve had no formal assistance at all. We have a warden but that’s it, full stop. So, it’s important that we support each other and look after each other. I help this other lady – I do her shopping because I have a car and take her to the post office because she can’t walk far... ‘It’s like a circle, isn’t it? You help them then they help you.’

(MIND women’s group)

This group of friends looking after each other is the same as we saw with the lesbian, gay and bisexual people who we talked to.

6 out of the **7** people from Making Space, the carers’ support group, said that they also wanted respite care for themselves. It is important to understand that people who look after others need some time to look after themselves.

People who looked after others said:

“If the care centre was a good one, then I’d consider it – but I prefer respite care to happen at home, and for me to go away instead.”

“...if you’re going to give me a break, give me a break with home visitors doing the caring for me.”

“To be frank, I’d like some of that money to make ME feel better, I could do with a break from my caring just for me, even if it was for just a few days. I’ve not had a proper break for years.”

(Respondents from Making Space group)

9.0 Recommendations – what people want the most.

We chose those things that people said they wanted the most to make a list of recommendations.

A lot of mental health service users and their carers said that they would prefer to be looked after at home. They said that they wanted hospitals and

care centres to stay open so that they could be looked after when they first needed help and when they were feeling very bad.

The tPCT's Strategic Plan 2008-2013 and the Bradford and Airedale tPCT Meeting of the board (Appendix A), agrees with what we found people said to us:

“...we will move from the current model of care that relies too much on inpatient and institutional models of care to one which is characterised by the design of services around the needs of individuals.”
(Achieving the best health for all: strategic plan 2008/2013, p.96)

“Building on the work already begun, specialist services will be redesigned to increase the provision of community-based services that meet service users’ needs in or nearer to their own home, rather than in older style bed based approaches to treatment.”

(Bradford and Airedale Teaching Primary Care Trust: Meeting of the board of directors on 27 January 2009: Appendix A - Proposed changed to adult psychiatric inpatient respite and rehabilitation services)

Most people said that they went to voluntary and community (third sector) groups to feel better. This was because they had the same culture or background (“community of interest”) as the other people in these groups and could talk about their feelings better. We believe that going to these groups helps people feel better and adds to the help that they get from hospitals and home visitors. The Strategic review of adult mental health services in Bradford and Airedale 2008 (quoted in section 2.0 of this report) and the tPCT's Strategic Plan agrees with what we found people said to us:

“We expect the next five years to see provision of care...from across the extended primary care, independent and third sectors that are looking to develop efficient, high quality services.”

(Achieving the best health for all: strategic plan 2008/2013, p.95)

People said that doctors and nurses were not as good at knowing about their background and culture. Some people even said that the groups that they go to are so important to them that they would want give these groups some of their own money for self-directed care to help the groups open longer and give more help.

From what we have learned, we think that this should happen:

- 1) Rehabilitation and respite mental health care should continue to focus on providing home care, but people should still be able to go to hospitals and care centres when they begin treatment or have a crisis.
- 2) Long-term carers of mental health service users should have more support and respite care.

- 3) We need to find and list organisations that help people with mental health needs who are from a “community of interest” to find out what services they are being given. We also need to ask the organisations what more they need to give extra help to people. We also think these organisations need professional help from the tPCT to work effectively.

10.0 Next Steps

This report is a first for us. We want learn from it so that we get better at talking to people. We think that if we can talk to people in a way that they understand and feel happy with, then we can ask more questions. By listening to people properly we will be able to help the tPCT give people what they want to help them feel better.

It is also really important that we tell the people we have talked to about this report so that they know that we have produced it. We hope that this will mean people trust us to talk to them in future reports.

- 1) We think that it is really important to keep in touch with all the people we talked to in this report. We should check to see if people are happier or less happy with the way they are being looked after. We also need to see that people still want the same things that they said they wanted when we wrote the report. We think that we should do the report again in 12 months’ time to see what has changed.
- 2) People who looked after others (carers) said that they needed to take time out (respite care) to look after themselves. We think that we should ask more questions of more carers to see what else they would like.
- 3) We need to do **two** more things for the people who talked about how useful “communities of interest” groups were. Both fit in with the Gateway workers Alliance plan written by the Bradford & North Commissioning Alliance (which used to be called the Yorkshire & Primary Care Alliance). This plan, which began at the end of 2008, will give each doctor’s surgery a mental health “Gateway worker” to help people with their mental health issues. These workers will also see people in their own homes and could give information to people about third sector “communities of interest” groups:

“PCMHT [Primary care mental health teams] work closely with a multitude of services from the voluntary sector. The Gateway pilot has reduced the numbers of referrals signposted to primary care service by utilising the extensive skills in these services. However the intention is to further develop, this relationship to ensure service users are signposted to the appropriate resource to meet their individual need.”

(Bradford and Airedale tPCT Provider Services CMB Commissioning Proposal Summary Sheet, Yorkshire and Primary Care Alliance, 2008 - Section 1d: p.9)

First, we think that all the medical staff who work for people with mental health needs, including the new Gateway workers, should be given more information about the “communities of interest” groups in the Bradford and Airedale area and how they help people. We also need to find out why medical staff have not been telling people about these groups in the past, in case there is something that is stopping them from talking about these groups that we do not know about.

Second, we need to make a full list of all the “community of interest” support groups in the Bradford and Airedale area. We also need to find out how they can best help people with mental health issues. Although a lot of these groups are listed on the DIVA database, this listing is not a full one. For example, DIVA lists 82 voluntary and community organisations in the Ilkley area, but Ilkley Voluntary Services says there are least 160, perhaps more. We should also learn what kind of help they give and what has gone well or badly in terms of helping mental health service users in the past. It might be useful to make a chart that shows organisations, what help they gave and what has gone well or badly. This chart would help these groups to learn from each other. It would also help the tPCT to know what groups are out there which can help. For example, the new Gateway workers could use it to tell people in doctor’s surgeries about what groups they could go to in their area. By doing this, the tPCT staff could work more closely with these groups. They could work together on projects and look at ways to get more money to help people with mental health needs.

(DSP 06/05/2009)

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Appendix A - Interview questions for adult mental health re: consultation, Bradford LINK

Explanation – Part 1

People spend time in hospitals to get better and feel better.

When they go back home they sometimes need to spend a few days in a hospital or other care centre every now and then, so that they and the people who care for them can stay feeling better – this is called **respite care**.

Sometimes when they are at home, or about to go home, they need to spend time learning how to live better so that they do not need to go to a hospital or care centre again – this is called **rehabilitation**.

Questions: respite care and rehabilitation

1. Have you ever had rehabilitation/respite care? (Closed question)
 2. Where did you have it? (Location question – could be multiple locations)
- (Open questions)
3. Did it feel close enough to your home?
 4. Were the people who were there to help you friendly and supportive?
 5. Did the place where you went feel peaceful and calm?
 6. Did the care make you feel better/more able to live better at home?

Explanation – Part 2

The people in charge of hospitals and medicine in the Bradford area would like to make people feel better by treating them at home more, with a team of people to help in different ways. To do this they are thinking about having fewer hospitals and care centres, and instead having more people who can come and help you in your home.

There will always be hospitals and care centres to go to, but if there are more teams of people to help there will be less hospitals -- and so you may have to travel further to go to one. Of course the teams of people will come to you in your own home.

You could also be given money to choose your own care to make you feel better (respite care). You could use this money to pay for a carer, do something you enjoy that makes you feel better, go away on a day-trip to a

care centre or somewhere else that you like, or go on a short holiday in a guest house or hotel.

Questions

Choices

1. When you want to feel better, do you prefer to have people coming to see you in your own home, or would you prefer to go to a special place like a hospital or care centre? (Closed question)
2. Do you think a person helping you at home would be better than you going away to a hospital or care centre, or not be as good? (Closed question)
3. Why do you think this is? (Open question)

(Supplementary closed questions)

4. Would you feel more comfortable being visited at home, or going to a hospital/care centre?
5. Do you think that the people who could come to help you at home will know more about your needs than those in hospitals and care centres, or less?
6. If you have a carer, would you rather be visited by people at home, or would it feel better for you (and your carer) to have a break from your carer in a hospital or care centre?

Home care

7. Have you had someone come to visit you at home to help you feel better (respite care) or live better (rehabilitation)? (Closed question)

(Open questions)

8. Were they friendly and helpful?
9. Was it easy to talk in your home?
10. Did you feel that they helped you enough?
11. Did they come back and see you when you wanted them to?
12. How could they look after you better at home

Individual care arrangements

13. Would you like to be able to choose and pay for your own services (carers/trips/holidays)?

Or would you like to talk about this with helpful people first, then decide?

Or would you prefer the people in charge of hospitals and medicines to decide for you by themselves? (Closed question)

14. Would you feel comfortable managing money for your own care? (Closed question)

15. Can you think of things you could do with the money to make you feel better? (Open question)

OPTIONAL

Bradford LINK will help you to tell the people who run health and social care services what you think. If you would like to know more about the kind of work that we do, and how you can help, you can leave your name and details so that we can contact you:

Your name is:

Your address is:

Your telephone number is:

Your email address is:

Bradford LINK promises not to give your name and details to anyone else.

You can telephone me on 1535 665258 or email daniel@bradfordlink.org.uk

(DSP 30/01/2009 – amended version 11/02/2009)

Appendix B: Adult mental health services in Bradford - summary of proposed work by the Bradford LINK to engage with communities on future commissioning

Introduction

Following the recent tPCT consultation on adult mental health services, the tPCT board proposed that the Bradford LINK engage with communities in the district.

The Bradford LINK will engage with communities, using the research methodologies and groups described below, and summarise its findings to the tPCT. Qualitative and quantitative data gathered from these interviews will be presented in the form of a series of general recommendations to Bradford tPCT within three weeks of completion of the interviews.

This summary report, due for completion on 31st March 2009, will not provide a specific recommendation in terms of models of care, but it is envisaged that the results will assist the tPCT in making decisions on these models; with a greater knowledge of the impact such changes will have upon “communities of interest” within the Bradford area.

Methodology

Using a Grounded Theory research approach to interview mental health service users from at least five “communities of interest”, including:

- Young People
- Women specifically using mental health services
- South Asian women
- Lesbian, gay and bisexual (LGB) community
- Former refugees and asylum seekers, eligible to access NHS services in the area
- Homeless or vulnerably housed people

We will approach twelve organisations to assist us with this task in terms of interviewing their service users. These organisations will be:

1. BAMHAG – Bradford and Airedale Mental Health Advocacy Group
2. Bradford Equity Partnership (LGB groups)
3. MIND in Bradford
4. Cellar Project, vocational training and rehabilitation for mental health service users
5. Edmund Street homeless shelter
6. Isis Project
7. Off the Record, young people’s counselling service
8. Out of Hours Project, a self-referral group
9. Roshni Ghar

10. Sharing Voices
11. SAWHAA (South Asian Women's Mental Health Awareness Association)
12. Bradford Speakout (homeless or vulnerably housed people)
13. Yorkshire Mesmac (LGB groups)

(Please note BAMHAG and Off the Record were involved in the initial consultation.)

Interview questions will centre on mental health care experiences both in hospitals/health centres and within home care settings, specifically focusing on rehabilitation and respite care. A supplementary question on the personalisation agenda and Individual Budgets will also be asked, where appropriate.

We envisage this interview stage will last three weeks.

Expectations of the Bradford LINK

As this is the first time that such work has been undertaken, there are as yet no protocols on how this work is taken forward. For the moment the Bradford LINK will describe some expectations it has once this work is under way:

The Bradford LINK expects to be kept informed of commissioning thinking and decision-making

The Bradford LINK will use this information to feed back to communities and describe to them how their opinions and desires are being reflected in commissioning processes

The tPCT acknowledges shortcomings in the recently concluded consultation on adult mental health services. The Bradford LINK expects that this work will contribute to an ongoing critique of consultation processes.