Reviewing the Care Programme Approach 2006

A consultation document

Care Services Improvement Partnership
Department of Health

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Foreword

In my report, *The National Service Framework for Mental Health 5 Years On*, I said that mental health services are becoming increasingly responsive to the needs and wishes of the people using them, and I stand by this.

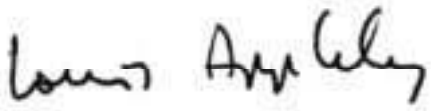
Yet I am also aware that services are not always organised to identify and meet the needs of some vulnerable and high risk groups. This applies particularly where an individual's personal and family needs go beyond those usually described as mental health services – for example those of housing, support for drug and alcohol misuse, and child support services.

Where no one service or agency is central to such a system of support, service users themselves should provide the focal point for care planning and delivery, and this is where the effective implementation of the Care Programme Approach (CPA) becomes critical.

I also want to emphasise the importance of the CPA process in supporting crisis planning and risk assessment and management. Care plans developed and managed in partnership with services users, and where appropriate their carers and families, which involve an open dialogue and information sharing, are more likely to result in positive outcomes.

The CPA does not replace the need for good clinical expertise and judgement but should act as a support and guiding framework which can help achieve these positive outcomes for service users by enabling effective co-ordination between services and joint identification of risk and safety issues and a vehicle for positive involvement of service users in the planning and progress of their care.

Clinicians themselves call for a system which allows for better connection with individuals receiving services. Service users want that too. Through this consultation we seek your views on how best this can be achieved. I am aware that some clinicians have been sceptical about the CPA and how it is applied in practice. I want them to adopt the refined CPA framework that will come out of this consultation and urge them to take the opportunity to help shape it.



Louis Appleby
National Director for Mental Health

Introduction

I was asked by The National Director for Mental Health, Louis Appleby, to lead an initial review of the policy and practice around the Care Programme Approach (CPA). Evidence and views for the review were gathered from a range of people working in and using mental health services. Additional evidence and views were drawn from a small number of relevant studies. The result of this review forms the essence and the main proposals of this consultation document.

The positive response to this initial work has been very encouraging with consistency in support for the principles and process of the CPA in parallel with concern for how it has become so bureaucratic. The only negative feature has been concern that, because of the review, prescriptive guidance will be issued that further removes the practitioner from the relationship with the service user. This is not our intention.

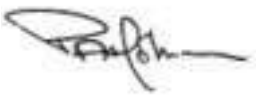
Concern about the loss of the relationship with users of the service was evident throughout. There was disquiet that the CPA has become a managerial tool rather than a system of engaging with people. Also, that the CPA has moved away from the original intention for a system that was mostly designed for people with a serious mental illness that should be used to form a plan of care and treatment and that is a dynamic process that changes through reviews.

It was recognised that there has been inconsistency in implementation and variable standards. Rigidity and inconsistent interpretation were cited as examples of the poor practice. The hypothesis developed that implementation, rather than policy, was at fault with part of the problem being the later changes to the CPA that led to a tick box mentality rather than a proper change process at the beginning with evaluation built in.

Service users expressed concern at the lack of attention to their wider social care needs within their care plan, particularly when the focus has been on problems, risk and subsequent treatment rather than building on their strengths towards recovery. There was equally a concern by service users that not enough attention is paid to contingency or crisis planning. Carers also aired views about their lack of involvement as partners in the care assessment and planning process.

In summary, the view is that the CPA principles are sound but that it is both the legacy of how it was introduced and the implementation in practice currently where the problems lie.

I hope that through this review and consultation process we can work together to address these issues and ultimately better meet the needs and aspirations of service users, their carers and families and the professionals that work in the service.



Pat Holman
Chief Executive
Norfolk and Waveney Mental Health Partnership Trust

Section 1: Background

The Care Programme Approach (CPA) was introduced in 1990 to provide a framework for effective mental health care for people with severe mental health problems. Its four main elements were:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- the formation of a care plan which identifies the health and social care required from a variety of providers;
- the appointment of a key worker (care co-ordinator) to keep in close touch with the service user and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care plan.

The importance of close working between health and social care services was stressed, as was the need to involve service users and their carers in the assessment and planning of service users' support and care.

The CPA model was reviewed in 1999 with publication of the Mental Health National Service Framework and to incorporate lessons learned about its use since its introduction. *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet*[1] sets out current policy on the role and purpose of the CPA.

1.1 The Need for a Review

There have been a number of significant developments since 1999, in the mental health field and wider, that have prompted this current review of the policy and practice of the CPA. The main areas are:

- Review of the 1983 Mental Health Act and Code of Practice
- The White Paper *Our Health, Our Care, Our Say*[2]
- The Social Exclusion Unit report *Mental Health and Social Exclusion* [3]
- The White Paper *Choosing Health*[4]
- National Service Framework for Mental Health 5 Years On[5]
- *Personality Disorder; No Longer a Diagnosis of Exclusion*[6]

A range of evidence has also pointed to the need for improvements, including:

- *Back on Track? CPA for service users who are repeatedly detained under the Mental Health Act*[7]
- Royal College of Psychiatrists Survey: *CPA Views of Consultant Psychiatrists 15 Years On*[8].
- Commission for Health Improvement reports[9] and Healthcare Commission and Commission for Social Care Inspection surveys[10]
- *National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness.*[11]

The review also needs to consider developments on: Connecting for Health (NPfIT); Payment by Results; Practice Based Commissioning; the New Ways of Working in Mental Health programme; Individual Budgets and Direct Payments; MONITOR's service contract with foundation trusts and wider changes to assessment and care management processes in health and social care.

1.2 The Aim of the Review

The overall aim is to ensure that the CPA:

- is underpinned by a set of agreed common values and principles;
- identifies and supports individuals and their families/carers with the highest needs and those who may be high risk to self or others;
- is able to meets the needs of service users, including ensuring that their physical health care and social outcomes are incorporated into care planning, and to make care plans clear about access to services in a crisis;
- reduces bureaucracy and enables effective partnerships and relationships between clinicians and services users, their carers and families;
- incorporates systematic approaches to clinical risk assessment, risk management and risk sharing between agencies into care planning and management;
- achieves a quality standard across the country against which services can be assessed;
- is compatible with current and developing information systems (eg Connecting for Health);
- integrates with implementation of the White Paper *Our Health, Our Care, Our Say* [2]; and
- supports legislative changes in the Mental Health Act and Code of Practice.

1.3 Document content and structure

This document is not intended to provide a comprehensive commentary on the wide range of issues that encompass the CPA. It intentionally focuses on key areas for change and improvement identified in the initial review and sets out a number of proposals and consultation questions. The main proposals and consultation points are around: the values and principles of the CPA; who the CPA should be for; the role of the care co-ordinator; continuity of care; service user and care engagement and involvement; physical health and social needs of service users; integrating clinical risk assessment and management into the CPA processes; tackling bureaucracy; and measuring and monitoring quality improvements.

The document also contains information on developments on the Health and Social Care Common Assessment Framework and NHS Connecting for Health as they relate to the CPA.

1.4 Consultation

This consultation document is drawn to the attention of a wide range of stakeholders and written comments are invited. The CPA review proposals and consultation questions are placed throughout the document and summarised on our website www.nimhe.csip.org.uk/cpa.

We will supplement the written consultation with active listening events, particularly with service users and carers, bespoke and as part of other events. We also welcome receiving examples of positive practice in implementation of the CPA in consultation responses. A form for suggestions on positive practice is available on our website www.nimhe.csip.org.uk/cpa.

The consultation period ends on 19 February 2007. Consultation responses should be sent to cpareview@londondevelopmentcentre.org. Consultation responses will be collated and considered. Updated policy, practice and implementation guidance will published in 2007 for implementation from April 2008.

1.5 Race and Gender Impact Assessments

During the formal consultation period we will work with relevant experts and groups to identify how policy proposals on the CPA will affect people from different racial groups and women and men. We will be carrying out race, ethnicity and gender screening and, if necessary, an impact assessment on the proposed changes during the consultation phase. The results will be published with, and inform, the final policy implementation guidance.

Section 2: Values and Principles Underpinning the Care Programme Approach

Proposal:

The Care Programme Approach should be underpinned by an explicitly stated set of values and principles.

We propose the following as the underpinning values and principles of the CPA:

The CPA is a person centred approach used to inform partnership working in mental health. This partnership should always, as a minimum, include the service user, any carers and the CPA co-ordinator. It should also include working relationships with health and/or social care professionals and other relevant organisations.

The CPA is the principal vehicle of care assessment and planning for a defined group of individuals receiving mental health care. The CPA is aimed at ensuring this group of people have access to support and services (across the provider spectrum) to meet their diverse needs, strengths, preferences and choices.

This whole systems approach to care planning and delivery promotes care activity across the individual's life domains (including housing, employment, leisure, education and other needs).

The CPA is an inclusive and dynamic process based on effective communication, appropriate information sharing and negotiation between partners. This negotiation is to draw on available resources to deliver an agreed plan of care.

All advice, care and treatment delivered in health and social care involves the making of an agreed plan. The CPA is a formalisation of existing care planning activity for those with complicated care planning needs and, when successfully delivered, will provide engagement and involvement from all participants in the partnership.

A CPA process which draws specifically on the *10 Essential Shared Capabilities*[12] will be entirely consistent with an approach which is consensual and valued by service users and carers; is person centred; which promotes safety, positive risk taking and recovery and which extols the virtues of evidence and values-based whole systems mental and physical health care.

Consultation question

Q. Are the values and principles set out in this section the right ones?

Q. Are they set out in a way that is meaningful to service users and providers?

Q. In what ways might the current systems of operating the CPA be improved to ensure that these values are met?

Section 3: Who should the CPA be for?

Proposals:

There will only be one level of the CPA.

The system of co-ordination of care and support for service users currently defined as "standard" will be for local determination, guided by the CPA values and principles.

There are currently two levels of the CPA – standard and enhanced. Concerns have been expressed that this leads to unnecessary bureaucracy which impacts on the capacity of services to care effectively for those with the highest levels of need. The concerns relate both to the use of the formal CPA documentation for straightforward interventions, and to the use of the enhanced level of the CPA when this is not warranted.

3.1 One Level of the CPA

Although aspects of their illness or distress can be severe the care co-ordination needs of the group of service users currently on the standard CPA are relatively straightforward (see Annex A). We propose not to continue with the requirement for the formal CPA for these service users in the future. The values and principles underlying the CPA (see Section 2) will apply to all those in contact with services, but the way in which these are demonstrated will be left to local services to determine, in consultation with their partners including service users and carers. However, providers of care will need to consider how, in future, they will be able to demonstrate what they provide and to whom for the purposes of commissioning and Payment by Results.

Increasingly mental health trusts are working with a range of providers outside the boundaries of traditional secondary care. This may be where there is an emphasis on early recognition or recovery or for specific client groups eg, early intervention services for young people with emerging mental health problems, or personality disorder. The development and maintenance of robust care planning mechanisms, whether service users are subject to the formal CPA in the future or not, is essential.

Q. If there is no longer the standard CPA, how do we best support partnership working between primary care, secondary care and the voluntary sector to ensure the needs of those previously on the standard CPA continue to be met?

3.2 The level of need the CPA should cover in the future

Proposal

The definition of who should be on the CPA in the future will be clarified to ensure it supports those with the highest care co-ordination and most complex needs.

We want to update the description of who the CPA will be needed for in the future to reflect service user and carer expectations and needs and the impact of new roles and New Ways of Working on the delivery of care. Some of the important elements that need to be considered are discussed below.

Current national policy definitions of service users who should be receiving enhanced CPA indicate those that are more likely to have multiple needs, require more frequent and intensive interventions and have higher levels of risk (see current national policy definition Annex A).

3.3 Defining Complexity

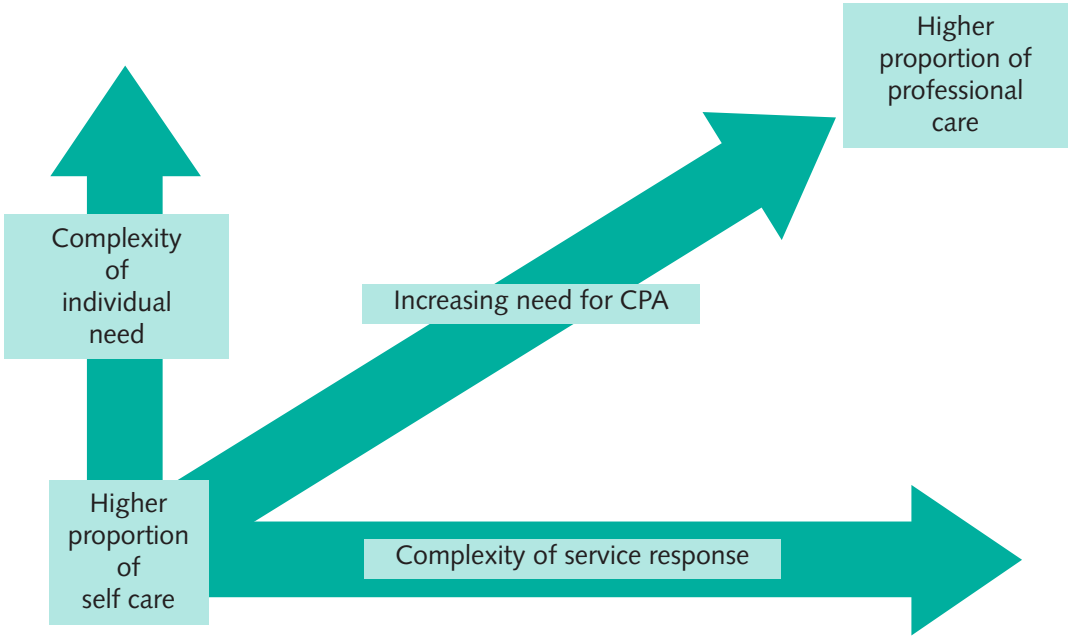
However, we know that some services use subtly different definitions to decide on the need for enhanced level CPA. Their policy definitions may describe characteristics of (and use the term) "complexity" which relates to the severity and range of an individual needs and the number and range of services provided to meet those needs.

There is a wide currency of the term "complexity" although it is not used or defined in the current CPA national policy guidance. The term is referred to in *Our Health, Our Care Our Say*[2] as a determinant of the ratio of self to professional care; in NICE guidelines as the key factor differentiating interventions at different levels of the stepped care model[13]; and in deciding on the deployment of different levels of professional skills in accordance with New Ways of Working[14].

Definitions of complexity solely based on **individual need** can be more person-centred. They can include consideration of any or all of the following: severity of distress and their effects; range of issues; risk and safety; duration; and contextual factors. Definitions based only on **service response** can become outdated. For example the development of new and enhanced skills and new roles can mean that fewer people, or fewer agencies, are needed to provide a package of care with multiple strands than in the past. Also, the two definitions are not always directly related, for example a person's individual needs can be complex, but the intervention to help them may be straightforward.

The conclusion might therefore be that neither complexity of individual need nor complexity of service response alone is sufficient to be able to describe who might require the CPA. However, if the degree of complexity along both these axes (see Figure A) is considered together, a higher level in both might be a good indicator of the need for the CPA. However, this might then prompt the question of how you define these "higher levels".

Figure A: The Relationship of Complexity to CPA



Consultation Questions

Q. How can the current description of characteristics of who should be on the enhanced CPA be improved for the future to describe those with the highest needs for care co-ordination and risk management ?

Q. Would considering the degree of "complexity" of both individual need and service response together, aided by guidance on these concepts, help to define more clearly those for whom the CPA is appropriate in the future?

3.4 Key Groups

Proposal

Services should review a number of key groups to ensure that they are not missed currently from the enhanced CPA.

We know that the number of people subject to the CPA varies in different areas and that this is not necessarily associated with variations in need or populations. In particular, there is increasing concern that a number of key groups which should meet the characteristics for enhanced CPA (Annex A) are not being identified consistently, and that services are sometimes failing to provide the support they need. These include people with severe mental illness and/or severe personality disorder:

- who have parenting responsibilities
- with a dual diagnosis (substance misuse)
- with a history of violence or self-harm
- who are homeless

Services should consider whether the needs of individuals in these key groups have been fully explored and that they are included under current and the future CPA provisions. The rationale and evidence for a renewed focus on these groups, and the evidence around the complexities of their needs which need to be taken into account, are outlined in Annex B.

In the past the need for the enhanced CPA has sometimes only been considered when associated with severe psychotic illness. People with severe personality disorders may have been excluded, even when demonstrating similar characteristics, on the grounds of untreatability. New evidence and experience has clarified a range of therapeutic interventions for personality disorder. The Government has also said that it plans to amend the Mental Health Act 1983 to abolish distinctions between different categories of mental disorder and to remove the so-called 'treatability test'. Thus the development of more needs-led practice is likely to lead to an increase in the numbers of people with personality disorder on the CPA.[6]

Consultation Questions

Q. What are the barriers to identifying and meeting the needs of the key groups described above and at Annex B and how may they be overcome?

Q. Are there other groups that should generally be considered to be included in the definition for the enhanced CPA that services are currently not identifying and who should be on the enhanced CPA?

Section 4: The Care Co-ordinator

Proposal:

National competencies to be identified for the role of care co-ordinator.

The role of the care co-ordinator is pivotal to the success of the CPA. We want to strengthen the role and consider the need for national frameworks of competencies and training.

4.1 Competencies

We acknowledge that the introduction of the care co-ordinator role in mental health did not specify clearly the role and function. This has resulted in practitioners being allocated as care coordinators according to criteria set locally, which has been variable in consistency.

We recognise that this role and function should now be explicitly based on competencies and frameworks such as the Knowledge and Skills Framework and National Occupational Standards. This must build on work already undertaken to establish competencies for other similar roles and functions, including case managers, care managers, community matrons and care navigators.

4.2 Training

There is no formal national training programme for mental health care co-ordinators, although some individual mental health trusts and social services have commissioned bespoke local training. Some of the identified skills include needs and risk assessment and management, agreeing and setting objectives, seeking expert advice, chairing meetings, negotiation, managing conflict, working across disciplines and organisations within and beyond mental health; commissioning and communication.

Furthermore, as collaboration between health, social care and the criminal justice services increases, it will be important for care coordinators to understand the processes for engaging and liaising with local National Offender Management Services (NOMS) [15].

Most important is the values and attitudes required to work collaboratively with the service user and carer(s) throughout the assessment and care planning process to ensure that interventions achieve outcomes meaningful to them. This means providing explicit training on those values and attitudes, based on 'Recovery'[16] and the Ten Essential Shared capabilities [12].

The issue of the competencies and training required for care co-ordination in general health and social care services will be considered as part of the development of the Health and Social Care Common Assessment Framework (see Section 10). It is likely that the shared set of skills needed to coordinate and to manage care will be generic although the context in mental health services will be different.

4.3 Capacity

Most, if not all, practitioners will have a caseload where they are providing an input to the care and treatment of service users. The additional function of care co-ordination can be carried out by any practitioner with the appropriate competencies. There will always be a tension between the different roles that the individual practitioners fulfil. The burgeoning bureaucracy around the CPA has led to the co-ordination function becoming negatively viewed and primarily administrative. The focus needs to shift to the essential assessment and care planning process, which underpins good and appropriate care for the service user.

There needs to be consideration of different levels of care coordination skills including of those who contribute to the process, whilst not carrying out the role itself. The principles on New Ways of Working, including delegation and dispersal of tasks, modernising of processes such as reviews, the use of electronic recording should also be brought to bear on the role and function of care co-ordination. A support role to the CPA care co-ordinator could, for example, remove some of the administrative tasks and be more effective and cost efficient for the organisation and the service user.

Q. Is there more that needs to be done to clarify and support the role of care co-ordinator?

Q. What kind of training would enhance the care co-ordinator role?

Section 5: Continuity of care

Proposal:

Services should review their CPA procedures to ensure pathway approaches to the CPA and improved continuity of care – particularly with in-patients and prisoners.

As systems of treatment and care are becoming more complicated so care pathways are becoming more complex and potentially disjointed. We need to find better ways of co-ordinating complex care and ensuring clinical governance across the whole of the care pathway. The function of the CPA and the role of the care co-ordinator are central to this. They are, or should be, the "glue" that holds it all together.

However, this has often not been the case, and sometimes the opposite occurs and the CPA is 'suspended' when something else happens – for example the person is admitted to hospital or to prison. This not only produces disjointed care, it also generates more paperwork and undermines the confidence of the service user in the system, and can cause distress and frustration when the same questions are asked repeatedly in different settings by different people.

Continuity of care is essential when the care setting changes, and is often identified as having been lacking when untoward incidents have occurred. The care co-ordinator has a key role in keeping the 'story' together across the care pathway, and the care plan should be the key reference document irrespective of where care is being delivered, added to and amended by the care co-ordinator as dictated by the care needs in each setting.

A number of mental health trusts have adopted patient pathway approaches when devising operational policies on implementing the CPA. Some trusts have also included CAMHS and older adults' services in their CPA policies. All trusts are required to have transfer/transition protocols, and these should be taken account of in care plans. This is particularly critical to avoid disruption of planning and services at age transfer points.

Considering the CPA from the viewpoint of the patients and their pathways can also help reduce bureaucracy – avoiding duplication of record keeping between different professionals or parts of the organisation. The need for a central database of information that can be accessed and updated remotely within an organisation is critical here. Information sharing arrangements and protocols should also be in place between relevant agencies involved in the care planning and provision processes.

5.1 In-patient and Residential Care

The fact that a service user needs additional support in an in-patient or residential setting should prove no barrier to continuity of care planning. For those on the CPA the responsibilities of the care co-ordinator will continue. For people not already on the CPA, a care co-ordinator should be appointed well in advance of discharge and arrangements made clear about future contact, risk and safety management and home care arrangements.

Increasingly, protocols are being developed to ensure consistent care planning and assessment processes across the service elements of acute mental health care – reducing variation and improving cross-pathway care co-ordination and discharge planning.

5.2 Prisoners and Offenders

Changing the Outlook[17] confirms the CPA as a process to support service users' mental health needs in prison. It makes it clear those prisoners who were on the CPA before entry into prison should have their programmes of treatment continued as far as possible within the prison setting. It also identifies that inmates whose profile would bring about the CPA in the community should begin the CPA in prison, and that mechanisms need to be in place to support this.

Offender Mental Health Care Pathway[18] documents a number of the CPA requirements around care co-ordinator involvement and contact. Local services should be aware of this guidance and consider the implications for service user pathways and how they will adapt their CPA procedures to meet these requirements.

Primary care trusts commissioning arrangements for services for the prisons within their areas should include the CPA requirements.

Q. Are there other key transition points that have an adverse impact on the continuity of care for someone on the CPA?

Q. What can services do to ensure that service users and their carers are better informed about what action to take, and who to contact, in a crisis?

Section 6: Service User and Carer Engagement and Involvement

Involving and enabling service users and carers should be at the heart of policy and practice in the assessment and planning of care. There are many areas of positive practice around both service user and carer involvement in the care planning process including:

- service user and carer development and leadership programmes;
- initiatives around self-assessment;
- involvement in research and evaluation;
- service user and carer led staff training;
- supported user and carer networks;
- development work on direct payments and individual budgets.

Yet studies and surveys confirm that active involvement from service users in the CPA process is still not fully achieved, or at least perceived as not achieved by a large number of service users. The 2006 *Mental Health National Patient Survey* [19] showed that 58 percent of service user reported *definitely* understanding their care plans; 32 percent understood to some extent and 9 percent did not understand their care plans. Of those surveyed 53 percent of service users had been offered a copy of their care plan. Forty percent of service users reported being involved in deciding what was in their care plan; 35 percent to some extent and 25 percent reported not being involved in their care plan. Seventy percent were told who their care co-ordinator was and 71 percent felt able to contact their carer co-ordinator if faced with a problem.

A study of nurses showed that they valued the concept of service user involvement, but also found it problematic at times. Factors which they said prevented them from involving services users more fully included: lack of time; staff shortages; the nature of individuals' mental health problems and negative staff attitudes. The provision of accurate information, user-friendly documentation, having the means for getting service user feedback and valuing their contributions, and high staff morale were all felt to promote and increase service user involvement. [20]

It has been demonstrated that where service users *are* involved in the process they are happier with the care and services they receive. Factors which make a difference include getting right the timing, venue and attendance at review meetings, all of which can help or hinder service user involvement. A trusting relationship between service users and the professionals was also seen as a key success factor. [21]

An approach which places an emphasis on the strengths and achievements of the service user while acknowledging their concerns and any difficulties is also likely to engender engagement. We should also aim for service users to lead their own CPA reviews as they successfully progress in recovery, as part of a more general ethos of self management and self determination.

Consultation question

Q. Is there more that should be done locally or nationally to improve service user and carer involvement and engagement in the CPA?

Section 7: Physical Health and Social Outcome Needs

International evidence shows that people with long-term mental health problems on average die 5 to 10 years younger than other citizens, often from preventable illnesses. They also live with poorer physical health, which means people who are already exceptionally socially excluded – on every measure from education and employment to housing and social networks – often face the additional challenge of diabetes, heart disease or other long term physical illness. This makes it harder to participate socially and economically as well as harder to play an active, valued role within the family and community.[22]

Services and commissioners should consider these wide-ranging needs at individual assessment and planning level and at aggregate service commissioning and planning levels across agencies to develop and co-ordinate service provision to meet the "whole person" needs.

Effective care co-ordination should facilitate both access and support for the service user to benefit from the full range of health and community support needed, including: physical health, housing, education, work skills training, employment, voluntary work, leisure activities, and welfare benefits. Parenting, caring responsibilities and the needs of any children should also be included in care assessment and planning processes.

Working arrangements need to be established across agencies, including those in the criminal justice and child protection systems. This CPA review should provide the opportunity for systems to address and reduce the health inequalities experienced by people with mental health problems as identified in the above-mentioned report *Equal Treatment: Closing the Gap*.

There is a range of mechanisms in place that can be used to support this, including:

- Local Area Agreements (LAAs) – that set out the priorities for a local area agreed between central government and a local area. They aim to deliver local and national priorities through partnership working and leadership to deliver a service that will enable a better quality of life for the individual.
- Multi Agency Public Protection Arrangements (MAPPA) which require police and probation services, supported by additional agencies including housing, health and social services, to work together to manage the risks posed by dangerous offenders in the community.

- The Quality Outcomes Framework (QOF) for GPs which provides for physical health reviews for all those with psychosis and bi-polar disorder.
- Mental health Local Implementation Teams (LITs) which have a role in local planning and development of services.

Guidance and good practice for service providers within and beyond mental health services, includes:

- The White Paper, *Choosing Health: Making Healthy Choices Easier*[23] identified mental health as a priority area for health improvement in England.
- The White Paper, *Choosing Health: Supporting the physical health needs of people with severe mental illness*[4] aims to help PCTs plan for, design and commission and monitor services that will deliver improved physical health and well-being for people living with severe mental health problems.
- *Equal Treatment: Closing the Gap*[22] a formal investigation into physical health inequalities
- *Vocational services for people with severe mental health problems: Commissioning guidance*[24]
- *From segregation to inclusion: Commissioning Guidance on day services for people with mental health problems*[25]
- *A guide to Action: Direct payments for people with mental health problems*[26]
- *Reaching Out: An Action Plan on Social Exclusion*[27].

NIMHE as part of its Anti Stigma and Discrimination Programme has produced four resource documents promoting healthy living and information about the physical health care of people with mental health problems. The target audiences are: people with mental health problems themselves; professionals working in community settings; staff working in inpatient services and professionals working in primary care. An evaluation framework is also available for people to record any changes in practice.[28]

Q. What more should be done to ensure that the physical and social outcome needs of services users are considered and met?

Section 8: Choice in Mental Health

The CPA should be used to record the wishes of service users, including any advance directives or decisions, when they are relatively well to inform their care and treatment when they are in crisis. The record should include the choice of interventions discussed with the service user and or carers and relatives, what was decided and by whom. This may help to address the concerns of professionals who may feel uncomfortable with the possibility of service users choosing an option which in their opinion is unsound or less effective.

The CPA should act as a prompting mechanism to make sure all dimensions of the service user's status, needs and support are taken into account. This will include their race, ethnicity, sexual orientation, employment status and housing arrangements. It can also be used to prompt discussion of direct payments, which can be a powerful instrument for articulating choice on the part of the service user.

The CPA process is seen by some as a documented mechanism for assessing an individual's needs of which risk seems to be the main focus and therefore can be at odds with concepts such as recovery and choice. The move towards a system in which service users are supported in their care and rehabilitation by a sense of optimism among those providing their care, and an expectation that their condition will improve so they can live as independently and make as many decisions as possible for themselves, is supported by the values and principles in Choices in Mental Health.

There are clear benefits in ensuring that the CPA enables the implementation and facilitation of Choice as it applies in mental health. The National Choice and Access Team can support this process. Further information on Choices in Mental Health (which has been developed through wide consultation with health professionals, service users and carers) can be obtained by visiting www.mhchoice.org.uk.

Our Health, Our Care, Our Say[2] announced the development of a social care risk framework. Good practice guidance on this is due to be published in 2007. The emphasis of the guidance will be on empowering people to make choices and supporting them to manage any risks inherent in the process. It will acknowledge that it is neither possible nor desirable to eliminate risk. The good practice guidance will promote the importance of service users being in the centre of the care planning process with choices and responsibilities. A choice impact assessment tool (which is currently being tested) and training materials will also be published with the guidance.

Section 9: Clinical Risk Assessment and Management

Proposal

The Department of Health is developing a framework on the evidence of effectiveness of risk assessment tools. Services should consider this when reviewing systems and approaches to assessing and managing clinical risk.

Risk assessment and management is an essential and on-going element of good mental health practice and a critical and integral component of the CPA. Yet service users and practitioners often see them as separate processes and as negative, not positive.

Assessing and managing risk or safety should not be seen as negative. Managing risk is about making good quality clinical decisions to support and sustain a course of action that, properly supported, can lead to positive benefits and gains for individual service users [29]. It should also be seen as a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual.

Risk management is often perceived as managing the risk of service users pose to themselves or others. People with mental health problems are often vulnerable and the potential risks to them from others must also be considered.

9.1 Recording Risk Information and Decisions

Safe practice indicates that professionals and organisations should have robust systems that allow for valid, reliable and retrospectively defensible risk assessment and management for every service user. Mental health professionals should be able to explain their reasoning and decision making with evidence for both. Organisations' governance processes should support this.

However, research with service users suggests that over-recording of risk impacts on service user involvement. Professionals, managers and organisations need to consider ways that they can ensure that practice is defensible rather than defensive and inclusive rather than excluding.

9.2 Risk Assessment Tools

There are tools and methods that can support, but not replace, professionals making judgements on levels of risk and how best to manage it. Research findings indicate that there is no single assessment tool that can help with this. DH has commissioned a review

of evidence on risk assessment tools – ranging from self-neglect and self-harm to violence to others. This will be produced in the form of a framework to support practitioners and organisations making decisions around risk and safety.

9.3 Service User and Carer Involvement in Risk Management

Service user and carer involvement in risk assessment and management is variable and can depend on individual professional initiatives. There does not appear to be a significant body of knowledge about how to involve service users considered to pose a risk to others in risk assessment and management. While most professionals would say that they discussed concerns with service users they do not necessarily use the language of risk and not all service users know that risk assessment and management was an integral part of the professional role and the care planning process.

A study with a small number of service users provides an account of their perspectives on, and experience of, posing a risk to other people. It shows that many service users were deeply distressed about their behaviour when experiencing psychosis and wanted support to reduce the likelihood of them acting in ways that potentially put other people at risk. The study also provides information about the extent of service user involvement in risk assessment and management and care planning and highlights examples of good practice. [30]

The Promoting Safety and Positive Risk Taking module of the *Ten Essential Shared Capabilities Framework*[11] tackles issues such as empowering the person to decide the level of risk they are prepared to take with their health and safety. It also includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members and the wider public.

Q. Is there more that can be done to embed positive risk and safety management within the CPA?

Q. How can the balance be struck between the need to record risk and decisions (defensible practice) yet avoid over-recording which can alienate service users and add to bureaucracy?

Q. Is there further support that professionals or others need to enable them to make better decisions around risk assessment and management?

Q. Is there further support that service users and carers need to be better involved in decisions about, and managing, risk and safety?

Section 10: Tackling Bureaucracy

National policy has aimed to avoid being over-prescriptive in what documentation should be kept in relation to the CPA, but experience suggests that this may have had the paradoxical effect of allowing local bureaucracy around the CPA to burgeon. Suggestions for reducing bureaucracy include:

- Removing the requirement for the standard CPA.
- Development and use of IT systems, in particular to support the updating of care plans and risk management plans without duplication.
- Developing care plan documentation which can be shared with all agencies without the need for other supporting documentation such as letters.
- Not having separate CPA review documentation.
- Combining assessment and initial care plan documentation.
- Using initial screening measures which are sufficiently thorough to identify those requiring a more in-depth assessment, but which do not require staff to undertake comprehensive assessments on everyone who is referred to a service.
- Having one care plan which follows the service user through all care settings.
- Using this single care plan as the mainstay of the documentation for Mental Health Act Managers' Hearings and Mental Health Review Tribunals.
- More use of joint assessments and review with common documentation between agencies and teams.

Some of the difficulties that will need to be overcome include:

- Providing more clarity to practitioners on the extent to which information sharing is permitted and encouraged with due consideration of confidentiality issues.
- Extending the involvement of eg housing, education, police and probation services without invoking the need for a multiplicity of parallel records.
- Striking the balance between the need to measure activity and performance and the need to reduce bureaucracy.
- The need for interim systems while organisations wait for the full impact of Connecting for Health on electronic record keeping.

Q. What should services do to reduce bureaucracy in the CPA process?

Q. Are there any national policy requirements that unintentionally encourage an overly bureaucratic local approach to the CPA?

Section 11: Measuring and Improving Quality

Audit and monitoring remain essential components of successful implementation of the CPA. Organisations, locally and nationally, should be working to ensure that systems are in place to monitor the quality and impact of the CPA with the main focus on achieving desirable outcomes for those who use the services.

Monitoring systems are more likely to be effective and sustained if performance management information is drawn from information routinely collected and then used to support service development, capacity planning, resource management, reflective practice and continuing professional development.

Commissioners of mental health services often use evidence of the CPA implementation as one of a number of quality standards to assess mental health service providers. Similarly, many service providers also use the CPA audit as a relatively quick and easy way of assessing their own performance. Researchers have also reported on the use of auditing the CPA as a proxy for measuring the quality of the service provided. [7]

Auditing and measuring the quality of the CPA is carried out in a variety of ways – both locally and nationally.

11.1 Local audits

An Audit Pack for Monitoring the Care Programme Approach [31] includes guidance on reporting into clinical governance and local council scrutiny committees and a section for development of audit from a service user focus by service users.

The CPA Association (CPAA) has produced standards and an accompanying protocol for the CPA [32].

The CPA Brief Audit Tool (CPA-BAT) has been developed for assessing the quality of the CPA care planning for service users who have been more than one compulsory admission to hospital in a period of three years [33].

11.2 Healthcare Commission and the Commission for Social Care Inspection

The Healthcare Commission's (HC) focus for assessing mental health trust performance is an annual health check which measures trusts' performance against a number of core and developmental standards, national targets and use of resources. In 2006 the developmental standards assessment of the clinical and cost effectiveness domain will gather data on service users on the enhanced CPA who are in work, education or training.

Other performance information is drawn from annual patient and staff surveys which provide performance indicators for the annual health check. Staff are asked a number of questions that relate to how well their views on their employers prioritise patient care. The service user survey focuses on the CPA and has been developed to include older adults, people with learning disability and in 2007-2008 will include in-patients. Services users are asked a range of questions related to their satisfaction with services including: what and how services are provided; staff behaviours and attitudes; their care plan and review process; community support; crisis care; and carer needs. Trusts are encouraged to support all their teams and survey to do the survey, to use the results in staff annual appraisals, and to publicise and use the results of surveys locally to improve the quality of services.

In 2006 the HC and the Commission for Social Care Inspection (CSCI) have worked together to assess outcomes of key community services in Local Implementation Team (LIT) areas that contribute to mental health and social care services for adults between 18 and 64. Assessment criteria are that:

- services are accessible to people according to their present circumstances;
- care arrangements focus on a range of needs and outcomes for service users;
- users of services, and where appropriate their carers, are involved in decisions and are able to make choices about their care.

The HC's planned acute in-patient improvement review will have a focus on the CPA along with further work planned around medicines management in mental health.

11.3 Mental Health Act Commission

Mental Health Act Commissioners take an active interest in the CPA process: to monitor the operation of Section 117 MHA 1983; in response to concerns raised by detained patients; to monitor that issues relating to Equality and Human Rights (including legal rights) are being supported by the CPA care planning process.

11.4 NHSLA/CNST standards

NHS Litigation Authority (NHSLA) are currently reviewing Clinical Negligence Schemes for Trusts (CNSTs) Mental Health and Learning Disability Clinical Risk Management Standards which are due to be piloted 2007. Current assessment of clinical information and care records allocates a score to each trust on how readily identifiable the CPA/care plan is on records used during in-patient consultation (Standard 4) and the occurrence and record of a full risk assessment prior to discharge from hospital (Standard 7).[34]

11.5 Independent Providers

DH Standards for independent providers of mental health care registered with the National Care Standards Commission (now CSCI) include the requirement for them to have written policies and procedures for implementing the CPA and care management, which must be reviewed at least every 3 years. These standards also included explicit requirements for planning and reviewing individuals' care, and for the effective planning and implementation of in-patient's discharge. These standards are currently being revised.[35]

Consultation questions

Q. Are there other ways that quality improvements in the CPA process and outcomes should be measured – either nationally or locally- without adding unnecessary bureaucracy?

Q. Are there ways in which current systems could be better aligned or organised?

Annex A: Current definitions for the CPA

Standard

Current guidance sets out that people on the standard CPA are likely to have the following characteristics:

- require support or intervention of one agency or discipline or require only low-key support from more than one agency or discipline;
- more able to self-manage their mental health problems;
- have an active informal support network;
- pose little danger to themselves or others;
- more likely to maintain appropriate contact with services

Enhanced

Current guidance sets out that people on the enhanced CPA are likely to have the following characteristics:

- multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;
- only willing to co-operate with one professional or agency but have multiple care and support needs;
- may be in contact with a number of agencies (including the criminal justice system)
- likely to require more frequent and intensive interventions, perhaps with medication management;
- more likely to have mental health problems co-existing with other problems such as substance misuse;
- more likely to be at risk of harming themselves or others;
- more likely to disengage with services.

Annex B: Key groups

Parents

Separation and specialisation in health and social care services can resulted in staff in adult mental health services focussing on the adult with insufficient attention paid to the adult as a parent and his/her dependent children. Staff in children's services may place insufficient emphasis on the mental health needs of parents and the potential adverse impact on children. This underscores the importance of ensuring effective communication and collaborative working between services.

Research and enquiry reports have established the possible adverse effects of parental mental illness on child development, well-being and safety and the need for mental health and children and family services to work collaboratively to meet the needs of families. *Crossing Bridges* highlights the public health implications of the potential impact of mental health on parenting, on the child, over time and across generations [35].

The Social Exclusion Unit report *Mental Health and Social Exclusion* identified parents with mental health problems and their children as one of four groups most likely to face barriers to getting their health and social needs addressed [3].

Recommendations from both adult homicide inquiries and child death reviews are remarkably similar – the need for improving communication, coordination and collaboration within and between all services and agencies to support better mentally ill parents who are struggling to meet the needs of their children including their safety (Falkov, A 1996 [36], Woodley 1995 [37]).

Including the needs of adults as parents into the CPA will re-enforce the understanding that adults with mental illness may also be parents and that this needs to be taken account of in assessment and care planning. This means identifying whether the child is also in need, including need of protection due to the direct or indirect impact of the mental illness. The fact that an adult is also a parent (or about to be a parent) should be addressed at every stage of the assessment, care planning and review process as should the needs of the wider family.

If the child is on the Child Protection register then the CPA documentation and review should explore the impact of the adult's and child's care plan and interventions and how they inter-relate to each other. The respective plans should clearly identify cross-agency communication strategy and responsibilities.

Where there are concerns about a child (including unborns) they need to be specific to the child i.e. would they be there whether the parent had a mental health problem or not? If the concerns are related to parental mental health then recording should be specific about what the concerns are being attributed to eg. severity, duration, history, dual diagnosis, compliance with treatment.

Dual diagnosis (Mental health and drug and alcohol misuse)

People with dual diagnosis are among the most vulnerable in the community. When compared with a mental health problem alone, people with dual diagnosis are more likely to have:

- Increased suicide risk
- More severe mental health problems
- Homelessness and unstable housing
- Increased risk of being violent
- Increased risk of victimisation
- More contact with the criminal justice system
- Family problems
- History of childhood abuse (sexual/physical)
- Greater likelihood of falling through the net of care
- Less likelihood of compliance with medication and other treatment (Banerjee et al. 2002 [38]).

The *Dual Diagnosis Good Practice Guide* encourages change for service delivery, from the commissioning of services to the structure and models of intervention [39]. The guide clarifies that all services, including drug and alcohol services, must ensure that clients with severe mental health problems and substance misuse are subject to the Care Programme Approach and have a full risk assessment.

It particularly highlights the trend of alcohol use as the most common form of substance misuse, often co-existing for people with other substance misuse problems. Also, people who are mentally ill, homeless or in prisons are associated with a high prevalence of substance misuse.

The key innovation is encouraging the two traditional treatment delivery systems (mental health services and drug & alcohol services) to work together to provide a 'mainstreaming' of clients with severe mental health problems. The CPA is the model which all services,

including drug and alcohol services, are advised to use for clients with severe mental health problems and substance misuse. Its key concept is that the primary responsibility for the treatment of individuals with severe mental illness and problematic substance misuse should lie within mental health services.

There are implications here for how multiple delivery systems can collaborate in constructing the CPA – avoiding replication of 'paperwork', managing confidentiality protocols, engaging with carers and families, and communicating information effectively. It would not be unusual for the CPA co-ordinators to liaise with professionals from health and social care services, the criminal justice system, housing providers, non-statutory support services, and primary care, amongst others such as prison workers. Change can be a lengthy process, with periods of remission, for this client group. The CPA structures need to reflect a strong collaborative aspect, which is valid over longer periods, and can manage the complexities that people with a dual diagnosis often find in their lives.

The CPA process will also take into account the associated physical health care complexities and public health issues that are often present for this client group.

Developing dual diagnosis strategies at a more local level need to include the issue of the CPA management at an early stage.

Violence and Self-harm

Safer Services found that a large number of service users, including many with severe mental illness, who commit suicide or homicide are not subject to the higher levels of the CPA [11]. It reported that many patients who commit suicide have been thought to need less intensive service support soon after their acute illnesses have subsided, even though their risk factors remain unchanged. The report suggests that the main indicators of suicide risk are: deliberate self-harm, alcohol or drug misuse, and a history of hospital admission. Other risk indicators include detention under the Mental Health Act, co-morbidity and social isolation.

Safer Services also found that a majority of service users who have committed homicides have previously been violent, particularly in the year before the homicide. They have high rates of alcohol and drug misuse and deliberate self-harm. They have frequently been admitted to hospital at some time, often under the Mental Health Act. Those with severe mental illness often have a secondary diagnosis.

A number of psychiatric liaison services have also reported that people with personality disorders who self harm of attempt suicide may be excluded from follow up services, and from the CPA arrangements regardless of risk.

Also see Section 9 on risk assessment and management as part of the CPA.

Homeless[1]

Mental health services need to overcome the difficulty that a homeless person has in initially accessing them, or wider health services, and ensure that housing needs are addressed in the CPA in conjunction with other health and housing needs. Health services and local authorities or the voluntary sector should work closely together to identify and deliver effective packages of care and support for this group.

People with mental health problems might stay in homeless hostels or acute psychiatric wards because there is no suitable move-on accommodation. The CPA is important here because health status may impact upon ability to get moved under Supporting People funding or local council criteria. Some studies have estimated that around a quarter of people in supported housing or residential care want to move. Stays of five years or longer in temporary housing in London are now common [(40)].

Gaining trust and engagement with this group of people can often be difficult and time-consuming. Failure to attend appointments can lead to discharge from care, although homeless people face more problems with attendance than others. There is evidence that homeless people have been subject to staff discrimination whilst on acute psychiatric wards. They are likely to have problematic drug and/or alcohol use. Many have some form of learning disability, but not sufficient to be engaged with specialist learning disabilities services.

Homeless people may move between team catchment areas and ensuring clinical notes are available is a challenge. Patient held notes seem to work well in some places.

Significant mental illness is present in 30 percent – 50 percent of the homeless population. Acute distress and personality dysfunction are prevalent although functional psychoses predominate. Studies of hostel and shelter populations have found the overall prevalence of psychosis to be 30-50 percent, mostly schizophrenia. Generally, rates of mental illness are twice those of the domiciled population and are of a more severe nature. [(41)]

The rate of alcohol misuse has been estimated to be three to five times higher amongst homeless people than the general population. At least a fifth of hostel residents can be expected to have co-morbidity of alcohol-related problems and major psychiatric disorders. Drug misuse is becoming more frequent, particularly amongst younger hostel users. Co-morbidity of mental illness and substance abuse occurs in 20 percent of homeless people.

1 The reference to homeless people here refers to people not in settled accommodation, this includes: rough sleepers; people living in insecure accommodation e.g. hostels, night shelters, squats, or living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the main homelessness duty.

Annex C: Health and Social Care Common Assessment Framework

Consultation on *Independence, Wellbeing and Choice*[42] and *Our Health, Our Care, Our Say*[2] showed that many people had concerns about the way that needs were being assessed in health and social care generally. The view was that assessment was not joined up and that the experience of many people was that they were asked to repeat the same information time and again to different health and social care workers. Many people felt disempowered by the existing process, which they felt was more designed around the needs of organisations, than the needs of the individuals being assessed.

As a result DH is working on the development of a common assessment framework for adults across Health and Social Care which will improve assessment and care management for those with long term and/or complex conditions whose care is best managed between primary care and adult social care. Its aims will be to:

- improve outcomes for adults with care and support needs;
- ensure that assessment better reflects the needs of individuals, rather than organisations;
- promote joined up working across health and social care;
- reduce duplication of information collection and procedures across different agencies;
- ensure clarity about the role of councils, and local partner agencies, in respect of assessing long-term care needs; and
- allow people to self-assess where possible.

The Common Assessment Framework for Adults will build on experience to date from implementing the Care Programme Approach, the Single Assessment Process (SAP) for Older People and Person Centred Planning (Learning Disabilities).

The intention is that the principles and processes of the CPA for those in secondary mental health services will remain intact but that the CPA, and the assessment of other mental health needs, will be incorporated within a wider common framework for managing long-term care. The aim is to ensure that the wider health and social care needs of people with mental health problems are taken into consideration and that there is improved management of mental health in the community where specialist mental health services are not in the lead.

The details of the inter-dependencies between the CPA and the Common Assessment Framework will be explored through a policy collaborative which will be commissioned in October 2006 and which will involve a wide range of stakeholders.

NHS Connecting for Health

NHS Connecting for Health (NHS CFH) is delivering the National Programme for IT (NPfIT). A central component of this programme is the NHS Care Records Service (NHS NCRS), which combines Detailed Care Records for every patient in England, held on local systems, and a Summary Care Record, which will be held in a national database, called the Personal Spine Information Service (PSIS). A Service User's Summary Care Record will contain the most important information relating to their care and will be available to those treating them anywhere in England. The Summary Care Record will be populated by "messages" sent from local systems to PSIS.

A team within NHS CFH has been working to identify the information requirements of the mental health community. The result of this work is a set of messages that enables the Summary Care Record to hold the most pertinent mental health information and make this available to health and social care professional staff at the point of care.

In designing the mental health messages, the team took as its starting point the CPA process and, specifically, the types of information gathered to create a care plan and at the CPA reviews. This provided the core data items for the mental health messaging work, with further requirements subsequently identified and validated to ensure the messaging would be adequate to cover the needs of Child and Adolescent Mental Health Services (CAMHS), Adult Services, Older People's Services, Substance Misuse Services, and Forensic Services. The CPA has, therefore, occupied a central position in NHS CFH's design of the Summary Care Record and there will be a message specifically dedicated to carry information resulting from the CPA summaries.

In addition to a dedicated CPA summary message, the NHS CFH mental health team also conducted a broad consultation exercise aimed at deriving an acceptable standardised format for capturing information resulting from mental health risk assessments. This consultation process yielded a clear preference for a particular format that will enable the safe communication of risk information, without forcing a change in local risk assessment processes. Again, this provides support to the CPA process.

Annex D: Consultation Code of Practice

This consultation follows the Cabinet Office code of practice www.cabinetoffice.gov.uk/regulation/consultation. This requires government departments to:

- Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of the policy.
- Be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses.
- Ensure that the consultation is clear, concise and widely accessible.
- Give feedback regarding the responses received and how the consultation process influenced the policy.
- Monitor the department's effectiveness at consultation, including through the use of a designated consultation co-ordinator.
- Ensure the consultation follows better regulation best practice, including carrying out a Regulatory Impact Assessment if appropriate.

The Code also invites respondents to comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process. For DH consultation, comments or complaints (but not your responses to this consultation) should be sent to:

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Skipton House
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London SE1 6LD
E-mail: steve.wells@dh.gsi.gov.uk

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), The Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

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