Back on Track?

CPA care planning for service users who are repeatedly detained under the Mental Health Act

In association with the Mental Health Act Commission

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Back on Track?

The title of this report comes from a service user who was interviewed as part of this project. When asked what he found helpful about being in hospital he said ‘The staff [are] really good and help you get your life back on track’.
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Chief Executives’ Foreword

This is the third report resulting from close collaboration between the Mental Health Act Commission and the Sainsbury Centre for Mental Health. Previous reports have focused on detained patients absent without leave and the care of women patients, and the care of detained patients from Black and minority ethnic groups. The second of these was an important stepping-stone on the route to developing Delivering Race Equality¹ and the National Mental Health and Ethnicity Census 2005 which took place on 31 March 2005.

This third report looks at the way the Care Programme Approach is undertaken with patients who are repeatedly detained. Mental Health Act Commissioners had for some time been concerned about the way in which the Care Programme Approach was operating. Commissioners noted that service users were re-admitted sometimes quite soon following discharge and that in many cases services did not have robust care plans for individual service users.

The report describes the quality of care planning for patients with repeat admissions under the Mental Health Act 1983 and assesses the extent to which the Care Programme Approach is being operated effectively and draws conclusions about factors that contribute to the best quality of care and outcomes for such patients. As might be expected the picture that emerges is rather variable.

On the one hand there appears to be some progress in the development of CPA but there are concerns the process is not being followed or recorded accurately, although in two thirds of cases a care plan relating to the previous discharge was found in the patient’s hospital case notes. On the other hand only one third of care plans had been signed by the service user. More worryingly, people in Black and Asian ethnic groups did less well than White service users in terms of having their daily living needs assessed, and Asian groups also did less well than White groups in terms of having action plans to meet their daily living and mental health needs.

The report highlights the development of good practice in some areas and this is to be welcomed. However, it also identifies shortfalls in the implementation of the Care Programme Approach and confirms continuing discrimination against Black and minority ethnic patients. Similarly it is of concern that, even with good CPA, service users are returning to hospital on average just under a year after discharge.

Future policy and planning must address the continuing annual ‘revolving door’ that the results appear to show, and the report will provide a helpful benchmark against which to measure future progress.

Christopher Heginbotham
Chief Executive
The Mental Health Act Commission

Angela Greatley
Chief Executive
The Sainsbury Centre for Mental Health

Mental Health Act
Commission
Chairman’s Foreword

I would like to express my thanks to all those involved in this innovative research project. The Sainsbury Centre for Mental Health has once again provided a sound research platform that has enabled Mental Health Act Commissioners to undertake a valuable piece of work identifying critical issues for detained patients. I hope the Department of Health and the National Institute for Mental Health in England will note the important conclusions of the research and use the results further to drive forward effective care planning for all patients and service users.

Prof. Kamlesh Patel

Chairman for the Mental Health Act Commission
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Executive Summary

KEY MESSAGES

❖ Effective implementation of the CPA is vital to ensure appropriate services are planned and delivered to service users who are repeatedly detained under the Mental Health Act.

❖ Local systems should ensure that all groups of service users are treated equitably.

❖ Staff from all disciplines and agencies should work together to ensure continuity of care between hospital and community services.

❖ Assessment and care planning should put service users at the heart of the CPA process.

❖ Assessment and care planning should be comprehensive, including all the factors that contribute to service users’ health and well being.

INTRODUCTION

Mental Health Act Commissioners undertake routine visits to facilities where service users are detained under the Mental Health Act 1983. From their experiences, they felt that special care was needed in the discharge planning, follow-up, and delivery of aftercare as part of the Care Programme Approach (CPA) for service users whose route into hospital was habitually through compulsion.

This joint project, undertaken between the Mental Health Act commission (MHAC) and the Sainsbury Centre for Mental Health (SCMH), aimed to describe the quality of the CPA care planning for service users in England who had been detained under the Mental Health Act more than once in a three year period. It also aimed to assess the factors that contribute to the best quality of care and the most effective care planning for these service users, and to develop a tool for use in monitoring, assessing and evaluating care planning.

Methodology

We devised a questionnaire to elicit a range of quantitative and qualitative information which was used by specially trained Mental Health Act Commissioners as part of their normal visiting programme. Visits were made to 119 wards in 57 units within 15 Trusts, drawn from all eight National Institute for Mental Health in England (NIMHE) regions. Information was collected from the case notes of 277 service users, 151 of whom were also interviewed.
## KEY FINDINGS

### Setting the scene
- Ethnicity was not recorded for all of the service users whose case notes we examined.
- Only 15% of wards had access to an electronic CPA system.
- Some case notes were difficult or impossible for Commissioners to find.

### Previous admission and discharge planning
- Two thirds of the service users had a copy of the CPA care plan relating to their previous discharge from hospital in their inpatient notes.
- The CPA level was recorded for less than two thirds of the service users, most of whom were on the enhanced level of CPA.
- The date of the next CPA review was recorded in just over half the care plans.
- The CPA Care Co-ordinator was recorded as attending the post-discharge CPA review in a third of cases, and a fifth of service user interviewees said their Care Co-ordinator was involved in drawing up their care plan.
- It was recorded that a third of the service users had signed their CPA care plans, and that a fifth had been given a copy of their care plan.
- There were some significant differences between the way different groups of service users had their needs assessed and their care planned. Ethnicity, age group and Section of the Mental Health Act under which they were previously detained were all found to be statistically significant factors.
- People in Black and Asian ethnic groups did less well than White service users in terms of having their ‘daily living’ needs assessed; Asian groups also did less well than White groups in terms of having action plans to meet their ‘daily living’ and ‘mental health’ needs.
- Commissioners identified some examples of good practice in relation to information sharing and record keeping.

### Life in the community
- A fifth of the service users were readmitted within 90 days, with seven people being readmitted within two weeks of their previous discharge. Readmissions within 90 days were found in 14 of the 15 Trusts visited.
- In terms of the care provided after their previous discharge from hospital, not all groups of needs were met equally well. The biggest variations were in meeting ‘mental health’, ‘risk’ and ‘relapse’ needs.
- Some groups of service users – women, and people who had been previously admitted on a treatment Section – had their needs less well met than others.
- More than half the interviewees said they had been seen by a mental health worker within a week of their previous discharge from hospital.
The current admission

❖ At the time of their current admission, 92% of service users were described in their case notes as being either a danger to themselves or to other people.

❖ More than half the service users were said to be non-compliant with treatment in the community. In a small number of cases, non-compliance was the only recorded reason for their compulsory admission.

❖ Over 40% of the service user interviewees were generally positive about being in hospital, while a similar number had negative feelings about their admission.

❖ Service users’ reports of negative experiences of acute inpatient care reiterate concerns which have been identified in other national studies.

CONCLUSIONS

We have described the quality of CPA care planning for service users with repeated detentions under the Mental Health Act 1983 in England, and have assessed the factors that contribute to the best quality of care and outcomes and to the most effective CPA care planning for such service users. We have also developed an effective tool – The CPA Brief Audit Tool (CPA-BAT) – for use in monitoring, assessing and evaluating care planning for service users with repeated detentions.

Our conclusions and recommendations relate both to existing requirements placed on NHS Trusts by legislation, guidance and performance monitoring arrangements, and on improving practice in order to make a difference to the lives of service users.

RECOMMENDATIONS

**Ensuring equitable service delivery**

1. NHS Trusts should record the ethnicity of all service users, in order to ensure that the services planned and delivered meet service users’ cultural needs and to avoid inequalities in the delivery of care.

2. Regular monitoring should enable NHS Trusts to assess whether some groups of service users – e.g. those of different gender, age, and ethnicity – are being treated less equitably than others. Where such inequities are detected, they should be addressed.

3. Service providers should ensure that aftercare services are provided equitably to men and women, and to people who were admitted on all assessment and treatment Sections of the Mental Health Act.

**Information sharing**

4. Local systems should ensure that case notes are securely stored and easy to access, so that information on previous care planning and interventions delivered is available to contribute to current care planning.

5. Local systems should ensure that CPA care plans are shared between hospital and community services, and with other service providers who are involved in an individual’s care. Effective liaison when planning service users’ aftercare may reduce the number of readmissions within 90 days.
Electronic CPA systems should be fully implemented in each NHS Trust to enable crucial information to be easily shared between staff across hospital and community sites, and between disciplines, and so facilitate co-ordinated planning and delivery of care.

NHS Trusts should ensure that the criteria for compulsory admission are correctly applied.

Managers of acute inpatient care should ensure that an adequate range of therapeutic activities is provided, along with social and recreational occupation, especially for detained patients who are unable to leave the ward.

All inpatients should be on the enhanced level of CPA, and this should be recorded in their notes.

Copies of CPA care plans relating to service users’ previous discharges from hospital should be kept in their inpatient notes to facilitate continuity of care.

The date of the next CPA review should be recorded in service users’ case notes before they are discharged from hospital.

The CPA Care Co-ordinator should take the lead in drawing up service users’ care plans, and should attend the CPA review meetings.

CPA assessment and care planning should be comprehensive, with all needs included. Individuals’ cultural and spiritual needs, at present rarely assessed and planned for, should be included in CPA care planning.

Timely discharge planning should enable appropriate community-based services – including housing, financial and occupational – to be arranged so that service users can be discharged as soon as their clinical need for inpatient care has ended.

Local systems should ensure that community services have face to face contact with all formerly detained patients within a week of their discharge from hospital.

Having a comprehensive CPA care plan is not an end in itself. Services should ensure that the interventions specified in the care plan are actually delivered to the service user.

Service users should be informed about the CPA, and fully involved in drawing up their care plans and participating in CPA reviews, with access to an independent advocate if they request this. Their own assessment of their strengths and needs, as ‘experts by experience’, should inform the care planning process. They should be asked to sign their care plan, and be given a written copy of it.

The good practice which has been identified can serve as an example for NHS Trusts wanting to improve their practice in this area.
Introduction to the project

BACKGROUND

This project arose out of concerns identified by Mental Health Act Commissioners as part of their routine visiting to facilities where service users are detained under the Mental Health Act 1983. They felt that special care was needed in the discharge planning, follow-up, and delivery of aftercare as part of the Care Programme Approach (CPA) for service users whose route into hospital was habitually through compulsion. This raised the question of whether this group of service users, who probably have the most complex needs, were receiving adequate care planning before their discharge from hospital and delivery of community-based services afterwards.

The Sainsbury Centre for Mental Health (SCMH) and the Mental Health Act Commission (MHAC) have previously collaborated successfully on two National Visits. The first, in 1996, looked at the numbers of detained patients, those who were absent without leave, staffing levels and the care of women who were detained (Ford et al., 1997). This was followed in 1999 by an examination of the care of detained patients from Black and minority ethnic groups (Warner et al., 2000). SCMH has also undertaken a number of programmes relating to acute services and the relationship between inpatient care and community services.

THE CARE PROGRAMME APPROACH

The Care Programme Approach (CPA) was introduced in 1990 as the framework for the care of people with mental health needs (DH, 1990a) in England, originally intended to be implemented by April 1991, running in tandem with the local authority Care Management system (DH, 1990b). Initially the CPA applied to current inpatients at the point of discharge, and new referrals to specialist mental health services, but this was extended to include everyone in contact with specialist mental health services. The key elements were the systematic assessment of individuals’ health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker to monitor the delivery of care, and the regular review and, when necessary, amendment of the care plan in line with the service user’s changing needs. The importance of close working between health and social services was stressed, as was the need to involve service users and their carers.
The CPA was revised and integrated with Care Management in 1999 to form a single care co-ordination approach for adults of working age with mental health needs, to be used as the format for assessment, care planning and review of care by health and social care staff in all settings, including inpatient care (NHSE & SSI, 1999). Two tiers of CPA, standard and enhanced, were established nationally and key workers were replaced by Care Co-ordinators. Standard CPA is described as being for those people whose needs can be met by one agency or professional or who need only low key support from more than one agency or professional, who are able to self-manage their mental health problem, who pose little danger to self or others, and who are likely to maintain contact with services. People on the enhanced CPA level are likely to have multiple care needs which require inter-agency co-ordination, to require more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services.

For further background on the history and current issues relating to the CPA see the literature review in Appendix 1. The full literature review is also available on the SCMH website at www.scmh.org.uk and the MHAC website at www.mhac.org.uk.

THE AIMS OF THE PROJECT

The project's aims were:

❖ to describe the quality of care planning for service users with repeated detentions under the Mental Health Act 1983 in England;

❖ to assess the factors that contribute to the best quality of care and outcomes and to the most effective care planning for such service users;

❖ to develop an effective tool for use in monitoring, assessing and evaluating care planning for service users with repeated detentions, under the current and any future Mental Health legislation;

❖ to set a baseline on the role of care planning for service users with repeated detentions;

❖ to enable a possible future phase of the study, which could assess changes in the efficacy of care planning following the introduction of a new Mental Health Act.

THE STEERING GROUP

A steering group was set up to guide the progress of this project, meeting regularly throughout the course of the project.
TERMINOLOGY

It is usual for SCMH reports to use the term ‘service user’ rather than ‘patient’. However, this project is about people who are detained in hospital under the Mental Health Act 1983, and the legislation uses the terms ‘patient’ and ‘detained patient’. Therefore, when referring to people detained under the Act, we will use these terms. When referring to CPA policy and guidance, we will use the expressions used in the published documents.

REFERENCES IN THIS CHAPTER


What we did

PROJECT METHODOLOGY

Review of the literature

A review of the literature relating to the CPA was carried out to inform the development of the project. Although many articles have been published on the use of the CPA, the search found very little relating specifically to detained patients. Information provided by the Care Programme Approach Association (CPAA) made a very useful contribution to this review, and it was also helpful to obtain examples of CPA documents currently in use by a number of NHS Trusts. The review aimed both to provide an understanding of the scope of current knowledge and practice, and to assess the extent to which the CPA is used as a proxy measure for evaluating quality of care. Only information on the implementation of the CPA in England was considered, excluding material relating to the introduction of the CPA in Scotland and Wales. Altogether, 99 data sources were examined.

The complete literature review is included as Appendix 1. It is also available on the SCMH website at www.scmh.org.uk and the MHAC website at www.mhac.org.uk.

The scope of the project and eligibility criteria

Information was collected by Mental Health Act Commissioners as part of their normal visiting programme. Service users were included in the project if they were currently detained under the Mental Health Act and had also had a previous compulsory admission during the three years prior to the visit. They were of working age (16 to 65), detained in an NHS facility in England, had a primary mental health problem (rather than a learning disability) and were drawn from as wide a geographical range as possible. Information on CPA care plans was collected by an examination of case notes, followed by a short interview with as many of the service users as possible.

Devising the questionnaire

The researcher, drawing on the literature and including information on existing good practice and advice from the steering group, devised a questionnaire to elicit the information needed for the project. This included information obtained from case notes on service users’ demographic characteristics, their current and previous admissions, the CPA care planning process and the content of their care plan at the time of their previous discharge from hospital, and the CPA review process following their discharge. The interview with service users included asking about their knowledge of and involvement with the CPA, the help they received following their previous discharge from hospital, and the circumstances of their current compulsory admission.
Piloting the study

There are several reasons for using pilot studies before embarking on a major piece of work. Firstly, it is important to check the reliability, validity and ‘usability’ of the research measure, in this case the questionnaire. Secondly, it is important from a research point of view to check whether the type of data collected will enable us to answer the questions posed in the study. Thirdly, piloting allows us to discover other previously unforeseen problems we might encounter during the main study. The piloting undertaken for this project proved valuable in all these aspects.

The questionnaire was piloted by MHAC Commissioners during their routine visits to acute inpatient wards in two NHS Trusts, one in London and one in the South East, with questionnaires being completed on service users who met the project’s inclusion criteria. Feedback from the pilot enabled improvements to be made to the questionnaire design before the start of the main project.

Piloting took place in two phases. Following training, a small group of Commissioners used the first draft of the questionnaire to obtain information on ten service users from acute inpatient units in the two Trusts, and seven of the ten were interviewed. The questionnaires were analysed, and feedback obtained from the Commissioners, resulting in several changes being made to the questionnaire. Commissioners then completed a further ten questionnaires, and interviewed two of the service users. Only minor changes resulted from this phase.

During the piloting, Commissioners who were unsure about any aspect of the visit, or the questionnaire, were encouraged to contact the researcher or MHAC staff for guidance. After completing and returning the questionnaires, the Commissioners contacted the researcher in order to resolve any queries about the data collected. These measures were intended to reduce missing data and inaccuracies as far as possible, and they were both continued during the main project.

Other issues emerged from the piloting and were addressed before the main project started. The matter of ward staff not being sufficiently prepared for the visit, making it harder to identify which service users met the inclusion criteria, was addressed by providing more information to Trust Mental Health Act Managers and ward managers, both in writing by the MHAC and by means of a phone call from the lead Commissioner before the visit. A difficulty which remained unsolved in many instances was the problem of locating the relevant set of case notes for some service users who had multiple volumes of notes, and of finding CPA care plans within many of the case notes.

THE MAIN STUDY

The Commissioners

Twenty Mental Health Act Commissioners received training in using the questionnaire, and went on to collect data.

The first sample

To obtain a national geographical spread, we made a random selection of one NHS Trust providing inpatient care to detained patients from each of the eight
NIMHE Regions. To maximise the chances of getting enough service users who met the criteria, we selected only from NHS Trusts which had had more than 200 formal admissions in 2001-02, based on information from Department of Health statistics. Visits were made to a total of 26 inpatient units across the eight Trusts, consisting of 55 wards, and data was collected on everyone who met the inclusion criteria. Altogether 130 questionnaires were completed, and 76 service users were interviewed. We were aiming to collect information on at least 250 detained patients.

**The second sample**

As the first attempt had resulted in less than the intended number of completed questionnaires, more data was collected in one additional Trust in each of the seven NIMHE Regions where the numbers were low. By means of purposive sampling, we chose the Trust with the highest number of compulsory admissions in each Region (as given in the DH figures provided for 2001-02), to maximise the chances of finding enough service users who met the inclusion criteria. In the second phase, 64 wards in 31 inpatient units were visited, 147 questionnaires were completed, and 75 service users were interviewed.

In all, 57 units in 15 Trusts were visited, consisting of 119 wards. A total of 277 valid questionnaires were completed and 151 service users were interviewed.

**The service user interviewees**

After examining the case notes of the people who met our inclusion criteria, the Commissioners attempted to interview all those service users. The interviews were anonymous, and no information was recorded by the Commissioners that could identify anyone who took part.

Over half the service users, 151 people (55%), were interviewed; 143 of them completed the interview while the remaining eight people answered only a few questions.

Of the 128 service users who were not interviewed, almost equal numbers were either not on the ward at the time of the visit (58 people, 45%), or refused (57 people, 45%), while 12 people were said by staff to be ‘too ill’ (9%), and one person was discharged before the interview could take place.

**The assessment tool**

One of the project’s aims was to develop an effective tool for use in monitoring, assessing and evaluating care planning for service users with repeated detentions. A version of the questionnaire devised for this project provides Trusts with a simple tool to assess their performance in care planning for service users who have repeated compulsory admissions – the CPA Brief Assessment Tool (CPA-BAT). Evidence from this project indicates that there are likely to be no more than a handful of people meeting these criteria in any Trust at any one time. They are, however, likely to be the people with the most complex needs, for whom a ‘CPA check’ would be most beneficial.
The CPA-BAT is included in this publication as Appendix 4, and is also available on the SCMH website at www.scmh.org.uk, and on the MHAC website at www.mhac.org.uk. It is not intended to replace the tools available for NHS Trusts to use in undertaking their annual audit of their performance on implementing the CPA for all service users, such as the assessment tool devised by the CPAA (CPAA, 2003) and that produced by Department of Health in collaboration with the Royal College of Psychiatrists (DH, 2001).

DATA ANALYSIS

The analysis of the quantitative and qualitative data is described in Appendix 2.

REFERENCES IN THIS CHAPTER


Setting the scene

KEY FINDINGS

❖ Ethnicity was not recorded for all the service users whose case notes we examined.
❖ Only 15% of wards had access to an electronic CPA system.
❖ Some case notes were difficult or impossible for Commissioners to find.

This chapter describes the characteristics of the 277 people included in the study, based on information taken from their case notes. It also describes the wards they were in, and where their CPA care plans were kept.

• **Type of ward:** Most of the service users (221 people, 80%) were in acute wards, with 40 (14%) in Psychiatric Intensive Care Units (PICUs) and 16 (6%) in other types of ward (e.g. eating disorders, rehabilitation). This is shown in Figure 1.

![Figure 1 Type of ward](image)
• **Gender**: There were 108 women (39%) and 169 men (61%).

• **Age**: The average (mean) age was 37 years, with a range of 17 to 65 years.

• **Ethnicity**: NHS Trusts are required to record the ethnicity of all their service users, using the current census categories. This information was aggregated into five groupings for the analysis. The majority of service users was White (175 people, 63%); 41 (15%) were Black or Black British; 31 (11%) were Asian or Asian British. In 18 cases (6%) ethnicity was not recorded. This is shown in Figure 2. The full list of categories, and the aggregated groups, is shown in Table 3 in Appendix 3.

![Figure 2 Ethnicity of the service users](image)

• **Interpreters**: We did not look for information on the service users' first language. However two service users, one reported to be Chinese and one Bangladeshi, were interviewed using an interpreter.
• **Diagnosis:** Schizophrenia was the most commonly recorded diagnosis (140 people, 51%) followed by bipolar disorder (58 people, 21%) and schizoaffective disorder (30 people, 11%). The diagnoses in the ‘other’ category included obsessional compulsive disorder, frontal lobe dementia, anorexia nervosa, drug use, ‘mental illness’ and ‘no diagnosis’. This is shown in Figure 3.

**Figure 3** Diagnoses of the service users

![Bar chart showing diagnoses of service users](image-url)
Where CPA care plans were kept: Staff in 113 of the 119 wards visited (95%) said that copies of CPA care plans were routinely kept in the inpatient case notes. Twelve wards (10%) reported keeping care plans in a separate folder on the ward, and 18 wards (15%) said they had an electronic CPA system either in operation or in the process of being introduced. Staff in a quarter of the wards (30 wards, 25%) said that copies of CPA care plans were kept in community teams’ notes as well as inpatient notes, while those in 4 wards (3%) said care plans were only kept in community teams’ notes and were not routinely included in inpatient notes. The location of CPA care plans is shown in Figure 4. (As copies of CPA care plans could be kept in more than one place, percentages come to more than 100%.)
COMPARISON WITH NATIONAL STANDARDS

The Healthcare Commission (HCC) makes an annual assessment of NHS Trusts’ performance against the standards in the National Service Framework for Mental Health (DH, 1999). Their NHS Performance Ratings 2003/4 include CPA Systems Implementation; to achieve this, care plans must be held on an electronic central database which is regularly updated and available 24 hours a day (HCC, 2003). In 2003/04 (HCC, 2004a) they found that 47 Trusts (57%) achieved this key target, 26 underachieved (31%) and ten significantly underachieved (12%).

In our project, only 18 wards (15%) said they had an electronic CPA (eCPA) system either in place or in the process of being introduced. Wards in seven of the 17 Trusts visited had no eCPA system in place or being introduced.

The Healthcare Commission’s Key Targets for the Star Ratings 2004-05 for mental health trusts again include CPA Systems Implementation. The CPA/complex care indicator has been revised and renamed ‘Enhanced CPA indicator’; this forms part of the ‘Balanced Scorecard’, which consists of a number of indicators chosen to provide a balance across a wide range of areas. Also within the ‘Balanced Scorecard’ are the service user survey questions on information and choice, and on safe, high quality co-ordinated care. An additional target relates to the full implementation of the Mental Health Minimum Data Set (MHMDS), which includes information on each service user’s CPA level, date last seen, and details of Care Co-ordinator. Performance will be assessed though examination of the quarterly MHMDS submissions.

FEEDBACK FROM MENTAL HEALTH ACT COMMISSIONERS

Commissioners provided information about the difficulties they had in locating service users’ case notes and CPA care plans, including several examples of being unable to find them at all. One Commissioner reported that the “notes relating to [his] previous admission are lost and untraceable”, and another that “one volume of case notes [is] missing, including CPAs for previous admission”.

REFERENCES IN THIS CHAPTER


BACK ON TRACK?
KEY FINDINGS

❖ Two thirds of the service users had a copy of the CPA care plan relating to their previous discharge from hospital in their inpatient notes.

❖ The CPA level was recorded for less than two thirds of the service users, most of whom were on the enhanced level of CPA.

❖ The date of the next CPA review was recorded in just over half the care plans.

❖ The CPA Care Co-ordinator was recorded as attending the post-discharge CPA review in a third of cases, and a fifth of service user interviewees said their Care Co-ordinator was involved in drawing up their care plan.

❖ It was recorded that a third of the service users had signed the CPA care plans, and that a fifth had been given a copy of their care plan.

❖ There were some significant differences between the way different groups of service users had their needs assessed and their care planned. Ethnicity, age group and previous Section were all found to be statistically significant factors.

❖ People in Black and Asian ethnic groups did less well than White service users in terms of having their ‘daily living’ needs assessed; Asian groups also did less well than White groups in terms of having action plans to meet their ‘daily living’ and ‘mental health’ needs.

❖ Commissioners identified some examples of good practice in relation to information sharing and record keeping.

This chapter deals with the service users’ previous compulsory admission, and the CPA care planning that took place before they were discharged from hospital.

• Mental Health Act Section on their previous admission: About two thirds of the service users were previously admitted on a Section 3 (173 people, 62%) while nearly a third (83 people, 30%) had been on a Section 2. This is shown in Figure 5 (overleaf).
Section 2 and Section 4 of the Mental Health Act 1983 are both admissions for the purpose of an assessment. Section 2 can last for 28 days, while Section 4 is an emergency Section, allowing detention for up to 72 hours. Section 3 is an admission for treatment. It can last up to 6 months in the first instance, and can initially be renewed for a further six months, and then annually.

Sections 37, 47 and 48 are all Sections from Part III of the Act which relates to ‘patients concerned in criminal proceedings or under sentence’. They are all Sections for treatment which can last up to six months in the first instance. Six of the service users who had been admitted under one of these forensic Sections were subject to further legal restrictions under Section 41; these restrictions can be imposed without any time limit.

Sections 135 and 136 permit a ‘mentally disordered person’ to be taken to a designated ‘place of safety’ in order to be assessed. Each Section can last up to 72 hours, and they apply to people who are found on private premises, and in a public place respectively.

Under Section 117, Health Authorities and local social services have a legal duty to provide aftercare for service users who have been detained on Sections 3, 37, 47 and 48.
PUTTING THE FINDINGS ON THE CPA IN CONTEXT

Key publications, along with some additional performance indicators, have been used as reference points for our findings on the implementation of the CPA. *Modernising the Care Programme Approach* (NHSE & SSI, 1999) clearly sets out what the CPA is, who it applies to, and how it should be implemented, complemented by the Department of Health's *Criteria for Robust CPA* (quoted in CPAA, 2003). The CPA is set in the context of the *National Service Framework for Mental Health (NSF)* (DH, 1999) which also includes standards for implementing the CPA. NHS Trusts are also required to meet a number of performance standards relating to follow up and aftercare once an individual has been discharged from an inpatient unit. In this section we report on our findings in relation to some of these standards.

**CPA levels**

*Modernising the CPA* says services are required to deliver the CPA according to two levels, standard and enhanced, and they should record the CPA level that applies to each service user. The characteristics of people on the enhanced level include having multiple, complex needs which are likely to be met by more than one agency; needing more frequent and intensive interventions, being more likely to harm themselves or others and being more likely to disengage with services. An assessment of risk also contributes to the decision about CPA levels. All inpatients should be on the enhanced CPA level.

**Findings**

❖ The CPA level was recorded for 164 service users (59%). The majority of these (145 people, 88%) were on the enhanced level and 19 (12%) were on the standard level.

**Care planning before discharge from hospital**

*Modernising the CPA* says that a service user’s care plan should be reviewed before they are discharged from hospital, and the date of the next CPA review should be recorded in their notes.

**Findings**

❖ For two thirds of the service users (178 people, 64%), a CPA care plan relating to their previous discharge from hospital was found in their case notes.

❖ The date of the next CPA review meeting planned to take place after discharge was recorded in just over half the care plans (95 people, 53%).

**The Care Co-ordinator**

*Modernising the CPA* says that the Care Co-ordinator’s responsibilities include overseeing care planning and the delivery of care. The NSF says that the care plan agreed at the point of discharge from hospital should identify the Care Co-ordinator, and the Care Co-ordinator should regularly review the care plan.
Findings

❖ In 62 cases (35% of care plans) the Care Co-ordinator was recorded as attending the first CPA review meeting following the service user's discharge from hospital.

❖ Only 27 service users (18% of interviewees) reported that their Care Co-ordinator was involved in drawing up their care plan. Psychiatrists were the professionals most commonly cited by interviewees as having been involved in drawing up their care plan (40 people, 26%). No interviewees mentioned an advocate being involved with drawing up their care plan.

❖ A minority of service users (28 people, 16%) was recorded as having a change of psychiatrist while the care plan was in place, with 27 (15%) having a change of Care Co-ordinator.

Involvement of service users

The Criteria for Robust CPA and the NSF both say that service users should participate in their own care planning, and should be given a written copy of their care plan. In the first National Patient Survey (HCC, 2004), in which the views of more than 27,000 people were obtained by means of a postal questionnaire, ten questions on the CPA were included. About half the respondents said they had been given (or offered) a copy of their CPA care plan, and 69% of people on enhanced CPA had a copy of their care plan. Three quarters of the respondents said they definitely, or to some extent, understood what was in their care plan, and most people agreed, at least to some extent, with what was in it.

Findings

❖ In a third of cases where a care plan was found in the notes (57 people, 32%) it was recorded that the service user had signed their care plan, and 38 people (21%) were noted as having been given a copy of their care plan. Only 25 people (14%) were recorded as both signing their care plan and being given a copy of it.

❖ A quarter of the 151 interviewees said they knew a lot about the CPA (36 people, 24%) while a further 63 people (42%) said they had heard of it.

❖ Thirty-seven service users (25%) said they had been involved in drawing up their CPA care plan at the time of their last discharge from hospital, and 53 people (35%) said they had been given a written copy of it. Nearly half (44 people, 47%) of those who had not been given a copy of their care plan, or didn’t know if they had received one, said they would have liked a copy.

Assessment and care planning

The requirement for care plans to include a crisis plan is stated in the NSF. Modernising the CPA says that care plans should include action and outcomes in all aspects of an individual's life where support is needed, including psychological, physical and social functioning. They should also reflect service users' cultural and ethnic backgrounds, and an assessment of risk should be included. The Criteria for Robust CPA says that service users' need for employment/occupational activity,
housing and welfare benefits should also be assessed and planned for, that care plans should reflect service users’ special needs relating to ethnicity, gender and disability, and reiterates that care plans for those on the enhanced level of CPA should include crisis and contingency plans.

Findings

❖ We identified 17 areas of an individual’s functioning which should be assessed as part of CPA care planning, based on the key documents and examples of good practice nationally.

❖ The percentage of service users for whom each topic was recorded as having been assessed varied from 94% who had had their ‘mental health’ needs assessed to just 9% who had had their ‘spiritual’ needs assessed.

❖ Of the 178 people who had a CPA care plan, the following nine topics – which are specifically mentioned in the key documents – were assessed and planned for to varying extents, as shown in Table 1 below.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Assessed (number &amp; %)</th>
<th>Planned for (number &amp; %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychological (mental health)</td>
<td>168 (94%)</td>
<td>166 (93%)</td>
</tr>
<tr>
<td>signs of relapse and crisis plan</td>
<td>144 (81%)</td>
<td>140 (79%)</td>
</tr>
<tr>
<td>risk*</td>
<td>139 (78%)</td>
<td>132 (74%)</td>
</tr>
<tr>
<td>physical</td>
<td>82 (46%)</td>
<td>60 (34%)</td>
</tr>
<tr>
<td>relationship with family and friends (social functioning)</td>
<td>101 (57%)</td>
<td>99 (56%)</td>
</tr>
<tr>
<td>cultural</td>
<td>22 (12%)</td>
<td>21 (12%)</td>
</tr>
<tr>
<td>employment/educational activities</td>
<td>82 (46%)</td>
<td>55 (31%)</td>
</tr>
<tr>
<td>housing</td>
<td>113 (63%)</td>
<td>107 (60%)</td>
</tr>
<tr>
<td>welfare benefits (finances)</td>
<td>90 (51%)</td>
<td>86 (48%)</td>
</tr>
</tbody>
</table>

Full details of which of the 17 needs were recorded as having been assessed, and those for which action plans were specified in the CPA care plans, are given in Figure 8 in Appendix 3. This figure also includes information on the help service users received to meet these needs.

*The term ‘risk’ is a broad one, encompassing risk to the health and safety of the service user and of other people. It can also include the risk of becoming homeless, losing employment or income, the risk of side effects of medication, and the risk of losing social and family support.
For the 178 service users who had a care plan, statistical analysis was used to examine the data about the assessment of service users' needs as documented in their care plans. The analysis is described in Appendix 2.

Using factor analysis, the assessed needs were found to form four groups. In each group, individuals who had one need assessed were likely to have had the others assessed. For example, we found that if a service user's 'mental health' needs had been assessed, they were also likely to have had their 'risk', 'relapse' and 'emotional' needs assessed.

The four groups were:

- **daily living** – includes: relationships with family and friends; housing; activities of daily living; work and/or education; financial; leisure activities
- **mental health** – includes: mental health; risk; relapse; emotional needs
- **practical issues** – includes: physical health; physical and sensory disability; communication; dual diagnosis; advocacy
- **sensitive issues** – includes: spiritual; cultural (including ethnicity).

There were some significant differences between the number of people who had been assessed for each group of factors. We found that:

- **daily living** – there was a wide range, with some people having all these needs assessed while others had few assessed
- **mental health** – most people had these needs assessed
- **practical issues** – few people had these needs assessed
- **sensitive issues** – very few people had these needs assessed.

There were also some statistically significant differences between groups of service users, with some groups having fewer needs assessed than others. We found that:

- people in the ethnic groups Black and Asian had fewer ‘daily living’ needs assessed than those in the White group;
- people aged 40 and above had fewer ‘mental health’ needs assessed than those in the 30-39 age group;
- people whose previous admission had been on an assessment Section had fewer ‘mental health’ needs assessed than those who had been on a treatment Section.

Similarly, statistical analysis was used to examine the data about the actions planned to meet each identified need, as recorded in service users' care plans.
Again, the variables were found to form four groups. These groups were slightly different from those found for the assessment variables. For example, service users who had an action plan to meet their ‘mental health’ needs were also likely to have action plans to meet their ‘risk’ and ‘relapse’ needs.

The four groups were:

❖ **‘practical issues’** – includes: relationships with family and friends; emotional; physical health; physical and sensory disability; communication; dual diagnosis; advocacy

❖ **‘daily living’** – includes: housing; activities of daily living; work and/or education; leisure activities

❖ **‘mental health’** – includes: mental health; risk; relapse

❖ **‘sensitive issues’** – includes: spiritual; cultural.

There were some significant differences between the number of people who had care plans for each group of factors. We found that:

❖ **‘practical issues’** – a few people had high numbers of action plans for these issues

❖ **‘daily living’** – there was a wide range, with some people having action plans for all these needs while others had few actions specified

❖ **‘mental health’** – most people had actions specified to meet these needs

❖ **‘sensitive issues’** – action plans to meet these needs were hardly ever recorded.

There were also some statistically significant differences between groups of service users, with some groups having fewer recorded action plans than others. We found that:

❖ people aged 40 and above had fewer actions specified to meet ‘daily living’ or ‘mental health’ needs than those in the 30-39 age group;

❖ people in the Asian group had fewer actions specified to meet ‘daily living’ or ‘mental health’ needs than those in the White group;

❖ people who had previously been admitted on an assessment Section had few actions specified to meet ‘mental health’ needs.

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**FEEDBACK FROM MENTAL HEALTH ACT COMMISSIONERS**

**Commissioners’ concerns**

Commissioners commented on problems they identified to do with sharing information to ensure continuity of the CPA plan. One example related to when a service user was transferred between private sector and NHS hospitals, a Commissioner reporting that:

“on his last admission he was transferred to a private unit ... and then on leave back into the community [there was] no CPA form for his last discharge – worryingly, he was allowed to slip out of contact although he has previous...
admissions [to a high secure hospital] for arson and his delusions motivate him towards violence. The care plans may be elsewhere but this should be a person in whom the CPA should be very carefully adhered to.”

There were also some problems of sharing information within the same Trust. In one example it was reported that:

“care plans do not follow him from community to hospital. The ‘seamless service’ isn’t evident, certainly communications could do with sharpening between community and hospital”, while another found that “three CMHTs admit to this ward, [but] only one completes CPA in detail.”

In another Trust, there were differences of approach towards discharge planning for service users detained on different Sections of the Mental Health Act 1983, with another Commissioner finding:

“no actual assessment of need or delivery of services available [for this service user]. [I was] told only [people on] Section 3 have a full discharge assessment, not much is done for [people on] Section 2.”

Some Commissioners mentioned serious worries about individuals’ care. Two service users were only on standard level CPA, despite having “complex needs”; one of these was described as having a tendency to “disengage with services”, while the other had “a history of risk to self and children and others” and the Commissioner added “this was a concern to me”. In another two instances, the legal documents relating to the service user’s current detention “could not be found on any files, even with the help of a nurse”. Another service user had been “awol [absent without leave] for 12 weeks”.

A Commissioner recorded concerns about a service user who did not have English as their first language:

“This interview was conducted with an interpreter who he has for about an hour a week; he is isolated, afraid and feeling helpless. I discussed this with the senior nurse who will support endeavours to improve this situation.”

Examples of good practice

Commissioners also found examples of good practice. For example, case notes in Newcastle, North Tyneside & Northumberland Mental Health NHS Trust included:

“a separate section [called] ‘Care co-ordination – your care plan’ containing a discharge care plan, risk management plan, care plan agreement, letters and other correspondence relating to care plan and discharge arrangements.”

Another Commissioner found that Avon and Wiltshire Mental Health Partnership NHS Trust had excellent CPA paperwork, commenting that:

“[The] team has put a lot of effort into getting it right. [It] demonstrates it can be done, given the will.”
In Pennine Care NHS Trust, the impetus for good practice was said to come from the Assertive Outreach Team, whose staff were responsible for:

“very detailed” CPA documentation. The Commissioner also commented that the Assertive Outreach Team “will send a copy of CPA documents to the ward.”

Also in Pennine Care NHS Trust, a Commissioner reported that:

“I met his CPN[community psychiatric nurse] and Care Co-ordinator and primary nurse and felt very assured that good communication exists between community and hospital services and court liaison.”

A third Commissioner visiting Pennine Care NHS Trust was impressed to find that a service user:

“had in place an ‘advance directive’; it was particularly important for this patient’s feelings, he was wanting some control and involvement in his care when his mental state became precarious; clearly there were some parameters but I felt it was particularly good practice.”

Birmingham and Solihull Mental Health NHS Trust had a:

“liaison nurse on the ward [who] works well in terms of co-ordinating discharge and admission.”

REFERENCES IN THIS CHAPTER


The service user’s journey
– Life in the community

KEY FINDINGS
❖ A fifth of the service users were readmitted within 90 days, with seven people being readmitted within two weeks of their previous discharge. Readmissions within 90 days were found in 14 of the 15 Trusts visited.
❖ In terms of the care provided after their previous discharge from hospital, not all groups of needs were met equally well; the biggest variations were in meeting ‘mental health’, ‘risk’ and ‘relapse’ needs.
❖ Some groups of service users – women, and people who had been previously admitted on a treatment Section – had their needs less well met than others.
❖ More than half the interviewees said they had been seen by a mental health worker within a week of their previous discharge from hospital.

This chapter deals with what happened after the service users were discharged from hospital after their last compulsory admission, using information obtained from case notes and interviews with inpatients.

• **Length of time the service user spent out of hospital, in between their last discharge and their current admission:** This information was available for 269 service users. The length of time between admissions ranged from three days up to almost three years (2 years and 10 months). The average (mean) length of time between admissions was ten months, and the median (mid-point of the scores) was seven months. (When there is a wide distribution of the figures, it is more common to use the median, as this prevents one extreme figure from skewing the average.) The length of time between admissions is shown in Figure 9 in Appendix 3.

Performance management of NHS Trusts includes reporting on the number of service users readmitted within 90 days of their discharge from hospital: 57 people (21%) of the service users in our study were readmitted within 90 days. Readmissions within 90 days were found in 14 of the 15 Trusts.

Seven service users were readmitted within two weeks of their previous discharge; their case notes were examined further to establish the reasons for this, and the results are shown in Table 4 in Appendix 3.
• **CPA review meeting after discharge from hospital:** 95 people (53%) had the date of their next CPA review meeting recorded in their notes before being discharged from hospital. In 71 instances (75% of the cases where the date was recorded) the review meeting was noted as having taken place, and the service user was recorded as having attended the review in 60 instances (85% of those whose review meeting took place).

Care Co-ordinators and psychiatrists were the professionals most often recorded as attending the CPA review meeting, each being present in around a third of cases (60 and 62 people respectively, 85% and 87% of those whose review was recorded as having taken place).

Carers were present in 25 instances (20%), and GPs attended in just six cases (8%). There were no recorded examples of an advocate attending a CPA review meeting.

• **Follow up and after care following discharge from hospital:** The CPA care plan sets out what is to be provided to the service user, and there is an expectation that the specified interventions will actually be provided. The *Criteria for Robust CPA* (quoted in CPAA, 2003) says that the Care Co-ordinator should have face to face contact with the service user within a week from discharge from hospital, as evidence shows this is a crucial time period in order to minimise suicide, self harm and readmission, and NHS Trusts are monitored on their performance in meeting this standard.

90 service users (60% of the interviewees) said they had been seen by a mental health worker within a week of their last discharge.

### HELP RECEIVED AFTER THEIR PREVIOUS DISCHARGE FROM HOSPITAL

#### Table 2 Help service users reported receiving

<table>
<thead>
<tr>
<th>Help received</th>
<th>Number of people (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychological (mental health)</td>
<td>95 (63%)</td>
</tr>
<tr>
<td>signs of relapse and crisis plan</td>
<td>48 (32%)</td>
</tr>
<tr>
<td>risk</td>
<td>39 (26%)</td>
</tr>
<tr>
<td>physical</td>
<td>29 (19%)</td>
</tr>
<tr>
<td>relationship with family and friends (social functioning)</td>
<td>32 (21%)</td>
</tr>
<tr>
<td>cultural</td>
<td>7 (5%)</td>
</tr>
<tr>
<td>employment/educational activities</td>
<td>23 (15%)</td>
</tr>
<tr>
<td>housing</td>
<td>49 (32%)</td>
</tr>
<tr>
<td>welfare benefits (finances)</td>
<td>49 (32%)</td>
</tr>
<tr>
<td>advocacy</td>
<td>16 (11%)</td>
</tr>
</tbody>
</table>
We wanted to know what help the interviewees had received after their previous discharge from hospital, and in order to compare this with what was in the care plans we used a checklist of the same 17 needs which we had looked for in the care plans.

A comparison between the needs which had been assessed and for which action plans were specified in care plans, and the needs for which service users said they had received help, is given in Figure 8 in Appendix 3.

The number of people reporting receiving help for ten important needs are presented in Table 2.

As with the needs assessed and planned for in the care plans, described in the previous Chapter, we examined the help received by service users following their discharge from hospital, using statistical tests to determine any differences.

The variables were again found to form four groups, in each of which the individuals who had received help for one need was likely to have had help for the others. For example, we found that if a service user’s ‘mental health’ needs had been met, they were also likely to have had their ‘risk’ and ‘relapse’ needs met.

The four groups were:

- **‘mental health’** – includes: mental health; risk; relapse
- **‘sensitive issues’** – includes: spiritual; cultural; leisure activities; dual diagnosis
- **‘practical issues’** – includes: relationships with family and friends; physical health; physical and sensory disability; communication
- **‘daily living’** – includes: housing; activities of daily living; finances; emotional needs; advocacy.

There were some statistically significant differences between the number of people who reported having needs met in each of these groups of factors.

We found that:

- **‘mental health’** – there was a wide range, with some people saying they had all their ‘mental health’, ‘risk’ and ‘relapse’ needs met while others had none of them met
- **‘sensitive issues’** – most people said they received help for some or all of their ‘spiritual’, ‘cultural’, ‘leisure’ and ‘dual diagnosis’ needs
- **‘practical issues’** – most people reported receiving help for some or all of their ‘relationship’, ‘physical health’, ‘disability’ and ‘communication’ needs
- **‘daily living’** – almost everybody said they received help for some or all of their ‘housing’, activities of ‘daily living’, ‘financial’, ‘emotional’ and ‘advocacy’ needs.
There were also some statistically significant differences between groups of service users in the number of needs met:

- ‘mental health’ – women reported having fewer needs met in this group
- ‘daily living’ – people who had previously been admitted on an assessment Section of the Mental Health Act reported having fewer needs met than those previously admitted on a treatment Section.

**SERVICE USERS’ VIEWS – GETTING HELP IN THE COMMUNITY**

We wanted to know more about service users’ experiences in the community, following their previous discharge from hospital, and to see what part their CPA care plan might have played in this.

Of the 146 service users who answered the question ‘What do you think helped you the most after you left hospital last time?’ nearly three quarters (107 people, 73%) could identify something that had helped them after they had gone home. The other 39 people (27%) either responded negatively to this question, stating they had received no help, or that what was offered was not helpful, or they could not think of anything that had helped.

Fifty-five (38%) people said professional workers had helped them; most commonly mentioned were community psychiatric nurses (by 19 people, 13%), with 11 people mentioning community services such as assertive outreach and crisis teams.

One interviewee said: “I was paranoid. My CPN is an excellent man, and he saw me, although I didn’t like where he placed me... he’s a really good man”, and a second said that “the assertive outreach team gave me lots of support”.

Thirteen people (9%) felt that medication had helped them.

One person reported that “the Home Treatment Team kept coming round and giving me my medication”. Another reported that “medication helped me most, the Crisis Team visited me every few days”.

Forty-seven respondents (32%) said that the emotional and practical support they got from their partners, family and friends helped them most.

One person said “My family [helped]. The care plan was good but they kept changing it and they lost it at one time”. Another person reported that “my boyfriend helped me most, he was there for me”.

Twenty-five people (17%) said they had helped themselves, with eight describing the importance of being independent and being able to sort things out for themselves.

One respondent referred to using their “inner strength”, and another felt that “feeling free from other people’s demands and doing my own thing” was most helpful. Another interviewee said “I think it’s up to myself to help myself. A community nurse used to come to see me but stopped, and a social worker used to come but stopped”.
Fourteen people felt that just being out of hospital was in itself therapeutic.

One person appreciated “just getting out and away from hospital”, while another commented that what helped was “just the freedom; they don’t understand how much I need freedom”.

For some people, it was a combination of factors that had been useful. For example, one interviewee said:

“I helped myself to get better. My Care Co-ordinator visited regularly, yes that helped as well”, and another reported “having a secure home to go to; being in a comfortable environment with friends and family. Olanzapine helped”. Another interviewee valued the help they had received from “social services home support workers, my family and friends”. A fourth person said “my CPN was a tremendous help, my fiancé proved very helpful, and my medication helps me a lot”.

Some people referred to having received help with housing and finances and others valued some type of leisure, social or educational activity.

One person said that “getting somewhere to live because I didn’t have anywhere” was the most helpful intervention, while another had valued “being transferred to a residential home with support available 24 hours a day”. Another reported “having a new flat to go to, best Christmas present ever!”, and a third said that a “Citizens Advice Bureau helped me get more money”. Other individuals valued “going to film society meetings”, “going swimming, reading”, and “going to the library to study architecture”, while one woman said she attended college “for English literature and poetry” which made her happy.

Although this question was framed to discover individuals’ positive experiences once out of hospital, a number of people described their negative experiences. Twenty-one respondents (14%) said they found the services offered to them were unhelpful. This included not getting on with specific staff such as their CPN or social worker, and feeling that community services such as assertive outreach teams were “pestering” them unnecessarily.

One interviewee, who was interviewed using an interpreter, said: “My CPN did not speak my language and was therefore not able to help me; he only called for a short time”, while another reported that “I didn’t think any of it was any use and I stopped seeing the CPN”. A third interviewee said: “I’m fed up with the community team, they think that because they have a file on you they can knock at my door and put me on a section... I didn’t want the care team, I wanted a social worker to help me with housing and going to the shops”. Another respondent said “I didn’t get any help with where I lived, I couldn’t sleep it was such a busy corner. I didn’t get the right medication”.

A few people mentioned workers turning up to see them unexpectedly which they found intrusive, preferring to be visited by appointment, or would have liked to be seen at another location.
One person felt that “nothing [helped]. I was pestered by a nurse, I didn’t know he was coming and told him to go away”, and another said “support [was] offered but I did not want to meet them for the first time at home so it didn’t happen”.

A few people felt their medication was not helpful, that they were not given the right medication for their needs, or that side effects were not being dealt with effectively. A small number said their physical health problems were not being met.

One interviewee reported that “the medication had so many side effects that I don’t like taking it except in small doses”, and another said “the [hospital] doctor gave me too much medication, I couldn’t walk steady, my family doctor reduced it right down and I felt better, the silly thoughts didn’t come back so the family doctor was right”, while a third said “I felt helpless, I felt physically unwell as well”.

Several interviewees said they had received no help at all following their last discharge from hospital, or that nothing had helped them.

One person reported that “I feel failed by the services as they didn’t come to see me”, while another said “I just wanted access to my daughter sorted out but no one helped me”, and a third said “Nothing helped me, no one supported me...I felt the only approach to me was ‘take your medication’”.

Five people said they did not have a mental health problem or had not needed any help.

One said “...they wouldn’t leave me alone. I don’t want anything from mental health services”, while another felt that “I do not want any care; I have no mental illness, only stress”.

### SERVICE USERS’ VIEWS – HELP THEY WOULD HAVE LIKED

We also asked the interviewees whether there was any help that they would have liked to get but that was not provided after their last discharge from hospital. Eighty-four people (56%) said they would have liked some sort of help that was not provided.

A third of those who wanted some more help (27 people, 32%) would have liked some form of therapeutic help, including visits from community mental health staff, counselling, and help with medication.

One interviewee said they wanted “help with the voices I hear”, while another felt they had been discharged too soon and “needed a bit more treatment in hospital – still had voices in my head telling me to ‘take care’”. One person said they “didn’t get enough help with medication”, another would have liked “some more regular arrangements with a CPN or whatever, that would have been helpful” while others wanted “…some counselling with regard to the root and cause of my mental ill health” and “a bit more relationship counselling...”.
Another would have liked help in dealing with “aggressive feelings and with sexual problems”. One interviewee reported a particular problem: “I am a mental health professional and often because of this staff stand off from me”.

Fifteen people (18%) would have liked help with housing, and 14 (17%) wanted help with their finances.

For example, one person said “I would like to have had help with money and better accommodation, and better furniture”, and another reported that “money was a problem... My benefits were not sorted out for six weeks”. A third said they would have liked someone “to help me with stress of money problems and losing my home due to being in hospital so long”. Another person said: “I want a roof over my head for my family. My son comes out [of prison] soon and I want a home for us and someone to help me with benefits”.

The lack of daytime activities and work was mentioned by 14 (17%) people.

One interviewee reported that “I would have liked to have more activity, would have liked to join a gym. If work or supported work was available I think this would be helpful”, and another said: “I would have liked it if [the] craft workshop had materialised but it wasn’t available”.

Physical health problems, and physical fitness, were important to two other interviewees.

One person said “I had a fit, and would like to have my epilepsy more controlled”, and the other reported they would have liked “more physical health care, particularly with my medication and its side effects”, adding that “I do not feel physically fit and would like to feel better. I would like help to stop me eating fatty food and putting on weight”.

Help with social activities was an issue for five people.

One person said “I need help in getting friends and keeping them”, and another felt that “there was something missing from my life, I think a girlfriend would have helped, I felt isolated. I would have liked to have activities, get healthy and lead a normal life”.

Four people said they would have liked help with activities of daily living (e.g. shopping, cooking, housework).

One interviewee said: “the only thing I needed help with was cooking... I wasn't much good at that side of looking after myself”, and another mentioned “the course on basic skills which I was told I would get but this didn’t happen”.

Two people mentioned wanting help with drug and alcohol problems.

One interviewee said “well they said they would help me get off drugs – I saw a drugs counsellor but only once so things got worse”, and the other reported...
“I would have liked to have more activities to help keep me away from the drug scene. It is hard to keep in the house 24 hours”.

One interviewee would have liked help with their family as well as their mental health, saying:

“I have not had the help I would have liked with the issues about my son, who has suffered from my situation. I have never been able to talk to anyone about the highs and lows, and my hypomania that people say I suffer from.”

One interviewee articulated the need to be seen as an individual, rather than pigeon-holed by other people’s expectations:

“I would have liked people to see things my way. People were always on at me and attacking me. I needed reassurance and care instead. I wanted people to think about me as ‘well’ not unwell. People always thought of me as a problem. I was Bohemian at home and people criticised me for that, wanting me to change and be clean and tidy, but I don’t want a structured life. I have some gifts and I need these to be recognised. My life will never be perfect with everything in its place, that’s just not me.”

As before, some interviewees mentioned things which had not helped them.

An interviewee said “I would have liked something more thought provoking than a CPN visiting and asking if I’m taking medication. Activities [offered] are not realistic and medication prevents me doing some activities”, and another said that “the social worker visited too frequently, [he was] too much on my case. It disrupted my work having to see him every two weeks, so what would have helped would be to have seen less of him.”

A few people were unhappy with how their carers were involved with the various support services.

One person felt that “they should have been more involved with me and less involved with my family”, and another said they “wanted to be treated like an individual, wanted [the] CRT[Crises Resolution Team] woman to see me in hospital and say she would see me on my own rather than always with my mother pulling the strings. I know she worries about me... I want my father concerned with my care, she [my mother] stifles me”.

REFERENCE

KEY FINDINGS

❖ At the time of their current admission, 92% of service users were described in their case notes as being either a danger to themselves or to other people.

❖ More than half the service users were said to be non-compliant with treatment in the community. In a small number of cases, non-compliance was the only recorded reason for their compulsory admission.

❖ Over 40% of the service user interviewees were generally positive about being in hospital, while a similar number had negative feelings about their admission.

❖ Service users’ reports of negative experiences of acute inpatient care reiterate concerns which have been identified in other national studies.

This chapter deals with the service user’s current admission, as reported in the 277 sets of case notes and in interviews with 151 service users.

❖ Mental Health Act Section on current admission: Three quarters of the detained service users had been admitted on a Section 3 (210 people, 76%), with 42 on a Section 2 (15%) and only small numbers of people on other Sections. This information was missing for one person. Mental Health Act Sections on current admission are shown in Figure 6 (overleaf).
For information on the different types of Sections, please see Chapter 4.

- **Reasons for current admission**: In many cases, more than one reason was given for the current admission. This is shown in Figure 7.

At the time of their current admission, most service users (256 people, 92%) were described in their case notes as being either a danger to themselves or to other people.

Of these 256 people, 86 service users (31%) were reported as behaving in a threatening way, while another 43 people (16%) had actually been violent towards other people or to property. In 16 further cases (6%) there was specific mention of using or carrying a weapon, most commonly a knife. Ninety-six people (35%) were said to be at risk to themselves through self harm or suicide, while a further 27 (10%) were at risk due to self neglect or vulnerability.

Twelve people (4%), included in the above categories, were reported to be both a danger to themselves and to others.
Altogether 159 service users (57%) were reported to be non-compliant with some aspect of their community-based care and treatment. Most commonly they were not taking medication as prescribed (108 people, 39%), while another 30 people (11%) were not co-operating with specific mental health staff. Nineteen people (7%) were non-compliant with their care or treatment plan in general. Although current legislation does not allow for compulsory admission solely on the grounds of non-compliance, in seven instances this was the only reason reported for the current admission.

In 20 cases (7%), misuse of alcohol, illegal drugs or other substances was mentioned as contributing to the service users’ deterioration, and the police were involved in the admission of 28 people (10%). Five service users had been transferred to hospital from prison, and a further six had come from other hospitals or residential homes.
SERVICE USERS’ VIEWS – REASONS FOR ADMISSION

The 151 service users who agreed to be interviewed were asked why they thought they had been admitted this time. We were interested to find out whether the reasons they gave had any implications for the care planning that had taken place at the time of their previous discharge from hospital, and for the implementation of their CPA care plan once they were in the community. Of those interviewed, 136 people gave one or more reasons for their current admission.

About half the interviewees (77 people, 51%) said they were admitted because of their mental ill health, or because of certain behaviours associated with this. In some cases, they acknowledged that they had needed help, while others found this harder to understand.

One interviewee said “I was manic, everyone recognised it except me”, and another reported “I tried to commit suicide, I was depressed and ill”. Another interviewee said it was because of the “delusions that I had, [I was] very confused, [my] thoughts were not clear”, while another reported that “they say because I was shouting, screaming, hearing voices”. One person said “I spoke to a social worker who said it was to do with me being paranoid, I didn’t think I had any symptoms of paranoia so I was annoyed to be brought into hospital under Section 3”. Another interviewee said they had been a “threat to myself, threat to others, [suffering from] self neglect, not allowing enough time for medication to work…”, while another accepted that “I do think I was unwell, things were getting on top of me, that was the reason”.

In some of these instances, the behaviour which sparked the admission had been threatening or violent.

One person said they were admitted “because I was becoming high and I was leaving the hostel. I was threatening to kill someone”, another felt it was “because someone said I was attacking someone with a knife…”, while a third said “I was short of money and I went into an empty house but a man came in and caught me. I hit him with a hammer because I was frightened”. Another person reported that “…I pointed a pellet gun at my neighbour and she thought it dangerous and called the police. I didn’t feel it was dangerous because it wasn’t loaded”.

In other cases, the interviewee had been on the receiving end of violence from other people.

One person reported that they were admitted due to “stress and pressure and domestic violence”, and another said it was “because I was thrown out of my house and I had been assaulted”. 
In several instances, members of interviewees’ families had initiated the admission process.

One person said “I think it is to do with my mum. I was smoking cannabis, playing music at night, not sleeping. Mum contacted the doctor”. Another reported that “my mum wanted to call an ambulance because she was worried about me”.

Eighteen people (12%) mentioned not taking their medication as prescribed, or not engaging with community-based mental health services.

One interviewee said they “didn’t take my tablets... Also, I had problems with my benefits”, another thought that “maybe it is because I wasn’t taking my medication as I was supposed to”, and a third reported they “stopped taking my Clozaril, I suppose that is why I started acting strangely”. Another interviewee said “sometimes I’m loud and over-talkative and I don’t take my medication...”.

Fourteen people (9%) reported having problems with misusing drugs, alcohol and other substances.

One person reported: “I was using drugs again, cannabis, and glue sniffing”, another said it was because of “a lot of alcohol and some drug abuse which makes me disinhibited”, and a third said “I was drinking too much and taking cannabis”. Another interviewee said “I don’t know, it was probably something similar to last time. I started hallucinating again, the family was concerned it was drugs, it probably was to a small extent”.

Others (10 people, 7%) did not believe they had been admitted for valid reasons, and a further 7 people (5%) said they did not know the reason for their admission.

One complained that “as far as I’m concerned an illegal sectioning took place, involving police and doctors”, another said “I was wronged by being put in here, there is nothing wrong with me...” while a third reported that “the police thought I was a transient ... they told the doctor to keep me in hospital”.

**SERVICE USERS’ VIEWS – BEING IN HOSPITAL**

We were interested to learn whether the factors that had led to interviewees’ current admission were being addressed, so we asked them what they were finding helpful about being in hospital. Of the 143 people who answered this question, 62 people (43%) were generally positive about being in hospital, although more than half of them (33 people) could not identify anything specific they were finding helpful. Twenty-one people (15%) had a neutral response, finding it hard to say whether being in hospital was helpful or not, and the other 60 (42%) felt that nothing about being in hospital was helping them.
Ten people were happy about therapeutic interventions they were receiving, including medication.

One interviewee said “I went to a relaxation group yesterday which was helpful”, while another reported that “my medication is helping me and the pressure to take it is helping me”. A third said “I’m not happy to be here but it has helped me to get the right medication”.

For nine people, the perceived benefit was less about being in hospital than about gaining respite from a difficult situation elsewhere.

One person reported that admission “got me away from where I was, I needed somewhere quiet to get away from my flat. I had two burglaries, [and was] very stressed”, while another said “it was life-saving ‘cos it separated me from [my partner]”, and for a third it was beneficial to have “…a roof over my head, something to eat”.

In seven instances, being away from the temptations of alcohol and drugs was crucial.

One interviewee said it was “very helpful, got me off the street drugs. I had never felt normal without drugs, now I feel OK just on the medication”, another said “it has helped me to stay off cannabis. Medication helps with the craving, keeps it down”, while a third reported it was “very helpful, [I’ve] stopped drinking, changed my drugs, my thoughts have gone away”.

Six of the interviewees felt that being in hospital had been helpful, but they were now ready to be discharged.

One said “it was helpful to come into hospital for the first month but now I’m bored with little to do”, while another reported “This was supposed to be my final week here but because no accommodation is available I’ve got to stay until there is some, Mum can’t have me any more. I spoke to a man [from housing service] today who will try to help with getting my own place…”. A third interviewee felt that “some of it was [helpful], swimming, football and outdoor activities are helpful to me, but I want to go”.

Three people mentioned being treated for physical health problems.

One said “yes I am becoming calmer, I am well looked after; my heart and diabetic condition is looked after”, and another person was pleased that staff had “found out I had a hernia. The doctor [is going] to get in a specialist. The staff [are] really good and help you get your life back on track”.

Two others were pleased that practical issues were being dealt with while they were in hospital.

One interviewee said it was “good to be in to rest and regenerate. I need a roof over my head as my mother doesn’t want me. [I’ve been] homeless since last informal admission 14 months ago. This will help me get somewhere
to live”, and the other appreciated that someone had “helped me with my finances”.

For 60 people (42%), the experience of being in hospital was completely negative. One interviewee said “it has made me feel worse; the injections make me feel worse; I don’t believe in doctors, drugs or anything”, another reported that “It hasn’t been helpful at all. I was brought here against my will. The only help I’m getting is ‘take your medication and you will be out of here as fast as possible’”, and a third, who was interviewed using an interpreter, said it was “no help, [because] they don’t speak my language”. Another interviewee said they found being in hospital “not very helpful because it’s messing with my head. I feel all my rights have been taken away from me”, while another reported that “it has been terrible here, I can’t take the atmosphere here and the enforced injections that make me feel so terrible, the side effects are indescribable”.

Some interviewees reported a lack of therapeutic interventions.

One person said “nothing [helps], all I do is sleep and eat”, another reported “it hasn’t helped me yet because the thoughts are still there”, while a third said “I don’t blame anyone but I’ve not achieved anything apart from food, a bed and a rest – no-one has the time to talk to me”.
Conclusions and recommendations

KEY MESSAGES

❖ Effective implementation of the CPA is vital to ensure appropriate services are planned and delivered to service users who are repeatedly detained under the Mental Health Act.

❖ Local systems should ensure that all groups of service users are treated equitably.

❖ Staff from all disciplines and agencies should work together to ensure continuity of care between hospital and community services.

❖ Assessment and care planning should put service users at the heart of the CPA process.

❖ Assessment and care planning should be comprehensive, including all the factors that contribute to service users’ health and well being.

In accordance with the project’s objectives, we have described the quality of CPA care planning for service users with repeated detentions under the Mental Health Act 1983, and have assessed the factors that contribute to the best quality of care and outcomes and to the most effective CPA care planning for such service users. We have developed an effective tool for use in monitoring, assessing and evaluating care planning for service users with repeated detentions, which can be used under the current Mental Health Act and national monitoring and inspection arrangements – the CPA Brief Assessment Tool (CPA-BAT). This could also be adapted for use under future legislation. The information we collected sets a baseline on the role of CPA care planning for service users with repeated detentions which could be used in a possible future phase of the study to assess changes in the efficacy of care planning following the introduction of a new Mental Health Act.

Our conclusions and recommendations relate both to existing requirements placed on NHS Trusts by legislation, guidance and performance monitoring arrangements, and on improving practice in order to make a difference to the lives of service users. They fall under a number of broad headings.
ENSURING EQUITABLE SERVICE DELIVERY

Ensuring that all relevant information is recorded is clearly crucial. This includes service users’ demographic characteristics, and in particular their ethnicity, which is not currently being recorded for everyone. Without information on gender, age and ethnicity, it is not possible for clinical staff to assess, plan and deliver care that meets individuals’ needs, nor is it possible for NHS Trusts to assess whether they are providing culturally appropriate services to all their service users in an equitable way.

In addition to their requirement to undertake an annual audit of CPA implementation, NHS Trusts should monitor its use in relation to the small number of people who have had multiple compulsory admissions. The tool developed for this project would provide the necessary information for this.

RECOMMENDATIONS

1. NHS Trusts should record the ethnicity of all service users, in order to ensure that the services planned and delivered meet service users’ cultural needs and to avoid inequalities in the delivery of care.

2. Regular monitoring should enable NHS Trusts to assess whether some groups of service users – e.g. those of different gender, age or ethnicity – are being treated less equitably than others. Where such inequities are detected, they should be addressed.

3. Service providers should ensure that aftercare services are provided equitably to men and women, and to people who were admitted on all assessment and treatment Sections of the Mental Health Act.

INFORMATION SHARING

Access to information, and information sharing between staff in different locations and from different disciplines, are also key factors in providing a co-ordinated approach – as envisaged in the CPA – to meeting service users’ needs.

Notes relating to individuals’ previous admissions and periods of service use in community settings can provide valuable information on what interventions were effective, and contribute to ongoing care planning, and should be available to all staff currently working with the service user.

Implementing a Trust-wide eCPA system will greatly assist with the sharing of relevant information by all those involved in planning and delivering care.
RECOMMENDATIONS

4 Local systems should ensure that case notes are securely stored and easy to access, so that information on previous care planning and interventions delivered is available to contribute to current care planning.

5 Local systems should ensure that CPA care plans are shared between hospital and community services, and with the other service providers who are involved in an individual’s care. Effective liaison when planning service users’ aftercare may reduce the number of readmissions within 90 days.

6 Electronic CPA systems should be fully implemented in each NHS Trust to enable crucial information to be easily shared between staff across hospital and community sites, and between disciplines, and so facilitate co-ordinated planning and delivery of care.

INPATIENT CARE

When assessing service users’ need for compulsory admission to hospital under the Mental Health Act, it is important that proper grounds for detention are used and clearly recorded.

Many people detained on inpatient wards have well-documented negative experiences of a lack of therapeutic and other activities, leading to boredom and frustration. These issues need to be addressed in order to maximise the beneficial impact of inpatient care for all service users.

Staff working in hospitals should be aware that the CPA applies to inpatients, as well as to people receiving community services, and that CPA care plans play an important part in ensuring the provision of care following service users’ discharge from hospital. All inpatients should be on the enhanced CPA level, and copies of service users’ care plans relating to their previous discharge from hospital should be kept in their inpatient notes to facilitate continuity of care.

RECOMMENDATIONS

7 NHS Trusts should ensure that the criteria for compulsory admission are correctly applied.

8 Managers of acute inpatient care should ensure that an adequate range of therapeutic activities is provided, along with social and recreational occupation, especially for detained patients who are unable to leave the ward.

9 All inpatients should be on the enhanced level of CPA, and this should be recorded in their notes.

10 Copies of CPA care plans relating to service users’ previous discharges from hospital should be kept in their inpatient notes to facilitate continuity of care.
The role of the CPA Care Co-ordinator is crucial in ensuring effective discharge planning and provision of aftercare, including setting and recording the date of the first review meeting to be held after the service user leaves hospital.

CPA care planning needs to take account of all service users’ needs, with attention being paid to topics which are at present poorly assessed and planned for. As some community services may take a long time to arrange, discharge planning should begin as soon after a service user’s admission as possible, to ensure they are not kept in hospital once it is no longer clinically necessary. Effective discharge planning should enable community staff to make contact with service users within a week of them leaving hospital.

**RECOMMENDATIONS**

11 The date of the next CPA review should be recorded in service users’ case notes before they are discharged from hospital.

12 The CPA Care Co-ordinator should take the lead in drawing up service users’ care plans, and should attend the CPA review meetings.

13 CPA assessment and care planning should be comprehensive, with all needs included. Individuals’ cultural and spiritual needs, at present rarely assessed and planned for, should be included in CPA care planning.

14 Timely discharge planning should enable appropriate community-based services – including housing, financial and occupational – to be arranged so that service users can be discharged as soon as their clinical need for inpatient care has ended.

15 Local systems should ensure that community services have face to face contact with all formerly detained patients within a week of their discharge from hospital.

16 Having a comprehensive CPA care plan is not an end in itself. Services should ensure that the interventions specified in the care plan are actually delivered to the service user.
CONCLUSIONS AND RECOMMENDATIONS

INVOVING SERVICE USERS IN THE CPA

National standards, guides to good practice, and service user-led research all emphasise the importance of fully involving service users in their own care planning. The CPA can only be effective if service users make a meaningful, not tokenistic, contribution to the process.

RECOMMENDATION

17 Service users should be informed about the CPA, and fully involved in drawing up their care plans and participating in CPA reviews, with access to an independent advocate if they request this. Their own assessment of their strengths and needs, as ‘experts by experience’, should inform the care planning process. They should be asked to sign their care plan, and be given a written copy of it.

LEARNING FROM EXAMPLES OF GOOD PRACTICE

We have found good practice in a number of NHS Trusts, including arrangements for effective liaison between hospital and community staff, and high standards of record keeping, which could be adopted by other service providers.

RECOMMENDATION

18 The good practice which has been identified can serve as an example for NHS Trusts wanting to improve their practice in this area.
INTRODUCTION

Since it was first used in 1991 as the framework for planning, monitoring and reviewing care for people with mental health problems in England, the Care Programme Approach (CPA) has been the subject of numerous reports and research studies. This review of the literature on the CPA was undertaken as part of the joint project by the Sainsbury Centre for Mental Health (SCMH) and the Mental Health Act Commission (MHAC) looking at the CPA in relation to patients who are admitted compulsorily more than once in a three year period. In view of its potential relevance to a wider audience, the literature review is also available through the SCMH web site at www.scmh.org.uk and the MHAC web site at www.mhac.org.uk.

Structure of the review

The emergence of the CPA from the case management model in the United States of America is described, and the further development of the CPA since its introduction in 1991 is chronicled. Strengths and limitations of this system are reported as are a number of uses to which it has been put, including its application in service evaluation and monitoring standards. Attention is also given to service users’ views and experiences of the CPA. The review aims both to provide an understanding of the scope of current knowledge and practice, and to assess the extent to which the CPA is used as a proxy measure for evaluating quality of care.

Search strategy

A computerised literature search was undertaken on material from the UK and North America published since 1980, using the International Bibliography of the Social Sciences, PsychINFO and Medline online databases. Searches were made using a combination of key words including: Care Programme Approach; CPA; care planning; case management; continuity of care; follow up; care pathways; evaluation; patient outcomes; quality of care; users’ views. More than 300 articles were identified through this method, of which 29 were thought to be relevant and were retrieved. As this review was initially undertaken with the specific SCMH/MHAC project in mind, searches were also made using the above key words in conjunction with Mental Health Act, compulsory admission, and repeat admissions, but no articles were identified through this method. Several other articles were identified from the references given in publications obtained through
the computerised search. Other published material from SCMH's own resources was examined, and several examples of CPA care planning documentation currently in use by NHS and independent sector providers of acute inpatient care were obtained. Reports of Inquiries into homicides committed by people in contact with mental health services were obtained from NHS Health Authorities and Trusts. Only information on the implementation of the CPA in England was considered, excluding material relating to the introduction of the CPA in Scotland and Wales. Altogether, 99 data sources were examined.

CASE MANAGEMENT

Case management was introduced in North American mental health services in the 1970s as a way of ensuring that services were provided in a co-ordinated, effective and efficient way. A range of case management models became widely adopted in England in the following decades (Mueser et al., 1998). In clinical case management, a professional worker uses their therapeutic relationship with the service user to assess needs, providing some services and arranging (brokering) others to meet them. The strengths model of case management focuses on service users’ abilities and potential for change, rather than their difficulties. Case management models include assertive community treatment, developed in the US by Stein and Test (1980) and intensive case management (Ford et al., 1993; Ford et al., 1997) which was a forerunner of assertive outreach in which low caseload sizes allowed workers to provide their clients with an intensive input (Ford et al., 2001). The Care Programme Approach can be considered a type of case management, albeit one not based on a specific case management model. Landsberg and Rock (1994), in New York State, evaluated the effectiveness of intensive case management in terms of reaching those most in need of mental health services, and of providing them with appropriate services, concluding that while it should not be taken as the only panacea for previous failures in the mental health care system, it was generally successful in “dealing with the complex problems of serving persons with serious mental illness”.

THE DEVELOPMENT AND IMPLEMENTATION OF THE CPA

The Care Programme Approach (CPA) was introduced in 1990 as the framework for the care for people with mental health needs (DH, 1990a) in England, originally intended to be implemented by April 1991, running in tandem with the local authority Care Management system (DH, 1990b). Initially the CPA applied to current inpatients at the point of discharge, and new referrals to specialist mental health services, but this was extended to include everyone in contact with specialist mental health services. The key elements were the systematic assessment of individuals’ health and social care needs, the formulation of a care plan to address those needs, the appointment of a key worker to monitor the delivery of care, and the regular review and, when necessary, amendment of the care plan in line with the service user’s changing needs. The importance of close working between health and social services was stressed, as was the need to involve service users and their carers.
The Mental Health Act *Code of Practice* (DH & Welsh Office, 1993) made it clear that the CPA applied to all those receiving specialist mental health care, including detained and informal hospital inpatients.

The Audit Commission’s review of mental health services for adults (1994) commented on the failure of many districts to implement the CPA and made recommendations on clarifying the eligibility criteria to ensure all those who should receive care under the system did so.

Interpretation and implementation of the CPA varied widely across the country. *Building Bridges* (DH, 1995) provided further “guidance on inter-agency working for the care and protection of severely mentally ill people”, while stressing that CPA was a systematic “approach” to care, and there was no intention to require uniformity of operation at the local level. It suggested a tiered approach in which only the most needy service users would receive a full multidisciplinary CPA; some mental health services operated with two CPA tiers while others had three. It also introduced the concept of the elements of “disability, diagnosis and duration” jointly contributing towards a definition of “severe mental illness” towards which group the CPA was aimed.

The CPA was revised and integrated with Care Management in 1999 to form a single care co-ordination approach for adults of working age with mental health needs, to be used as the format for assessment, care planning and review of care by health and social care staff in all settings, including inpatient care (NHSE & SSI, 1999). Two tiers of CPA were established nationally, standard and enhanced, and key workers were replaced by Care Co-ordinators. Standard CPA is described as being for those people whose needs can be met by one agency or professional or who need only low key support from more than one agency or professional, who are more able to self-manage their mental health problem, who pose little danger to self or others, and who are more likely to maintain contact with services. People on the enhanced CPA level are likely to have multiple care needs which require inter-agency co-ordination, to require more frequent and intensive interventions, to be at risk of harming themselves or others, and to be more likely to disengage with services.

Standard 4 of the *National Service Framework for Mental Health* (DH, 1999) set out the requirement for service users to have a written copy of their CPA care plan. The care plan should: include the action to be taken in a crisis by service users themselves, their carers, and their Care Co-ordinators; advise the GP how they should respond if the service user needs additional help; and be regularly reviewed by the Care Co-ordinator.

In the Code of Practice to the Mental Health Act 1983, revised in 1999 (in Section 27, relating to aftercare following discharge from hospital) the need to implement the CPA for all patients, and the key elements of the CPA, are restated (DH & Welsh Office, 1993).

Plans to abolish Supervision Registers were conditional on Trusts establishing “robust CPA”, with the Department of Health stipulating the criteria for robust CPA (in, CPAA, 2003b).
The Social Services Inspectorate set a number of national priorities and strategic objectives relating to the social care of mental health inpatients (SSI, 2003). These include the requirement for social care workers to be part of the CPA care planning and review process. Similarly, the Department of Health's standards (DH, 2002) for independent providers of mental health care registered with the National Care Standards Commission (now the Commission for Social Care Inspection) included the requirement for them to have written policies and procedures for implementing the CPA and care management, which must be reviewed at least every three years. These standards also included explicit requirements for planning and reviewing individuals’ care, and for the effective planning and implementation of inpatients’ discharge.

The CPA was introduced in Scotland in 1992 (SOHHD, 1992), and more recently, in Wales in 2004 (WAG, 2002).

**SUPPORTING THE IMPLEMENTATION OF THE CPA**

The Care Programme Approach Association (CPAA) was established in 1996 to support the implementation, operation and development of the CPA, with members drawn from mental health service providers, commissioners and other interested groups. Their publications on national standards and auditing the CPA (CPAA, 2003b), and providing guidance for CPA Care Co-ordinators (CPAA, 2003a) stemmed from wide experience in the implementation of the CPA. They summarised the key principles of the revised CPA policy as aiming to ensure integration of health and social care, providing consistency of approach nationally through the adoption of common definitions of standard and enhanced levels of care, ensuring a streamlined approach through the collection and recording of relevant data, for example the advance setting of the date of individuals' next review, and providing a focus on risk assessment and management.

Keys (2002) pointed out that the CPA is based on simple principles which underpin and support the delivery of complex packages of care, and identified the important role of the CPA administrator in its successful implementation.

Howells and Thompsell (2002) described a computer-based CPA system, designed to improve the quality of information in CPA care plans and assist with the delivery of care in South London and Maudsley (SLaM) NHS Trust. This 'eCPA' could be emailed between community teams and inpatient wards as the service user moved through the care system, and was capable of being quickly and easily updated. The system allowed assessment and interventions for individuals on the enhanced level of the CPA to be unified and co-ordinated between health and social care services (SLaM et al., 2000).

A study by Thomas and Balls (2003) for the London Integrated Mental Health Electronic Record Project examined the progress made by the 11 Trusts which provide mental health services in London in developing an electronic record for patients on the enhanced level of CPA, with a view to generating a debate about taking a common approach. Described as being a “snapshot” rather than a comprehensive survey, it found that while most Trusts had started from scratch
in designing the electronic record, they broadly captured similar information, although methods of inputting data, and rules on who could access the records, varied widely. Most of the London Trusts had, or were about to implement, an eCPA system. The authors’ argument that it would save time and money if Trusts were to collaborate on standardising both paper-based systems and eCPAs is relevant for services in the rest of the country.

Firth (2004) outlined the expectation that the needs of people on the standard level of CPA will be managed by primary care services, and highlighted the challenges and benefits this brings. He also discussed the possible effects of *Fair Access to Care Services* (FACS), the guidance on eligibility criteria for adult social care which applies to local authorities, mental health and social care Trusts, and health and social services organisations which are operating pooled budgets (DH, 2003). He speculated that some people may lose the service they have been receiving once Trusts fulfil their requirement to review all currently eligible service users, before concluding that the result of using the CPA as a mechanism for the application of FACS might be “to engender a much-needed fiscal reality in the delivery of services, their development and commissioning”.

**EVALUATING THE IMPLEMENTATION OF THE CPA**

A number of research studies have examined the implementation of the CPA on a local or wider scale. Some benefits of the system have been identified, along with a number of difficulties in fully implementing the CPA, although a few authors have been unremittingly negative.

A research project undertaken on behalf of the Department of Health to identify the factors influencing the implementation of the CPA (North & Ritchie, 1993) in four health authorities found that its implementation, and in particular its monitoring, was not very far advanced at that time. Fragmentation of service provision, and lack of joint working between health and social services, were contributing to the delays, as was resistance from staff. Some clinicians perceived the CPA as an over-inclusive, bureaucratic and time-consuming exercise, while others felt their existing systems already met its requirements, although the principles of effective assessment, care planning and joint working were widely accepted. While health staff were in the early stages of CPA implementation, their social services colleagues were grappling with the new care management system, and experiencing difficulties and delays for very similar reasons (Newton *et al*., 1996).

When Wolfe *et al.* (1997) examined CPA implementation in an inner London service, involving 80 service users who had been discharged from inpatient care, they found that although three quarters of the participants had attended a CPA meeting before their discharge, only half of them were given copies of their care plans, and only half knew who their key worker was at the point of discharge. The researchers also examined the service users’ needs as assessed by staff and compared this with what the service users themselves said they needed. Service users assessed themselves as having more needs than did the staff, although there was some agreement about the range of interventions needed, with medication and other
help for mental health problems scoring high with both groups. However, staff were more likely to identify housing and employment as problem areas than were service users, who were more likely to say they needed help with financial problems. When they were asked if they had received all the services planned in their CPA most service users said they had, and they were generally satisfied with the services they had received. This study also highlighted a low level of carers’ involvement in the CPA process.

Using the CPA as an example, Kessler and Dopson (1998) examined the difficulties of implementing change within the NHS, discussing the wider issue of the decision-making process and how an understanding of this is necessary to appreciate how policy objectives are pursued. They described the tensions between centralised and devolved management within an organisation which was driven by the competitive ethos caused by the “purchaser-provider split” and increasingly subject to performance review, and the determination of the “centre” to drive through rapid changes which many clinicians saw as merely a bureaucratic data collection exercise. The authors also presented a framework for decision-making which should assist with future changes within the NHS.

Rospopa (1998) examined the CPA’s role as a framework for multidisciplinary working, describing how one Trust had approached joint working between health and social care organisations, embracing the concepts of shared assessments and care planning. He concluded that the CPA merely formalised existing systems of good practice, and was achievable through effective communication and collaborative working between agencies.

Schneider et al. (1999) conducted a national survey of the individuals responsible for implementing and administering the CPA in all NHS Trusts in England, asking questions about the involvement of professionals in the CPA processes of care planning, key working and review, and also about the participation of service users and carers in care planning and reviews in both hospital and community settings. They found that about one fifth of service users ‘always’ attended CPA meetings, while about half ‘often’ did so; carers ‘sometimes’ attended these meetings; similar numbers of service users and carers attended CPA reviews. The study was conducted at a time when greater integration between the CPA and care management was being predicted, and it found wide variation in the extent to which health and social care organisations were achieving harmonisation.

Bindman et al. (1999) used a postal survey of all NHS Trusts in England in an evaluation of the practical application of the CPA. They found that wide variation in the number of people subject to the CPA in different areas was not associated with variations in the populations’ needs. Although the CPA is designed to ensure services are targeted at those with the highest level of need, they found that prioritisation for receiving mental health services was inconsistent and could therefore result in inequitable use of resources.

Downing and Hatfield (1999) examined the first six months of CPA implementation in one inpatient unit, through interviews with key workers, looking at whether the care given was based on a comprehensive assessment of health and social care needs, whether it was multidisciplinary, whether the service users and their
carers were involved in the planning and delivery of care, and that care was co-ordinated by a key worker. The specific areas included in the needs assessment were: physical health, mental health, medication, finance, housing, social support at home, daily living skills, occupation, social networks, and legal problems, and evidence was found of both assessment and planned intervention across all the domains, although mental health symptoms and medication were the most common. The authors concluded that the CPA as it had been implemented in this acute unit included most of the key features of identified good practice.

Appleby (2000), commenting on the 1999 National Confidential Inquiry into Suicide and Homicide by People with a Mental Illness, the Safer Services report (Appleby et al., 1999), recommended an overhaul of the CPA system to ensure priority for enhanced level care be given to service users in high risk groups, especially those with a history of violence. He also argued that CPA documentation should be redesigned and simplified to make it compatible with clinical and risk assessment, and to facilitate transfer of information between services.

Simpson et al. (2003a) reviewed the literature on case management and the CPA, identified ongoing problems with implementation ten years after its introduction, and argued that it had failed to fulfil its true potential, concluding that the CPA was a “cheaper, unbranded and ultimately faulty version of case management” which was never adequate for the purpose for which it was introduced. They argued that if the CPA had been identified as “clinical case management”, this could have given it legitimacy among clinical staff and made explicit the importance of the therapeutic relationship between service user and key worker, and had it included the principles of the strengths model, the CPA might have provided an underlying philosophy of care to unite the health and social care members of the multidisciplinary team. Further work by Simpson et al. (2003b) described the CPA as a system which was, from the start, “destined to fail”, and they concluded that this failure was due to inadequate resources, a top-down managerial approach which failed to engage with frontline clinical staff, the introduction of standards and performance targets, poorly functioning community teams and an unrealistic political agenda. The authors did, however, concede that the CPA had improved the ability of services to maintain contact with people who have severe mental health problems, and that service users value having written care plans.

Researchers have also examined the CPA from the specific viewpoint of mental health nurses. For example, Anthony and Crawford (2000) examined service users’ involvement in care planning from the mental health nurse's perspective, set in the context of the growing “consumerist ethos”. Their small qualitative study, using semi-structured interviews, found that although nurses valued the concept of service user involvement, they also found it problematic at times, experiencing contradictions between the “consumerist ideology” and their statutory duties and responsibilities, such as those in relation to the Mental Health Act. The researchers found that factors preventing nurses from involving service 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. In response to this, Rush’s overview of mental health service user involvement in England (2004) concluded that the inherent conflicts in nurses’ roles, which served to inhibit meaningful service user involvement, would not be resolved unless they were made explicit and discussed with other professionals and service users.

Mental health nurses Stickley and Masterson (2003) looked at CPA documentation in current use and identified a number of shortcomings, offering advice to nurses on making the CPA less bureaucratic and de-humanising, including challenging the medical model of care, and advocating for a more user-centred assessment tool that allowed service users’ “strengths, wishes, desires, interests and hopes” to be recorded, and stressed the need to record service users’ views irrespective of the documents’ format.

The Health Advisory Service’s review of mental health inpatient care in London (HAS, 2003) highlighted difficulties caused by service providers developing individual policies and procedures relating to the CPA, and the resulting fragmentation of care. While some London Trusts were actively working to implement the CPA as required, some still reported feeling it more of a bureaucratic exercise than something of genuine use. The HAS also found many Trusts were more effective at assessing risk than at assessing individuals’ needs, and in only a very small number of cases had the service user signed their care plan. They recommended that the London Development Centre (NIMHE) should keep copies of all London Trusts’ policies on CPA, needs assessment and risk assessment as a resource which could be accessed through the Acute Care Group.

THE CPA AS A PERFORMANCE INDICATOR

Health service commissioners often use evidence of CPA implementation as one of a number of quality standards to assess mental health service providers. Similarly, many service providers also use 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.

As part of a multidisciplinary audit process, Perkins and Fisher (1996) examined CPA care plans in one London Trust. Stressing the need to do more than simply record the presence of a care plan as being a positive indicator, they argued that a meaningful assessment of its content and effectiveness was also required. They assessed the extent to which the care plans reflected the strengths and problems defined by staff and by the service user, how well the care plans addressed all areas of the service users’ lives (including social, work and leisure activities), whether targets were set which were not related to staff or service users’ assessments of need, and how well the targets were achieved. They found that care plans were not always based on the assessments which had taken place; that some areas of service users’ lives, especially financial issues and psychological well being, were relatively neglected; that staff-defined problems received more attention than those defined by the service users themselves; that despite the services’ adoption of a strengths model of care planning, the care plans focused more on problems...
than on strengths; that although a large number of targets (85%) were met overall, targets relating to leisure and work activities were less likely to be met (38% and 53% respectively). When the findings were fed back into the quality cycle, a number of improvements resulted.

By means of a thematic review (2002), Thornicroft et al. considered what types of research would be useful to mental health policy makers, identifying gaps in completed research and formulating research questions to address the missing issues. In relation to Standard 4 of the NSF – the CPA’s role as a framework for care of those with severe mental health problems – they considered that the effect of crisis plans on rates of admission to hospital and to service users’ and carers’ satisfaction had not been sufficiently investigated, and nor had the impact of giving service users copies of their care plans.

Lockwood and Marshall (1999) reported on a pilot study in which the introduction of “needs feedback” to the CPA process was aimed at making it more effective. This approach focused more on service users’ social, employment, housing, activities of daily living and financial needs, rather than the more traditional diagnosis-led medical model. This small study found significant improvements in the number of service users’ unmet needs at the six month follow up, and in the level of some symptoms of mental ill health, with some improvement also in social functioning.

Clarkson and Challis (2002) discussed the history and development of performance indicators and monitoring techniques for mental health services, and made suggestions for more meaningful future methodology to capture the quality as well as the quantity of services provided. They recommended that several questions on local CPA implementation be included in mental health services’ performance indicators, including the number of people on the enhanced CPA, information on overdue reviews, and the degree of involvement of service users and carers in the care planning process.

An examination of 199 sets of case notes of service users discharged from acute inpatient care in four Trusts (Warner & Hoadley, 2004) found that although three quarters of the inpatients had been known to mental health services before admission, only a half had a current CPA care plan. A third of inpatients in one site had the date of their next CPA review recorded in the notes at the time of discharge, with fewer examples found in the others. Similarly, while a third of the service users in one site had a copy of their care plan on discharge, only five people altogether in the three other sites received them.

NATIONAL PERFORMANCE MANAGEMENT

The former Commission for Health Improvement (CHI), as part of its routine clinical governance reviews in England and Wales, assessed most mental health Trusts, awarding a star rating to each based on how well they had fulfilled a number of criteria (CHI, 2003a). Among the evaluation criteria were the progress made in developing the services described in the NSF and the NHS Plan (DH, 2000), and in implementing the CPA, the specific criterion being that CPA details and care plans are held on electronic systems which are regularly updated and available 24 hours
a day. Targets relating to service user involvement included the requirement for service users to have copies of their CPA care plans. A review of CHI’s findings in mental health services (CHI, 2003b) reported that “large numbers of users are not being placed on the Care Programme Approach or allocated a care plan and co-ordinator”. This was ascribed to continuing clinical resistance and the burden of the documentation in some trusts, with the result that practice surrounding the CPA “remains inconsistent”.

The Healthcare Commission (HCC) took over from CHI the responsibility to assess Trusts’ performance against the standards in the NSF in 2003. Their Performance Ratings for 2003/04 showed Trusts’ performance against a number of standards, one of which was CPA Systems Implementation (HCC, 2004a). To achieve this, care plans had to be held on an electronic central database which was regularly updated and available 24 hours a day.

In addition to key targets a number of indicators, chosen to provide a balance across a wide range of areas, were grouped together under the heading ‘A Balanced Scorecard’. Within a Clinical Focus grouping, there was an indicator called Enhanced CPA indicator (formerly the CPA/complex care indicator), for which Trusts were assessed on the CPA status of service users receiving complex specialist mental health care. This was assessed by examination of the Mental Health Minimum Data Set (MHMDS), a computerised record of all episodes of care, or finished consultant episodes (FCEs), submitted quarterly by Trusts. The HCC’s presentation of the aggregated results for the components of Clinical Focus do not show how Trusts performed on this one factor, but in 2003-04 overall 47 Trusts scored high (57%), 21 scored medium (25%), and 15 scored low (18%) on Clinical Focus.

The Healthcare Commission’s key targets for the star ratings in 2004-05 for mental health trusts again included CPA Systems Implementation, and the CPA/complex care indicator within the ‘Balanced Scorecard’ (HCC, 2004b). An additional target related to the full implementation of the MHMDS, which includes information on each service user’s CPA level, date last seen, and details of Care Co-ordinator. Performance was again assessed though examination of the quarterly MHMDS submissions.

The Healthcare Commission is now changing the way it assesses Trusts’ performance (HCC, 2005a; HCC, 2005b; HCC, 2005c). An annual health check is being introduced in 2005-06, aimed at assessing whether Trusts are getting the basics right and meeting existing targets, and also if they are making and sustaining progress towards new targets. Trusts will in future make an initial declaration of how well they are meeting the standards, and this information will be supplemented by announced and unannounced visits, in order to arrive at an overall performance rating. The criteria for assessing core standards in mental health services still include information drawn from the MHMDS on the implementation of the CPA, and questions on care planning will be asked as part of another national patient survey. An additional standard has been added to the clinical and cost effectiveness domain, that of data on service users on the enhanced CPA who are in work, education or training.
Trusts can also audit their own performance in implementation of the CPA. The Department of Health first published an audit pack for monitoring the CPA, drawn up in collaboration with the Royal College of Psychiatrists, in 1996, and this was revised and reissued in 2001 (DH, 2001). Services were expected to use the audit tool for “reporting into NHS clinical governance structures and Local Authority Cabinets and Scrutiny Committees”. Clinical governance provides systematic feedback at the local level to those bodies with responsibility for the level and quality of services, with reporting based on service user feedback and objective data.

The CPA Association has also published an audit tool which mental health services can use to survey the views of service users on the enhanced level of CPA, with a number of different issues being examined sequentially over a three year period (CPAA, 2003b). This can be complemented by a survey of carers, an audit of case files, and a review of the organisational implementation of the CPA.

The importance of involving service users in care planning and the whole CPA process is explicit. Much service user-led research has explored the extent to which the CPA has been implemented, and how involved service users were in the process. Findings suggest that service user involvement in the CPA is still not widely practised, although where service users are involved in the process, they are happier with the services they receive.

Beeforth et al. (1994) examined the implementation of the clinical model of case management, from the service users’ point of view, in particular its claim to be a “client-centred approach”. Respondents were generally positive about their experience of the system, valuing the relationship with their care manager and feeling involved in setting their own priorities and goals and drawing up their care plan. Practical assistance with issues such as housing and finance made a big difference to service users’ lives, as did help with leisure and social activities. The researchers concluded that service users experienced case management as qualitatively different from – and a vast improvement on – other community-based systems of care.

The first SCMH User Focused Monitoring (UFM) project, which began in 1996, was designed to assess services users’ knowledge of, and satisfaction with, community mental health services in three London trusts (Rose et al., 1998). Interviews took place with service users on the top tier of the CPA (then equivalent to the current enhanced CPA), who all had a key worker and a care plan. It was found that less than two thirds knew they had a key worker; a third of the group knew they had a care plan, but only a fifth said they had been involved in drawing it up. A small minority knew about their CPA review, but nobody considered they were involved in the CPA review process. Two thirds of respondents felt their needs had been fully assessed, while just one third felt their strengths had been taken into account in
the process. When the UFM team returned to the area two years later (Rose, 2001), they found a statistically significant improvement in service users' knowledge about their key worker, care plan, and CPA review.

McDermott (1998) examined the attitudes and experiences of a group of service users on the then top tier of the CPA in outer London. He found that over half the respondents did not understand the term ‘CPA’ and a third did not understand why they were subject to it, although most understood the concept of keyworking and knew the name of their key worker (now Care Co-ordinator). Although most had received copies of their CPA care plan, few fully understood it, and some felt under pressure to sign it, fearing readmission if they did not. Service users generally felt they were not consulted as equals by the professionals responsible for their care planning. While most felt their care had been unaffected by the introduction of the CPA, some felt it had got worse, while a smaller number reported an improvement. The author concluded that effective communication and collaboration between service users and professionals was essential to the successful implementation of the CPA.

Lawson et al. (1999) assessed the extent of service user involvement in CPA care planning in one London Trust from the users’ perspective. Through interviewing a small sample of respondents, they found that although all service users knew who their key worker was, most wanted to be more involved in planning their care and would have liked to be given a copy of their CPA care plan.

Webb et al. (2000) developed a tool to assess service users’ knowledge of, and satisfaction with, aspects of the CPA, using it to survey individuals in contact with community and hospital services in five trusts nationally. They found a third of the service users had not been told what a key worker was, and nearly one fifth did not know their key worker’s name. More than two fifths did not know what their care plan was and over half had not been involved in drawing it up, while only a third knew the date of their next review. Further analysis revealed that procedures for implementing care plans was one of the factors most predictive of overall satisfaction with the service.

Rose returned to the CPA and the issues of partnership, co-ordination of care and the place of service user involvement, exploring whether increasing co-ordination of care at a structural level was associated with greater service user involvement (2003), concluding that this was not necessarily the case, but that where service users were involved in planning their own care they were more satisfied overall with the care they received.

Valentine et al. (2003), although not directly studying the CPA, found that involving residents of a rehabilitation unit in their own care planning had positive effects in terms of the delivery of care.

In 2001, service users in Northamptonshire carried out an audit of the CPA using a postal questionnaire and interviews (Users’ Support Service, 2004). The researchers found that a third of respondents did not know they had a Care Co-ordinator, and less than half had a copy of their care plan which they had agreed and signed.
Langan and Lindow (2004) undertook research into service users’ involvement in risk assessment and management, interviewing inpatients who were considered by the clinical teams to pose a potential risk to other people. Identifying the CPA as “the bedrock of mental health policy and practice”, they found that although most service users had a CPA care plan on discharge, in only a few instances did this include a risk management or relapse plan. The authors highlighted the difference between service users being “involved in” and “having influence over” the care planning process, noting that independent advocacy could have helped individuals to have their views taken into account in shaping their care plans, and that making an informed choice about care planning was only possible when service users knew about the full range of available services. They also observed that service users who were detained when follow-up and aftercare arrangements were being made were not in a position to refuse any aspect of the care plan.

Carpenter et al. (2004) conducted a large study in four districts in the north of England. They examined the extent to which the CPA and Care Management (CM) systems were integrated, and looked at nearly 300 service users’ involvement in, and satisfaction with, their care planning. They found that most service users felt involved in planning their care and treatment, and felt they had more choice, when in the community, but this was less often the case when they were in hospital. Altogether less than half the service users thought they had a care plan, although there were differences between the districts ranging from 37% to 60% of service users. Service users who had a care plan were generally positive about it, and nearly all service users knew who their key worker was. Service users in the two districts where CPA and CM had been integrated were statistically more satisfied with services than those in the districts where the systems were separate, and the authors concluded that service user involvement and choice are facilitated by the integration of health and social care.

The Healthcare Commission is now responsible for the programme of national patient surveys initiated by CHI, and the first patient survey in mental health was completed in 2004. This is the largest ever survey of service users in England, in which the views of more than 27,000 people were obtained by means of a postal questionnaire (Osborn et al., 2003; Picker Institute Europe, 2003). Ten questions on the CPA were included. About half the respondents said they had been given (or offered) a copy of their CPA care plan, and altogether three quarters said they definitely, or to some extent, understood what was in it. Most people agreed, at least to some extent, with what was in their care plan. Half the service users had not had a review in the past year; of those who had, most felt they had been given the chance to express their views at the meeting. Two thirds of respondents knew who their Care Co-ordinator was, and a similar number had seen them within the last month. The national report, reports for all individual Trusts, and the detailed responses for the questions on the CPA, for each Trust, are available on the HCC’s website (HCC, 2004c; HCC, 2004d).

A recent study in Devon (in, Hounsell and Owens, 2005) examined “bridges and barriers to user and carer involvement in care planning”. The service user researchers identified factors which could help or hinder the CPA process, such as the timing, venue and attendance at review meetings, while a trusting relationship
between the service users and the professionals was seen as a key factor. Although the findings were based on data from a small number of people, a further, longer-term study is being planned in order to provide more information.

**FINDINGS ON THE CPA FROM HOMICIDE INQUIRIES**

Where a person in contact with specialist mental health services has committed a homicide, the Health Authority concerned must set up an independent inquiry into the circumstances. These inquiries’ terms of reference typically include the examination of the appropriateness and quality of any assessment, care plan, treatment or supervision provided to the individual. Sixteen inquiry reports published between 2000 and 2004 were obtained from Strategic Health Authorities, Primary Care Trusts and Mental Health Trusts, along with information on the action plans or progress reports relating to a further four inquiries (Armstrong et al., 2004; Bhatoa et al., 2003; Calderdale Council et al., 2004; Crissel et al., 2004; Curwen et al., 2003; Downham et al., 2003; Eldergill et al., 2001; Georgiou et al., 2004; Gledhill et al., 2004; Holwill et al., 2003; Johns et al., 2003; Joyce et al., 2003; McKay et al., 2004; Mishcon et al., 2000; Price et al., 2004; Smallridge et al., 2004; West Yorkshire Strategic Health Authority, 2003a; West Yorkshire Strategic Health Authority, 2003b; Winter et al., 2002). Altogether, these related to the care and treatment of 22 individuals, known to mental health services, who had committed homicides.

Many of these inquiries found evidence of incomplete or ineffective implementation of the CPA in some areas, leading to negative outcomes. Recommendations included calls for local practice to be driven by adequate local policies and procedures, based on national standards, and the need to ensure comprehensive multidisciplinary assessment, care planning, and review processes take place. Many reports stressed the need for service users and carers to be fully involved in the CPA, and for effective liaison and communication with other services. The importance of including risk assessment and management, signs of relapse, and contingency plans for working with people whose care plans fail and those who are difficult to engage with services, was noted. Some reports emphasised that service users should be placed on the appropriate level of CPA, with safeguards to ensure they are not removed from the CPA by one professional acting without agreement at a multidisciplinary review. Many reports concluded that the CPA should be supported by clear documentation, easily accessible by all agencies involved, with regular local auditing to ensure effective implementation.

**THE CPA IN RISK ASSESSMENT AND MANAGEMENT**

The assessment of risk and the development of strategies to manage it are essential elements of the CPA process. These processes should be fully integrated with the CPA and included as part of the care plan. A number of authors have examined how well this is being achieved.

When Dick et al. (2003) in Dundee examined 43 sets of case records in order to identify the past risk-related behaviour of service users who were being referred to
the CPA, they found the information was not recorded in a standardised way or in a consistent part of the records, leading them to recommend that a risk summary should be included in the CPA care plan.

Paley and McGinnis (2003) described the implementation of risk assessment and care planning into the CPA process, in one northern Trust, by the addition of the FACE risk profiling system (Clifford, 1999). The authors reported that the inclusion of a standardised approach to risk assessment complemented the existing CPA assessment and care planning, enabling clinical staff and service users jointly to explore and document this key area.

**DISCHARGE PLANNING AND CONTINUITY OF CARE**

Planning for the discharge of hospital inpatients and devising care plans to support the service users when they are back in a community setting, is an important part of the CPA. The transition from hospital to community care is a period during which there is the most potential for service users to slip out of contact with services. Some authors have focused on this stage of the care planning process.

In Canada, Forchuck et al. (1998) evaluated a programme designed to help with the discharge process of inpatients in a ‘psychiatric hospital schizophrenia program’, in which inpatient nurses provided community follow-up after discharge, and community-based nurses made ‘inreach’ visits while patients were still in hospital. When service users were asked for their views on what they found most helpful in making the transition back into the community, in addition to having an ongoing relationship with staff they reported greatly valuing being involved in the discharge planning process, particularly in relation to finance and housing issues, and with activities of daily living.

In the USA, Fortney et al. (2003) generated five indicators of continuity of care for people in community settings, which could be easily measured using routine administrative data. These were: the timeliness of the service use; the intensity of the services received; the comprehensiveness of the services received; the stability of the relationship between the service user and the provider team; and the co-ordination of service provision through the case management model, the key features of which are similar to those of the CPA in England. They suggested that these measures could be used as performance indicators for services, evaluating systems of care and their ability to engage with service users over time, and also to assess individual service users’ pattern of service use, including the identification of those at risk for poor health outcomes.

**A COMPREHENSIVE CARE PLAN**

A comprehensive CPA care plan could be regarded as one which combines a full assessment of the service users’ needs and a clear plan of care and intervention (what, who by, when, etc.), collaboratively arrived at and agreed by the service user and Care Co-ordinator, with the minimum of bureaucratic effort for the mental health worker who has to complete the paperwork. The development of an
The electronic CPA (eCPA) has already been described (Howells and Thompsell, 2002), and it is clear from CHI’s progress report on mental health trusts (CHI, 2003b) that they expected this to become the norm.

Through SCMH’s and MHAC’s routine contact with NHS Trusts and independent mental health providers, we obtained a number of examples of CPA documentation, and examined these in the light of the CPA Handbook (2003a), and the National Standards and CPA Association Audit Tool (2003b), to assess whether all the essential elements were included. From these, the eCPA forms for the enhanced CPA provided by South London and Maudsley NHS Trust (SLaM) most closely matched the ideal. SLaM has subsequently developed ‘The Patient’s Journey’, a single, integrated clinical information process, designed to include all relevant information about patients’ care from their first contact with the Trust until their final discharge from the service (SLaM, 2004). It supports the CPA, and will also meet the requirements for the Mental Health Minimum Data Set and other statutory returns.

**CONCLUSIONS**

Since its introduction in 1991, the CPA has provided a framework for the systematic assessment, care planning and review of service delivery by health and social care staff in hospital and community settings, for people with mental health problems. Since its combination with care management in 1999, it has been the single care co-ordination approach for this group of service users. Guidance on the implementation of the CPA has been provided by the CPAA, and is included in the Mental Health Act Code of Practice.

The Department of Health and the Social Services Inspectorate have monitored the use of the CPA by statutory and independent sector providers against required standards, and a number of service commissioners expect Trusts regularly to audit their own performance. The Commission for Health Improvement, succeeded by the Healthcare Commission, have also used CPA implementation as a performance indicator; this approach has also been taken by researchers seeking a proxy for measuring the quality of the services provided.

It is explicit in the CPA guidance from the DH & SSI that service users must be involved in the CPA care process. Service users’ experiences of the CPA are variable, but it has been shown that where they are properly involved in the process they are happier with the services they receive, and there is evidence that many service users welcome the care co-ordination aspects of the CPA.

CPA care planning is crucial to the process of discharge from hospital to ensure service users receive continuity of care.

CPA documentation should include a comprehensive assessment of needs, including an assessment of risk, and a clear plan of the actions and interventions to be provided, along with other necessary factual information; these should be contained within a concise format so as to encourage completion by the Care Coordinator. Care plans also need to be accessible to the service user, their carer, and all agencies involved. Electronic versions of the CPA have been developed which include all these features.
REFERENCES


The Care Programme Approach Association (2003b) *National Standards and CPA Association Audit Tool for the Monitoring of the Care Programme Approach*. Chesterfield: CPAA.


Commission for Health Improvement (2003b) *What CHI has found in: mental health trusts*. Available from: http://www.healthcarecommission.org.uk/assetRoot/04/00/00/51/04000051.pdf


Department of Health (1990a) *Caring for People. The Care Programme Approach for people with a mental illness referred to specialist mental health services*. Joint Health/Social Services Circular. C(90)23/LASSL(90)11.


South London and Maudsley NHS Trust (2004) Further information on The Patient Journey is available from Matthew.Broadbent@slam.nhs.uk or at SLaM, Reay House, 108 Landor Road, Stockwell, London SW9 9NT.


QUANTITATIVE DATA ANALYSIS

We used frequencies, percentages and means to describe the sociodemographic and clinical characteristics of the service users and to describe elements of the quality of care planning they received.

For the service users who had a care plan, we used exploratory factor analysis to summarise the variables which record the needs assessed in the care plans. This allows us to answer questions about how different variables are related to each other i.e. to see whether those people who have a high chance of having one need assessed would also have a high chance of the other being assessed. Factor analysis groups items together, for example putting together all the factors relating to service users' mental health needs.

We used the same technique to examine the variables that record the care specified in the care plans, and those that record the help the service user interviewees reported receiving.

For the analysis, ethnicity was classified into the five groups described in Appendix 3: White, Mixed, Asian, Black and Other.

Age was grouped into six bands: under 20, 20-29, 30-39, 40-49, 50-59, and 60 and over.

Diagnoses were grouped into: schizophrenia, bipolar disorder, schizoaffective disorder, other psychotic disorder, depression, personality disorder, and other diagnosis.

Previous Sections were categorised as either ‘assessment’ (Sections 2 and 4), or ‘treatment’ (Sections 3 and 37).

We compared the groups of factors with gender, ethnicity, age, diagnosis and previous section, to determine whether there were any statistically significant differences between any groups of service users in terms of their needs assessment, the care that had been planned, and the help they had received. Looking at the statistical significance tells us how meaningful the numerical differences are between the groups.
QUALITATIVE DATA ANALYSIS

The qualitative data from the interviews with service users was analysed with the help of a software package (WinmaxPro) to develop a coding framework and to code and retrieve sections of the texts. Content analysis was used to identify themes emerging from the qualitative data.

Further qualitative information and observations about the visit, including examples of good practice, was recorded by the Commissioners. This was also subjected to content analysis to identify themes and specific illustrative examples.

SOME LIMITATIONS OF THE STUDY

Project assumptions  We used the presence of CPA care plans in service users’ case notes, and the quality of the information contained in those care plans, as proxy measures for good practice in the delivery of care. Some criticisms may be directed towards this approach.

It is good practice for a CPA care plan which was drawn up at the time of a service user’s last discharge to be included in their inpatient case notes. However, the absence of such a care plan in the notes does not necessarily mean that a care plan was not produced and sent to the community team responsible for the individual’s follow-up and aftercare. In some instances, Commissioners were told that care plans were only kept in community notes. In other instances, the sheer size of case notes, and the confusing way in which they were assembled, might have prevented Commissioners from finding a CPA care plan that could have been present. The figures presented on numbers of care plans in the inpatients’ notes should, therefore, be taken with some caution.

In addition, the presence of a comprehensive care plan is also taken as a proxy of good practice, but having a care plan does not guarantee that the actions specified in it were actually delivered. Commissioners were only able to find out about what was actually delivered from the service users they were able to interview. This represents about half the total number, and no conclusions can be drawn about the remainder.

Missing data  There are two possible types of missing data – information which was not recorded in the service user’s case notes and so could not be entered onto the questionnaire, and information which was present in the case notes but was not recorded on the questionnaire by the Commissioner. It is only possible to distinguish between the two types of missing data on the occasions where a Commissioner has recorded that a piece of information was not present in the case notes.

Twenty-three completed questionnaires were excluded from the data analysis either because the service users did not meet the inclusion criteria, or because crucial information on their admission dates and/or MHA Sections was missing so their eligibility could not be determined.
## Tables and Figures

### Table 3  Ethnic groups

<table>
<thead>
<tr>
<th>White</th>
<th>Asian or Asian British</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 White British</td>
<td>08 Indian</td>
</tr>
<tr>
<td>02 White Irish</td>
<td>09 Pakistani</td>
</tr>
<tr>
<td>03 Any other White background</td>
<td>10 Bangladeshi</td>
</tr>
<tr>
<td></td>
<td>11 Any other Asian or Asian British background</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed</th>
<th>Black or Black British</th>
</tr>
</thead>
<tbody>
<tr>
<td>04 White &amp; Black Caribbean</td>
<td>12 Caribbean</td>
</tr>
<tr>
<td>05 White &amp; Black African</td>
<td>13 African</td>
</tr>
<tr>
<td>06 White &amp; Black Asian</td>
<td>14 Any other Black or Black British background</td>
</tr>
<tr>
<td>07 Any other mixed background</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Chinese</td>
<td></td>
</tr>
<tr>
<td>16 Any other ethnic group</td>
<td>17 Not stated</td>
</tr>
</tbody>
</table>
## Table 4  Details of patients who were readmitted within two weeks of discharge

<table>
<thead>
<tr>
<th>Number of days before readmission</th>
<th>Did they have a care plan at time of discharge</th>
<th>Reason given in notes for readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>yes</td>
<td>Non-compliance with medication; threatening to mother, paranoid</td>
</tr>
<tr>
<td>5</td>
<td>no</td>
<td>Found by police in public place in need of mental health assessment. Detained/brought to the ward under S136 following lengthy periods when absent from ward without consent</td>
</tr>
<tr>
<td>7</td>
<td>no</td>
<td>Required inpatient care as he behaves as being deluded and previously psychotic. Eating very little and at risk of self neglect, and at risk of harming others</td>
</tr>
<tr>
<td>11</td>
<td>no</td>
<td>Not compliant with medication and relapse</td>
</tr>
<tr>
<td>11</td>
<td>no</td>
<td>Deterioration of mental state; suffering from grandiose and delusional ideas; pressure of speech; neglect of diet and unable to take care of her serious physical illness</td>
</tr>
<tr>
<td>12</td>
<td>yes</td>
<td>Relapse in mental health and behaviours associated. Failure to maintain antipsychotic medication.</td>
</tr>
<tr>
<td>13</td>
<td>yes</td>
<td>Schizophrenic illness; relapse due to non-compliance with medication; paranoid delusions; refused informal admission</td>
</tr>
</tbody>
</table>
Figure 8 Needs assessed, actions specified and help received

Key

Were assessed
Had care plan
Received help

Number of people

Mental health
Risk
Relapse & crisis plan
Family & friends
Housing
Activities of daily living
Work/education
Finances
Leisure
Spiritual
Cultural
Emotional
Physical health
Disability
Communication
Dual diagnosis
Advocacy
**Figure 9** Length of time between admissions in months

- **Number of months**
- **Number of people**
The CPA Brief Audit Tool (CPA-BAT) 
for assessing the quality of CPA care planning for service users who are repeatedly detained

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The CPA-BAT can be downloaded from the SCMH website at www.scmh.org.uk and the MHAC website at www.mhac.org.uk.

GUIDANCE FOR USING THE CPA BRIEF AUDIT TOOL (CPA-BAT)

Introduction

This audit tool (the CPA-BAT) is designed to be a quick and simple way for staff in mental health services to assess the quality of their CPA care planning for service users who have more than one compulsory admission in a period of three years. Evidence from the joint SCMH/MHAC project indicates that there are likely to be no more than a handful of people meeting these criteria in any NHS Trust at any one time. It could also be used to assess CPA care planning for other groups of service users.

The CPA-BAT includes a small number of key questions that indicate the quality of CPA care planning for this group of service users, enabling steps to be taken to correct any identified deficiencies. It is not intended to replace established audit tools such as those published by the CPA Association (CPAA, 2003) and by the Department of Health (DH, 2001) with which Trusts can fulfil their requirement to conduct an annual audit of their CPA implementation (NHSE & SSI, 1999) and ensure they are meeting the standards set out in the National Service Framework for Mental Health (DH, 1999) and the Criteria for a Robust CPA (quoted in CPAA, 2003).
The CPA-BAT is based on the questionnaire devised for the joint SCMH/MHAC project. With hindsight, there are other questions which we might have included. These are indicated in this Guidance, and are included in the CPA-BAT.

**Selecting the service users**

Our study involved service users whose current admission had been compulsory, who were detained on the day of our visit, and who had been previously admitted compulsorily within the three years prior to our visit. Trusts may wish to use the CPA-BAT in relation to other groups of inpatients.

**Using the audit tool**

There are two parts to the CPA-BAT. The first involves examining the service user’s case notes, and the second involves interviewing the service user. This could be undertaken by members of the NHS Trust’s Clinical Governance Department, including local service users who are involved in audit and monitoring of services. The Trust Information Department, IT Department, and CPA Manager should also be consulted about how this information can best be managed, for example whether to create a new database or to adapt an existing one.

**Information from the case notes**

*The CPA care plan*

The assessment can only go ahead if there is a CPA care plan relating to the service user’s discharge from hospital following their previous compulsory admission. This may be in their notes, in an electronic CPA system, or even in a separate folder on the ward. The crucial factor is that it should be easily accessible to ward staff who are responsible for planning the service user’s discharge and after-care in relation to their current hospital stay, so they may see what was planned and delivered on the previous occasion and learn from past experience.

*Service user information*

Each service user should have a unique ID number, such as their NHS number. Information should be collected on the gender, age and ethnicity of each service user, along with what section of the Mental Health Act they were admitted under for their current and previous admissions.

*Assessment of needs and care planning*

We would expect there to be evidence in the care plan that the service user had been assessed in terms of all the possible needs listed. For each of these needs, the care plan should say either how these needs will be met, or that the service user has been assessed as not needing any intervention in this area.

No attempt has been made to ‘weight’ the needs, as we believe they are all important and should all be assessed for all service users. However, there are some specific requirements to which NHS Trusts should pay particular attention (NHSE & SSI, 1999). These are for: risk assessment and plan; signs of relapse and crisis plan; psychological needs; physical health needs; social functioning; cultural; employment and educational activities; housing; and finances and welfare benefits. Routine Trust audits may have identified other issues of particular concern locally.
**Additional questions:**

Were needs associated with the service user's gender assessed and planned for?

Were needs associated with the service user's sexuality assessed and planned for?

Were the service user's dietary needs assessed and planned for?

Were the needs of carers and family members assessed and planned for?

Were any needs identified for which no help was available?

Was the name of the person responsible for implementing each action given in the care plan?

Was the Care Co-ordinator identified?

**CPA level**

All detained patients should be on the enhanced level of the CPA. CPA level should be recorded for all service users.

**The service user's involvement in care planning**

The service user should have signed the care plan, or there should be a record of why they did not, for example if they were asked but declined to do so. It should also be recorded that they were given a copy of the care plan – or that they were offered one but chose not to take it.

**The CPA review after their last discharge from hospital**

The date of the next CPA review after the service user's discharge from hospital should be recorded in their case notes. If the review took place, it should be recorded who attended.

**Additional question:**

Was the service user seen by a mental health worker within seven days of their last discharge?

**Knowledge of, and involvement with, the CPA**

The service user should know what the CPA is; even if they are unfamiliar with the term, they should understand that there is a system in place to guide how their care is planned and delivered. They should have been given a copy of the CPA care plan when they were last discharged from hospital, and they should have been involved in drawing it up, along with other key people.

**Additional questions:**

To what extent was the service user involved in drawing up their care plan, were they happy with this level of involvement, and did the care plan adequately reflect their own views of their strengths and needs?
Was the service user given information about a local advocacy service who could help with drawing up the care plan?

**What happened after discharge from hospital**

For each of the needs listed, the service user should be able to say whether they got help or not, or whether they did not need help in this area. They should have been seen by a mental health professional within a week of being discharged from hospital. They may feel they did not have all their needs met after leaving hospital.

**Additional questions:**

Did you know who your Care Co-ordinator was?
Were your needs met in relation to your gender?
Were your needs met in relation to your sexuality?
Were your dietary needs met?
Were the needs of your carer and family met?

**Open-ended questions**

Trusts should find it useful to record the service user’s answers to the questions about what they felt helped them the most after their last discharge from hospital, any other help they would have liked to have, why they were admitted to hospital this time, and how helpful they think this has been.

**Using the information**

The information from the case notes and service user interviews can be used to ‘trouble-shoot’ individual instances where the implementation of the CPA falls short of what is expected, or where some other problem is identified. Issues which are identified from a number of case notes or service user interviewees may require a more formal operational response leading to a revision of policies and procedures.

It is also possible to aggregate some of the information. The data collected can be numerically recorded and entered into a database, and then analysed. For example, NHS Trusts might find it useful to calculate the total number of needs which were satisfactorily assessed and planned for in relation to each service user. This information could then be used, along with the service users’ demographic details, to examine whether particular groups of people (e.g. from different genders, age groups, ethnic groups or section of the Mental Health Act) are faring better or worse than others in terms of the quality of their care planning. These scores could also be used to measure progress over time. The total number of needs met for each service user could be used in a similar way.

Trusts can also use the data to focus on issue of particular local interest, such as involvement of carers in CPA reviews, or the follow-up arrangements for discharged service users provided by community-based staff.
REFERENCES


## Service User Information

1. **Name of Unit:**

2. **Name of Ward:**

3. **Unique service user ID number – e.g. NHS number:**

4. **Gender** – *please circle one:*  male / female

5. **Age** – *please write in:*  years

6. **Ethnicity** – *please circle one:*

   **White**
   - 01 White British
   - 02 White Irish
   - 03 Any other White background

   **Asian or Asian British**
   - 08 Indian
   - 09 Pakistani
   - 10 Bangladeshi
   - 11 Any other Asian or Asian British background

   **Mixed**
   - 04 White & Black Caribbean
   - 05 White & Black African
   - 06 White & Black Asian
   - 07 Any other mixed background

   **Black or Black British**
   - 12 Caribbean
   - 13 African
   - 14 Any other Black or Black British background

   **Other**
   - 15 Chinese
   - 16 Any other ethnic group
   - 17 Not stated

7. **Date of current admission:**  *please write in:*

8. **What section were they admitted under – *this* admission?**  *please write in:*

9. **Date of previous admission:**  *please write in:*

10. **What section were they admitted under – *previous* admission?**  *please write in:*

11. **Date of previous discharge:**  *please write in:*

12. **Is there a CPA care plan in the notes relating to the previous discharge?**  *yes / no*
### Information from the Case Notes

#### 1. Assessment of needs and care planning

<table>
<thead>
<tr>
<th>Needs associated with:</th>
<th>Assessment of needs: Does the CPA care plan include an assessment of the following needs? <em>Please circle one</em></th>
<th>Care Planning: Does the CPA care plan say how these needs were to be met after they were discharged? <em>Please circle one</em></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>This was assessed in the care plan</td>
<td>Action is specified in the care plan OR They were assessed not to need help with this</td>
</tr>
<tr>
<td>mental health</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>risk assessment</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>signs of relapse and crisis plan</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>relationships with family &amp; friends</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>housing</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>activities of daily living</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>work and/or education</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>financial (including benefits)</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>leisure activities</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>spiritual</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>cultural (including ethnicity)</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>emotional</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>physical health</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>physical &amp; sensory disability</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>communication</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>dual diagnosis – substance misuse</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>advocacy</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>gender</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>sexuality</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>dietary requirements</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
<tr>
<td>needs of carers &amp; family members</td>
<td>yes / no</td>
<td>yes / no</td>
</tr>
</tbody>
</table>

Continued...
# Information from the Case Notes (continued)

2. **Were any needs identified for which no help was available?**
   
   *Please circle one:* yes / no

   *If yes, please record what:*

3. **Was the name of the person responsible for implementing each action given in the CPA care plan?**
   
   *Please circle one:* yes / no

4. **Was the Care Co-ordinator identified in the CPA care plan?**
   
   *Please circle one:* yes / no

5. **What CPA level was the service user on when they left hospital?**
   
   *Please circle one:* enhanced / standard

6. **Did the service user sign the CPA discharge care plan?**
   
   *Please circle one:* yes / no

   *If ‘no’, please record why not:*

7. **Was the service user given a copy of the CPA discharge care plan?**
   
   *Please circle one:* yes / no

   *If ‘no’, please record why not:*

8. **Was the date of the first CPA Review to be held after discharge recorded?**
   
   *Please circle one:* yes / no

9. **If ‘yes’, did this review take place?**
   
   *Please circle one:* yes / no

10. **If ‘yes’, did the service user come to this review?**

    *Please circle one:* yes / no

   Continued...
### Information from the Case Notes (continued)

**11. If ‘yes’, who else came to this review?**

*Please circle yes or no for each:*

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Co-ordinator</td>
<td>yes/no</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>yes/no</td>
</tr>
<tr>
<td>GP</td>
<td>yes/no</td>
</tr>
<tr>
<td>Carer</td>
<td>yes/no</td>
</tr>
<tr>
<td>Other</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

*please say who (job title)*

**12. Was the service user seen within seven days of their last discharge from hospital?**

*Please circle one: yes/no*
<table>
<thead>
<tr>
<th>Question</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you know what the Care Programme Approach is? It’s also known as the CPA.</td>
<td>Please circle one: yes / no</td>
</tr>
<tr>
<td></td>
<td>If ‘no’, please explain what the CPA is and why it is important for their care.</td>
</tr>
<tr>
<td>2. After your last discharge from hospital, were you given a written care plan that set out what treatment and help you would get? This may have been part of the Section 117 process.</td>
<td>Please circle one: yes / no</td>
</tr>
<tr>
<td></td>
<td>If ‘no’, skip the next 4 questions</td>
</tr>
<tr>
<td>3. If you had a written care plan, how involved were you in drawing it up?</td>
<td>Please circle one: a lot / a bit / not at all</td>
</tr>
<tr>
<td>4. If you were involved in drawing up your care plan, were you happy about the amount of involvement you had?</td>
<td>Please circle one: yes / no</td>
</tr>
<tr>
<td>5. If you had a written care plan, were you happy that it took account of your own views of your strengths and weaknesses?</td>
<td>Please circle one: yes / no</td>
</tr>
<tr>
<td>6. If you had a written care plan, who else took part in drawing it up?</td>
<td>Please circle yes or no for each:</td>
</tr>
<tr>
<td></td>
<td>Named nurse yes / no</td>
</tr>
<tr>
<td></td>
<td>Care Co-ordinator yes / no</td>
</tr>
<tr>
<td></td>
<td>Psychiatrist yes / no</td>
</tr>
<tr>
<td></td>
<td>GP yes / no</td>
</tr>
<tr>
<td></td>
<td>Carer yes / no</td>
</tr>
<tr>
<td></td>
<td>Other yes / no</td>
</tr>
<tr>
<td></td>
<td>please say who (job title)</td>
</tr>
<tr>
<td>7. Did you know who your Care Co-ordinator was?</td>
<td>Please circle one: yes / no</td>
</tr>
<tr>
<td></td>
<td>Continued...</td>
</tr>
</tbody>
</table>

Continued...
Service User Interview (continued)

8. After you left hospital last time, did you actually get help with these areas of your life?

   Please circle an answer in one column only

<table>
<thead>
<tr>
<th>Needs associated with:</th>
<th>I got help with this</th>
<th>OR</th>
<th>I didn’t need any help with this</th>
</tr>
</thead>
<tbody>
<tr>
<td>mental health (including medication)</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>risk assessment</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>signs of relapse and crisis plan</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>relationships with family &amp; friends</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>housing</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>activities of daily living</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>work and/or education</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>financial (including benefits)</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>leisure activities</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>spiritual</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>cultural</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>emotional</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>physical health</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>physical &amp; sensory disability</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>communication</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>dual diagnosis – substance misuse</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>advocacy</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>gender</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>sexuality</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>dietary requirements</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
<tr>
<td>needs of carers &amp; family members</td>
<td>yes / no</td>
<td>OR</td>
<td>yes</td>
</tr>
</tbody>
</table>

Continued...
Service User Interview (continued)

9. After you left hospital last time, were you seen by any mental health professional within a week of being discharged?
   Please circle one: yes / no

10. What do you think helped you the most after you left hospital last time?
    Please write in what they say:

11. Was there any other sort of help you would have liked to have after you left hospital but which you didn't get?
    Please circle one: yes / no

12. If 'yes', what other help would you have liked?
    Please write in what they say:

13. Why do you think you were admitted to hospital this time?
    Please write in what they say:

14. How helpful do you think it was for you to come into hospital this time?
    Please write in what they say: