

# Refocusing the Care Programme Approach

*Policy and Positive Practice Guidance*

March 2008

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# Foreword by Louis Appleby

*Our NHS, Our Future* interim report sets out the vision for the NHS to deliver services which are fair, personalised, effective and safe. In many ways mental health services can claim to lead the way in delivering such an approach across health and social care.

Since the publication of the Mental Health National Service Framework in 1999 mental health policies have increasingly focused on personalisation through an emphasis on meeting the wider needs of those with mental illness, addressing equalities, tackling the problems of social inclusion, and promoting positive risk management. The setting of Public Service Agreement (PSA) indicators to improve housing and employment opportunities for people with severe mental illness will provide a welcome additional lever.

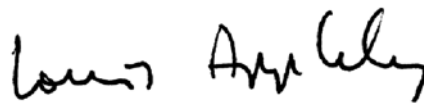
The Care Programme Approach (CPA) is at the centre of this personalisation focus, supporting individuals with severe mental illness to ensure that their needs and choices remain central in what are often complex systems of care. It provides an excellent framework, the principles of which are supported by all.

But it is clear from the recent review that there needs to be more consistency in applying these

sound values and principles across the country. There is much good practice, but more needs to be done so that individuals directly feel the impact of policy advances in their daily interactions with services, and can recognise and realise the tangible benefits and outcomes from receiving them.

This document *Refocusing The Care Programme Approach* updates guidance and highlights good practice. It emphasises the need for a focus on delivering person-centred mental health care and also repeats that crisis, contingency and risk management are an integral part of assessment and planning processes.

I urge everyone working in mental health services to critically examine current policies and practice against this guidance so that progress can continue to be made.



Louis Appleby  
National Director for Mental Health

# Executive summary

The Care Programme Approach has been reviewed to ensure that national policy is more consistently and clearly applied and unnecessary bureaucracy removed.

All individuals receiving treatment, care and support from secondary mental health services are entitled to receive high quality care based on an individual assessment of the range of their needs and choices. The needs and involvement of people receiving services (service users) and their carers should be central to service delivery. An underpinning set of values and principles of person-centred care which apply to all is essential, and is described.

Individuals with a wide range of needs from a number of services, or who are at most risk, should receive a higher level of care co-ordination support. From October 2008 the system of co-ordination and support for this group only will be called the Care Programme Approach (CPA). The revised characteristics of this group is set out and trusts should review policies against this.

Assessments and care plans should address the range of service users' needs. Risk management and crisis and contingency planning is integral to the process. A number of critical issues are highlighted, including assessing the needs of parents; dual diagnosis; physical health; housing; employment; personality disorder; history of violence and abuse; carers; and medication.

Whole systems approaches should support CPA. Services and organisations should work together to: adopt integrated care pathway approaches to service delivery; improve information sharing; establish local protocols for joint working between different planning systems and provider agencies. The role of commissioners is key in ensuring a range of services to meet service users' needs and choices. Joint planning across agencies through Local Strategic Partnerships and Local Area Agreements are also critical.

To ensure that services are person-centred and values and evidence based an appropriately trained and committed workforce is needed. For individuals requiring the support of CPA the role of the care co-ordinator is vital. National competences for the care co-ordinator are outlined and the development of national training for care co-ordination, risk and safety has been commissioned. Guidance is given on measuring and improving capacity and effectiveness.

The quality of assessment and care planning should be focused on improving outcomes for service users and their families across their life domains. Attention to local audit; performance management; national regulation; and issues of equalities is needed to ensure equitable outcomes for all.



# Section 1: Introduction

The consultation document *Reviewing the Care Programme Approach 2006* set out the reasons and aims of the current review of the Care Programme Approach (CPA). It made clear that the ultimate aim was to ensure that there is a renewed focus on delivering a service with the individual using the services at its heart – in which national policy is more consistently and clearly applied and where bureaucracy does not get in the way of the relationship between the service user and practitioner.

A clear response from everyone contributing to the review of CPA was support for the principles underpinning a system of care assessment, planning and review in secondary mental health services. These principles are set out in the Mental Health National Service Framework (MHNSF) (Standard Four)<sup>1</sup> and Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach: A Policy Booklet<sup>2</sup>. More recent documents about mental health and wider have echoed these principles.

*The National Service Framework for Mental Health 5 Years On*<sup>3</sup> recognised that services

were becoming increasingly responsive to the needs and wishes of services users, yet urged that continued effort needed to be made. Other major Department of Health (DH) publications emphasise, at their core, the need for services to empower individuals to achieve greater independence and improve their lives through more personalised care, more choice, and their active engagement in service development<sup>4, 5, 6, 7</sup>.

However, the review also found that, although much positive practice exists, there still remain variations around the country in applying these sound principles. In particular improvements still need to be made in service user and carer engagement and involvement, and in consistency in the identification and support of individuals most in need of engagement who are at risk.

This document *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* aims to build on the strong foundation of the MHNSF<sup>1</sup> *Effective Care Co-ordination in Mental Health Services*<sup>3</sup>, and other DH policy guidance and to reinforce them by:

<sup>1</sup> Department of Health, *National Service Framework for Mental Health: modern standards and service models*. 1999.

<sup>2</sup> Department of Health, *Effective care co-ordination in mental health services: modernising the care programme approach – A policy booklet*. 1999.

<sup>3</sup> Department of Health, *National Service Framework for Mental Health, Five Years On*. 2004

<sup>4</sup> Department of Health, *The NHS Improvement Plan: Putting people at the heart of public services*. 2004

<sup>5</sup> Department of Health, *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults*. 2005

<sup>6</sup> Department of Health, *Our Health, our care, our say: a new direction for community services*. 2006

<sup>7</sup> CSIP, *Our Choices in Mental Health: a framework for improving choice for people who use mental health services and their carers*. 2006

- > setting out an underpinning statement of values and principles that all in secondary mental health services should aim for;
- > highlighting positive practice around service user and carer involvement and engagement;
- > providing a clearer definition of individuals and groups who may need a higher level of engagement and co-ordination support;
- > focusing on areas of assessment and care planning that should be strengthened;
- > presenting an overview of the systems that can support multi-agency delivery to meet the range of an individual's needs;
- > strengthening workforce capabilities by describing the core competences needed by a care co-ordinator and commissioning national training for CPA and risk and safety management; and
- > announcing a review of local CPA audits to enable a renewed focus on service user and carer satisfaction and engagement.

## Scope

This guidance is focused on the support needed for individuals receiving secondary mental health services. This will mainly include adults of working age but the principles should be applied to any individual receiving these services regardless of their age. Annex B provides guidance on applying CPA principles in CAMHS. Annex C provides guidance on CPA and older people and CPA and the Single Assessment Process (SAP).

Services are reminded that the Mental Health Act 2007 establishes a new, simplified single definition of mental disorder which does not distinguish between different categories of mental disorder, so the same criteria apply to all individuals. In particular, people with a personality disorder should be able to benefit from treatment and support, and this guidance applies to them just like anyone else.

## Consultation

Around 300 responses were received from individuals, groups and organisations as part of the formal consultation. This was supplemented by discussion with service users and carers at a number of events. We are grateful for the time, consideration and expertise put into the replies. A summary of these responses is at [www.nimhe.csip.org.uk/cpa](http://www.nimhe.csip.org.uk/cpa).

## Using the Guidance

Each section of the guidance aims to give a brief summary of current policy, evidence and positive practice. Where it is silent on an issue readers should refer to existing policy guidance on CPA as this will still be relevant. A summary of critical points made is set out at the end of each Section to provide an overview of issues that services should address when reviewing policy and practice in light of this guidance.

For ease of reference many of the policy documents, briefing papers, publications and good practice examples cited in this guidance can be accessed by clicking the *hyperlinks* in the

text in the electronic version. A glossary of some of the words and phrases used in this guidance is at Annex D.

## Implementation

The Care Services Improvement Partnership (CSIP) will be supporting a number of workshops around the country in 2008 to enable discussion on this guidance to aid implementation. Further details will be available early in 2008 on [www.nimhe.csip.org.uk/cpa](http://www.nimhe.csip.org.uk/cpa).

## Information for Service Users and Carers

This guidance is mainly aimed at professionals. So that service users and carers can understand the principles and application of good practice around CPA a separate leaflet, booklet and DVD has been produced. The intention is that these resources can be used to provide accessible information to individual service users and carers; as a focus in service user and/or carer group discussions; and for discussions and training between service users, carers and professionals. Hard copies are available from:

Write to:  
DH Publications Orderline  
PO Box 777  
London SE1 6XH  
Telephone: 0870 155 54 55  
(8 am to 6 pm Monday to Friday )  
Fax: 0162 372 45 24  
Email: [dh@prolog.uk.com](mailto:dh@prolog.uk.com)

## Equality Impact Assessment

As part of its statutory obligations, the Department of Health (DH) is required to assess the impact of any policy proposals on different groups in the community in terms of equality of access and impact on the rights and needs of those groups. It is also DH's policy to extend such an assessment to consideration of impact on equality in terms of religion or belief and sexual orientation. In producing this guidance we have undertaken a Single Equality Impact Assessment (SEIA) to help ensure that this guidance takes account of the diverse individual needs of the service user, paying proper attention to issues of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs. A report of the SEIA and action plan is available on [www.nimhe.csip.org.uk/cpaseia](http://www.nimhe.csip.org.uk/cpaseia). Issues for services to address, and the guidance and support available, have been threaded through this document.

## Values and Principles

CPA review respondents agreed that setting out an underpinning statement of values and principles would help secondary mental health services check that their assessment and care planning systems are focused on personalised care with an ethos of recovery. This statement is set out in Table 1.

There was much consensus on the broad issues and approach in developing this statement, but getting the language right so that everybody

## Section 2: Personalised Mental Health Care

receiving or providing services understands and owns it was more of a challenge. For example “recovery” will mean different things to different people and the concept of “person-centred” or “personalised” services can change depending on an individual’s perspective, client group and service setting.

What is clear, however, is the importance of open discussions on values and principles between individuals and professionals, and between professionals in and beyond mental health services. Open discussions will help ensure that issues of meaning and the values underpinning service delivery can be understood, acknowledged and addressed.

Services may wish to use the statement below as a basis of local discussion with staff and service users as part of reviewing their approaches to care planning and delivery for all. Certainly at an individual level an exploration of values is critical so that service responses can be tailored to individual need and choices.

The following statement draws on the *Ten Essential Shared Capabilities* framework<sup>8</sup>, *Human Rights in Healthcare – A Framework for Local Action*,<sup>9</sup> and person-centred approaches to healthcare.

<sup>8</sup> Department of Health. *Ten Essential Shared Capabilities – A framework for the whole of the Mental Health Workforce*. 2004

<sup>9</sup> Department of Health. *Human Rights in Healthcare – A Framework for Local Action*. 2007

## Statement of Values and Principles

## Table 1

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The approach to individuals' care and support puts them at the centre and promotes social inclusion and recovery. It is respectful – building confidence in individuals with an understanding of their strengths, goals and aspirations as well as their needs and difficulties. It recognises the individual as a person first and patient/service user second.

Care assessment and planning views a person 'in the round' seeing and supporting them in their individual diverse roles and the needs they have, including: family; parenting; relationships; housing; employment; leisure; education; creativity; spirituality; self-management and self-nurture; with the aim of optimising mental and physical health and well-being.

Self-care is promoted and supported wherever possible. Action is taken to encourage independence and self determination to help people maintain control over their own support and care.

Carers form a vital part of the support required to aid a person's recovery. Their own needs should also be recognised and supported.

Services should be organised and delivered in ways that promote and co-ordinate helpful and purposeful mental health practice based on fulfilling therapeutic relationships and partnerships between the people involved. These relationships involve shared listening, communicating, understanding, clarification, and organisation of diverse opinion to deliver valued, appropriate, equitable and co-ordinated care. The quality of the relationship between service user and the care co-ordinator is one of the most important determinants of success.

Care planning is underpinned by long-term engagement, requiring trust, team work and commitment. It is the daily work of mental health services and supporting partner agencies, not just the planned occasions where people meet for reviews.

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## Understanding Mental Health: A Shared Vision

To develop discussion on values in mental health further DH has commissioned CSIP to develop draft guidance for consultation on *Finding a shared vision of how people's mental health problems should be understood*. The draft guidance aims to:

- > identify a shared vision of how people's mental health problems should be understood that is recognised equally by different provider groups and by service users and their carers;
- > raise awareness of the wide variety of different approaches to assessing mental health problems and wellbeing; and
- > build mutual understanding of these different approaches as resources for drawing together, through a shared process between service users, carers and service providers, ways of understanding a mental health problem that reflect the particular and often very different strengths and needs of individual service users.

## Service User Engagement and Involvement

To make sure that service users and their carers are partners in the planning, development and delivery of their care, they need to be fully involved in the process from the start. Processes should be transparent, consistent and flexible enough to meet expectations of service users and carers without over promising or under delivering. Service users will only be engaged if

the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected.

The CPA review consultation process helped to identify a number of areas of good practice. These are summarised in a [Briefing Paper](#) and Annex B addresses some issues for involving young people. However, most of what is set out will not be new to services. What is needed is a renewed attention by all to the evidence, principles and good practice to ensure that activity takes place through governance systems, training and audit to ensure service user and carer involvement and effect real change.

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

## Advocacy

Commissioners and services should recognise the positive role that advocacy can play in enabling effective service user involvement in the development and management of their care and the benefits that a skilled advocate can bring in helping service users engage with what can often feel like an overwhelmingly complicated and intimidating system.

Section 30 of the Mental Health Act 2007 gives certain patients access to independent advocacy services to be delivered by Independent Mental Health Advocates (IMHAs). Local commissioners

are expected to contract for these service in their areas and DH is currently considering how best this can be achieved. The provision of IMHAs is subject to secondary legislation on which there is current consultation.

### Ensuring Quality: Tackling Inequalities

To help ensure that quality mental health services are provided to all, appropriate to their needs, services must also pay attention to the potential for inequalities in outcomes of individual care assessment and planning, and the service they provide. Public services have clear legal requirements under Race, Gender and Disability legislation. DH would also urge services to adopt good practice when addressing any adverse impact due to inequalities in terms of age, religion or belief and sexual orientation of the service user and carers.

A number of frameworks, guidance documents and implementation support programmes is available to help mental health services identify and address issues of equality, including:

- > *National Service Framework for Older People* (DH 2001)<sup>10</sup> which includes a standard on mental health
- > *National Service Framework for children, young people and maternity services*<sup>11</sup> (and also see Annex B)
- > *Mainstreaming gender and women's mental health: implementation guidance* (DH 2003)<sup>12</sup> and CSIP/NIMHE implementation programme
- > *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett* (DH 2005) and CSIP/NIMHE DRE programme.<sup>13,14</sup>
- > *Inspiring Hope: Recognising the Importance of Spirituality in a Whole Person Approach to Mental Health* (NIMHE/Mental Health Foundation 2003).<sup>15</sup>

<sup>10</sup> Department of Health, *National Service Framework for Older People* 2001

<sup>11</sup> Department of Health, *National Service Framework for Children, Young People and Maternity Services*. 2004

<sup>12</sup> Department of Health, *Mainstreaming gender and women's mental health: implementation guidance* 2003

<sup>13</sup> Department of Health, *Delivering race equality in mental health care: An action plan for reform inside and outside services and the Government's response to the Independent inquiry into the death of David Bennett*. 2005

<sup>14</sup> NIMHE/CSIP Delivery Race Equality Programme <http://www.csip.org.uk/about-us/about-us/equality-and-diversity-.html> (accessed on 25 Feb 2008)

<sup>15</sup> NIMHE/Mental Health Foundation. *Inspiring Hope: Recognising the Importance of Spirituality in a Whole Person Approach to Mental Health*. 2003

- > *Everybody's Business: Integrating mental health services for older adults* (2005)<sup>16</sup>
- > *Green Light for Mental Health; how good are your services for people with learning disabilities?* (Valuing People Support Team, DH 2004)<sup>17</sup>
- > *Mental Health and Deafness: Towards Equity and Access* (DH 2005)<sup>18</sup>

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

**Summary** In reviewing policies and practice in light of this guidance mental health trusts should:

- > use the statement of values and principles as a basis for discussion with staff and service users and carers
- > understand and implement good practice in service user and carer involvement and engagement, including the value of advocacy support
- > note draft guidance for consultation on *Finding a shared vision of how people's mental health problems should be understood*
- > ensure that equalities are addressed for individuals and by organisations by implementing relevant legislation and guidance

<sup>16</sup> CSIP. *Everybody's Business: Integrating mental health services for older adults* (2005)

<sup>17</sup> Department of Health, Valuing People Support Team, *Green Light for Mental Health; how good are your services for people with learning disabilities?* 2004

<sup>18</sup> Department of Health. *Mental Health and Deafness: Towards Equity and Access*. 2005



# Section 3: Refocusing the Care Programme Approach

The term Care Programme Approach (CPA) has been used since 1990 to describe the framework that supports and co-ordinates effective mental health care for people with severe mental health problems in secondary mental health services. Two levels of support and co-ordination are currently determined:

- > standard support for individuals receiving care from one agency, who are able to self-manage their mental health problems and maintain contact with services;
- > enhanced support for individuals with multiple care needs from a range of agencies, likely to be at higher risk and to disengage from services.

It is clear that all service users should have access to high quality, evidence-based mental health services. For those requiring standard CPA it has never been the intention that complicated systems of support should surround this as they are unnecessary. The rights that service users have to an assessment of their needs, the development of a care plan and a review of that care by a professional involved, will continue to be good practice for all.

However, using the term CPA to describe the system of care provided to those with less complex, more straightforward support needs has often led to more attention being paid to the system (with ensuing needless bureaucracy) rather than a focus on good professional care. So, from October 2008 the term CPA will no longer be used to describe the usual system of provision of mental health services to those with more straightforward needs in secondary mental health services (formerly standard).

Where a service user has straightforward needs and has contact with only one agency then an appropriate professional in that agency will be the person responsible for facilitating their care. Formal designated paperwork for care planning and the review process for these service users is not required. However a statement of care agreed with the service user should be recorded. This could be done in any clinical or practice notes, or in a letter, and this documentation will constitute the care plan. It is not necessary to engage in further bureaucracy for these individuals.

However, as a minimum, service providers must continue to maintain a short central record of essential information is maintained on all individuals receiving secondary mental health services and that reviews take place regularly.

## Refocusing CPA

The term Care Programme Approach in future (from October 2008) will describe the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with secondary mental health services who have complex characteristics (as outlined below). It is called an "approach", rather than just a system, because the way that these elements are carried out is as important as the actual tasks themselves. Active service user involvement and engagement will continue to

be at the heart of the approach, as will a focus on reducing distress and promoting social inclusion and recovery.

In the remainder of this guidance we use the term (new) CPA to describe this refocus. However, in future publications the term CPA will be used to describe the revised description of support and co-ordination for people with more complex needs.

### Who Will Need (new) CPA?

In the main, the individuals needing the support of (new) CPA should not be significantly different from those currently needing the support of enhanced CPA. The current characteristics of those needing enhanced CPA are described as individuals who need: multi-agency support; active engagement; intense intervention; support with dual diagnoses; and who are at higher risk.

However, we know that there are different interpretations of this locally leading to some individuals, and some key groups (see below), tending to be overlooked. On the other hand, some individuals who are concordant with treatment, well supported in the community and/or have recovered from a complex episode of mental illness are inappropriately identified as needing enhanced CPA.

To provide clearer guidance to services so that they can better target engagement, co-ordination and risk management support (new CPA) to individuals that most need it, the current list of characteristics has been refined

and a new list set out in Table 2. This list was reached by looking at the current description of characteristics for enhanced CPA, combined with issues of complexity highlighted in the CPA review consultation document and in consultation responses. The list was validated by working with a range of multi-professional clinical teams in a number of trusts who tested and developed the list against their case loads (not including CAMHS).

The list is not exhaustive and there is not a minimum or critical number of items on the list that should indicate the need for (new) CPA. But there was clear consensus among those testing the list that it should provide the basis of a reliable and useful tool. However, it is also critical to stress that clinical and professional experience, training and judgement should be used in using this list to evaluate which service users will need the support of (new) CPA.

### CPA and eligibility for services

Most importantly it must be emphasised that the list in Table 2 should *not* be used as indicators of eligibility for secondary mental health services. Services should continue to use current local eligibility criteria to make initial decisions on an individual's need for secondary mental health services. The list in Table 2 should then be employed to decide if, having been accepted as needing secondary mental health services, further support is needed with engagement, co-ordination and risk management (i.e. needing (new) CPA).

(New) CPA is a process for managing complex and serious cases – it should *not* be use as a “gateway” to social services or as a “badge” of entitlement to receive any other services or benefits. Eligibility for services continues to be in accordance with statutory definitions and based upon assessment of individual need. Local mental health services will want to continue to work in an integrated and flexible way to make sure that those needs are met as effectively as possible.

Because CPA is a process and not a measure of eligibility, services that currently equate CPA levels with Fair Access to Care Services (FACS) eligibility levels should review their policies accordingly. Whether an individual needs the support of (new) CPA (or not) should not affect whether s/he is entitled to take advantage of new and emerging models of service delivery such as Individual Budgets.

### Characteristics to consider when deciding if support of (new) CPA needed **Table 2**

- 
- > Severe mental disorder (including personality disorder) with high degree of clinical complexity
- 
- > Current or potential risk(s), including:
    - Suicide, self harm, harm to others (including history of offending)
    - Relapse history requiring urgent response
    - Self neglect/non concordance with treatment plan
    - Vulnerable adult; adult/child protection e.g.
      - exploitation e.g. financial/sexual
      - financial difficulties related to mental illness
      - disinhibition
      - physical/emotional abuse
      - cognitive impairment
      - child protection issues
- 
- > Current or significant history of severe distress/instability or disengagement
- 
- > Presence of non-physical co-morbidity e.g. substance/alcohol/prescription drugs misuse, learning disability
- 
- > Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies
- 
- > Currently/recently detained under Mental Health Act or referred to crisis/home treatment team
- 
- > Significant reliance on carer(s) or has own significant caring responsibilities
-

## Table 2 (continued)

- 
- > Experiencing disadvantage or difficulty as a result of:
- Parenting responsibilities
  - Physical health problems/disability
  - Unsettled accommodation/housing issues
  - Employment issues when mentally ill
  - Significant impairment of function due to mental illness
  - Ethnicity (e.g. immigration status; race/cultural issues; language difficulties; religious practices); sexuality or gender issues
- 

## Key Groups

The consultation document set out concerns that some key groups who should meet the characteristics of enhanced CPA (or new CPA) are not being identified consistently and that services are sometimes failing to provide the support they need. Consultation respondents agreed that information should be sought from individuals in these groups so that holistic assessments can be made on the range of their needs, and appropriate liaison and support arrangements put in place. Many respondents also urged that service users with significant caring responsibilities should be added to the list of key groups. So, the key groups are service users:

- > who have parenting responsibilities
- > who have significant caring responsibilities
- > with a dual diagnosis (substance misuse)
- > with a history of violence or self harm
- > who are in unsettled accommodation

The needs of individuals from these key groups should be fully explored to make sure that the range of their needs are examined, understood and addressed when deciding their need for support under (new) CPA. The default position for individuals from these groups would normally be under (new) CPA unless a thorough assessment of need and risk shows otherwise. The decision and reasons not to include individuals from these groups should be clearly documented in care records.

Services should also consider whether there are any groups locally that might benefit from this targeted approach, e.g. in some areas the needs of refugee and asylum seekers might warrant a similar approach.

## The Mental Health Act and (New) CPA

All service users subject to Supervised Community Treatment (SCT), or subject to Guardianship under the MH Act (section 7)<sup>19</sup> status should be supported by (new) CPA.

<sup>19</sup> Mental Health Act – Section 7 [www.hyperguide.co.uk/mha/s7.htm](http://www.hyperguide.co.uk/mha/s7.htm)

If this is not considered appropriate for any particular individual the reasons should be clearly documented in care records.

### When (new) CPA is No Longer Needed

Services should consider at every formal review whether the support provided by (new) CPA continues to be needed. As a service user's needs change, or the need for co-ordination support is minimised, moving towards self-directed support will be the natural progression and the need for intensive care co-ordination support and (new) CPA will end. However, it is important that service users and their carers are reassured that when the support provided by (new) CPA is no longer needed that this will not remove their entitlement to receive any services for which they continue to be eligible and need, either from the NHS, local council, or other services.

Services should also be careful that the support of (new) CPA is not withdrawn prematurely because a service user is stable when a high intensity of support is maintaining his/her well-being. A thorough risk assessment, with full service user and carer involvement, should be undertaken before a decision is made that the support of (new) CPA is no longer needed.

It is also critical that there should be a process for changing arrangements when the need for (new) CPA or secondary mental health services ends. The additional support of (new) CPA should not be withdrawn without:

> an appropriate review and handover (e.g. to the lead professional or GP);

> exchange of appropriate information with all concerned, including with carers;

> plans for review, support and follow-up, as appropriate;

> a clear statement about the action to take, and who to contact, in the event of relapse or change with a potential negative impact on that person's mental well-being.

Where (new) CPA is appropriate in prison or hospital (normal criteria will apply), the same safeguards should be continued for an appropriate period when the individual is released or discharged. Automatically removing the support of (new) CPA at this point could compromise the safety and treatment of the individual at a vulnerable point in their care pathway.

In reviewing a care plan as part of discharge planning from hospital, prison or other residential settings, appropriate liaison with mental health teams in the community is essential. The period around discharge is a time of elevated risk, particularly of self-harm. This underlines the need for thorough review and assessment prior to discharge and effective follow up and support after discharge.

### Overview

Table 3 summarises the main similarities and differences between service responses to service users needing the support of (new) CPA and those that do not.

Table 3

Service users needing (new) CPA	Other service users
<b>An individual's characteristics</b>	
Complex needs; multi-agency input; higher risk. See detailed definition in Table 1	More straightforward needs; one agency or no problems with access to other agencies/support; lower risk
<b>What the service users should expect</b>	
Support from CPA care co-ordinator (trained, part of job description, co-ordination support recognised as significant part of caseload)	Support from professional(s) as part of clinical/practitioner role. Lead professional identified. Service user self-directed care, with support.
A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks	A full assessment of need for clinical care and treatment, including risk assessment
An assessment of social care needs against FACS eligibility criteria (plus Direct Payments)	An assessment of social care needs against FACS eligibility criteria (plus Direct Payments)
Comprehensive formal written care plan: including risk and safety/contingency/crisis plan	Clear understanding of how care and treatment will be carried out, by whom, and when (can be a clinician's letter)
On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly	On-going review as required
At review, consideration of on-going need for (new) CPA support	On-going consideration of need for move to (new) CPA if risk or circumstances change
Increased need for advocacy support	Self-directed care, with some support if necessary
Carers identified and informed of rights to own assessment	Carers identified and informed of rights of own assessment

**Summary** In reviewing policies and practice in light of this guidance mental health trusts should:

- > consider whether the documentation used to record the needs and plans of service users not needing (new) CPA can be simplified
- > consider the refined definition of (new) CPA to ensure individuals with higher support needs are identified and appropriately supported; and that individuals not needing this level of support are also appropriately cared for
- > review key groups and consider need for (new) CPA
- > be clear on the links between need for CPA and eligibility criteria
- > ensure systems are in place for service users to be appropriately and safely allocated to and from CPA

## Section 4: Assessment and Care Planning

Everyone referred to secondary mental health services should receive an assessment of their mental health needs. This initial assessment, which aims to identify the needs and where they may be met, may have alternative names such as screening (assessment) or triage (assessment).

The outcome of the initial assessment should be communicated to the individual (in a way that they will understand) and the referrer promptly. If it is agreed that the person's needs are best met by a secondary mental health service, a care plan should be devised and agreed with the service user and, where appropriate, their carer. This section of the guidance refers to the assessment and re-assessment which will then occur as part of the CPA process. It does not cover the part of the care pathway prior to the decision about whether secondary care is required, or whether CPA is required.

The MHNSF sets out the range of issues and needs a multi-disciplinary health and social care assessment and care plan may cover depending on need. These including: psychiatric, psychological and social functioning, including impact of medication; risk to the individual and others, including contingency and crisis planning; needs arising from co-morbidity; personal circumstances including family and carers; housing needs; financial circumstances and capability; employment, education and training needs; physical health needs; equality

and diversity issues; and social inclusion and social contact and independence.

The assessment and planning process should aim to meet the service user's needs and choices and not just focus on what professionals and services can offer. It should address a person's aspirations and strengths as well as their needs and difficulties. Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services.

To reduce documentation and cut down on duplication, services should aim to develop one assessment and care plan that will follow the service user through a variety of care settings to ensure that correct and necessary information goes with them. More use of joint assessments and review, with common documentation between agencies and teams, would avoid duplication of paperwork.



**Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

### Contingency and crisis planning

Although improvements are being made surveys<sup>20</sup> show that almost half of service users still report not being given a telephone number they could use to contact someone from NHS mental health services out of hours.

<sup>20</sup> Healthcare Commission, *Survey: community mental health services show improvements but concerns remain over social inclusion and access to counselling*. 2007 available from <http://www.healthcarecommission.org.uk/newsandevents/pressreleases.cfm>



All care plans must include explicit crisis and contingency plans. This will include arrangements so that the service user or their carer can contact the right person if they need to at any time, with clear details of who is responsible for addressing elements of care and support. Copies of the plans should be offered to the service user and given to his or her GP and any other significant care provider, including carers, if appropriate. Further good practice on contingency and crisis planning and service user and carers and involvement and engagement is available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp).

## Updating Policy and Practice

Developments in policy, practice and legislation since 1999 indicate that services should pay greater attention to issues of choice; social inclusion; and equalities. Further guidance is now available on risk assessment and management. The CPA review also highlighted a range of critical issues within assessment and care planning that would benefit from renewed consideration. Trusts should consider the range of issues highlighted below and review local policies and practice to ensure that they reflect current national policy, legislation and good practice in the areas outlined.

## Choice

*Our Choices in Mental Health*<sup>21</sup> establishes the core principles for promoting choice in acknowledging that people have the right to choose their treatment, and that choice applies across the spectrum of care and settings. It emphasises the increasing importance of:

**Direct payments** which should be a standard option for all those eligible to receive social care services. *Direct payments for people with mental health problems: A guide to action (DH, 2006)*<sup>22</sup> provides a comprehensive framework for implementation.

**Individual budgets (IBs)** which can enable people to use their resources to design the type of support that works for them in meeting outcomes. DH has funded a pilot of the IB system, and national roll out is expected shortly.

[www.individualbudgets.csip.org.uk](http://www.individualbudgets.csip.org.uk)

**Statements of wishes and advance directives** which are a useful way to help plan for the future, and people should be supported in developing these where wanted.

<sup>21</sup> CSIP/NIMHE, *Our Choices in Mental Health*, 2006

<sup>22</sup> Department of Health. *Direct payments for people with mental health problems: A guide to action*. 2006

## Outcomes

Assessments and care plans should routinely include arrangements for setting out, measuring and reviewing specific outcomes. An outcomes focus can help to improve understanding of the impact of services on the lives of people who use them; give assurance that treatments and care provided are producing results; and ensure that outcomes related to treatment, care and support are monitored on an on-going basis. The desired outcomes should be explicitly agreed with the service user and carer(s) at the beginning of the care process so that the plan is personalised to the service user).

It is expected that for people on (new) CPA, HoNOS (Health of the National Outcome Scale) ratings will be completed at significant points of change within the care pathway and at any event, at least once a year. In addition, however, there is a growing number of instruments available to help measure outcomes. Different instruments cover different aspects of outcomes and some are designed for a specific age group or service area. Those who develop individual measurement tools generally advise on usage and best practice. CSIP/DH are commissioning a compendium of outcomes tools to provide information about most that are available and their use in measuring outcomes in mental health services. It is expected that the first release of the compendium will be available in 2008.

## Risk Assessment and Management

Risk assessment is an essential and on-going element of good mental health practice and a critical and integral component all assessment, planning and review processes. DH guidance *Best Practice in Managing Risk*<sup>23</sup> sets out a framework of principles covering self-harm and suicide, violence to others and self-neglect to underpin best practice across all adult mental health settings.

The guidance provides a list of tools that can be used to structure the often complex risk assessment and management process. The philosophy underpinning this framework is one that balances care needs against risk needs, and that emphasises: positive risk management; collaboration with the service user and others involved in care; the importance of recognising and building on the service user's strengths; and the organisation's role in risk management alongside the individual practitioner's. It emphasises the importance of the assessment of dynamic (changing) risk factors, as well as the more well-understood static ones.

<sup>23</sup> Department of Health, *Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*. 2007 <http://www.nimhe.csip.org.uk/risk>

Where appropriate, criminal justice agencies (particularly the Offender Manager Service using the OASys system and the Multi-Agency Public Protection Arrangements) can provide essential support to risk assessment in relation to some offenders and should be consulted as part of a holistic assessment.

Risk assessment for people with a learning disability needs to be multi-agency, including speech and language therapists where necessary, so that a balance between risk management and the individual having a fulfilling life is achieved.



**Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

## Equality

Assessments, care plans and reviews should take account of the needs of individuals in respect of age, disability, gender, sexual orientation, race and ethnicity and religious beliefs. Supporting guidance is available – see Section 1.

## Parents

Between 30% and 50% of users of mental health services are parents with dependent children. These parents and their children may

face difficulties and barriers in accessing services and support. The assessment should take into account the impact over time, as well as at the moment of assessment, and needs to reflect the complex interplay of stressors that can occur in families and the cumulative impact of these.

Establishing whether a service user is a parent at the initial assessment stage is critical, and should be routine. Parents who are temporarily separated from their children (e.g. when in prison) should also be included. Assessment, including risk assessment, should assess the potential or actual impact of mental health on parenting, the parent and child relationship, the child and the impact of parenting on the adult's mental health and what appropriate support might look like and how it can be accessed. It should also assess the indirect impacts of mental illness e.g. financial problems, poor housing, stigma and discrimination.

It is also important to identify whether an individual has good relationships and support from family, friends and the community to establish whether there is a risk of the individual becoming isolated.

Further information: *Briefing Paper: Parents with Mental Illness*.<sup>24</sup>

<sup>24</sup> [www.nimhe.csip.org.uk/cpa](http://www.nimhe.csip.org.uk/cpa)

## Dual Diagnosis

The importance of assessing substance misuse, having a care plan related to this and for staff to be trained to work with people with dual diagnosis, has been consistently highlighted.<sup>25,26,27</sup>

Drug and alcohol misuse should be considered in all assessments undertaken by mental health services. Current and past substance use should be asked about and an assessment made of the risks with an appropriate risk management plan. Staff in mental health settings should routinely ask service users about recent legal and illicit drug use. The questions should include whether they have used drugs and if so what type and method of administration, quantity and frequency.<sup>28</sup>

## Physical Health

The links between mental ill health and physical ill health are well documented. Research has shown that people with mental health problems have higher rates of physical illness, resulting in increased rates of morbidity and mortality.<sup>29</sup> There are also physical health issues associated

with substance use. Certain medication may compound physical health risks, for example by causing weight gain or increasing the risk of diabetes.

Assessing and addressing the physical health needs of a mental health service user should be given a high priority. Service users should be encouraged and supported to access support for their physical health needs and receive at least a basic physical medical assessment, including issues around smoking and obesity, through primary care if this has not already been undertaken.

Mental health professionals should consider the service users' needs holistically and aim to improve their quality of life and their health. Assessments and care plans should identify and tackle the impact that mental illness symptoms and possible treatment programmes can have on physical health and the impact that physical symptoms can have on an individual's mental well-being.



**Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

<sup>25</sup> Department of Health, *Mental health policy implementation guide: Dual diagnosis good practice guide*. 2002

<sup>26</sup> Department of Health, *Dual Diagnosis In-patient guidance: Dual diagnosis in mental health inpatient and day hospital settings. Guidance on the assessment and management of patients in mental health inpatient and day hospital settings who have mental ill-health and substance use problems*. 2006

<sup>27</sup> Appleby et al. *Avoidable deaths; a five year report of the national confidential inquiry into suicide and homicide by people with mental illness*. 2006. University of Manchester.

<sup>28</sup> NICE, *Drug Misuse – Psychosocial Interventions*. 2007

<sup>29</sup> Department of Health, *Choosing Health: Supporting the physical health needs of people with severe mental illness (commissioning framework)*. 2006

## Housing and Homelessness

People who are homeless or living in temporary or insecure accommodation (unsettled accommodation) have higher rates of mental illness than the general population. Generally, rates are double and illnesses are of a more severe nature. Between 30% – 50% have a significant mental illness.<sup>30</sup> Functional illnesses predominate although acute distress and personality disorders are also common.

People who are in unsettled accommodation need similar care and support packages as others with the same mental health problems. However, the way in which care is delivered and the order in which problems are addressed may be different reflecting individual circumstances.

Assessments should address the adequacy of housing needs and where appropriate assessments, including risk, should be shared with local housing agencies.

The socially excluded adults Public Service Agreement (PSA)<sup>31</sup> has signalled the Government's priority in achieving improved settled accommodation outcomes for adults receiving secondary mental health services.

Further information Briefing Paper: *Understanding Homelessness and Mental Health*.<sup>32</sup>

<sup>30</sup> Department of Health, *Getting Through: Access to mental health services for people who are homeless or living in temporary or insecure accommodation*. 2007

<sup>31</sup> HM Treasury, Public Sector Service Agreements 2008 – 2011  
<http://www.hm-treasury.gov.uk/pbr-csr/psa/pbr-csr07-psaindex.cfm>

<sup>32</sup> <http://www.icn.csip.org.uk/housing/index.cfm?pid=5221catalogueContentID=2667>

<sup>33</sup> Bertram, M. & Howard, L. *Employment Status and Occupational Care Planning for People Using Mental Health Services*. 2006 *Psychiatric Bulletin*, 30, 48 – 61.

<sup>34</sup> Healthcare Commission, *Service User Survey*. 2006



**Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

## Employment, Education and Training

Only around 20% of those in contact with secondary mental health services are in paid work. Yet only 8% of case notes of people supported by Community Health Teams address vocational needs.<sup>33</sup> 50% of service users want help with finding paid work but have not received it.<sup>34</sup>

Assessments should explore service user's current and longer term needs for support with employment, education and training and agree realistic outcomes. Many people with mental health problems want to work and services need to be able to support them to do this. For other people with mental health problems, accessing education and training may be both an important stepping stone to employment or have value in its own right. Care co-ordinators should promote access to employment information, advice and support, options for skill development and link with local employment agencies including Jobcentre plus.

The support needed to enable people with severe mental health problems to gain and sustain employment is set out in the Social Exclusion Unit's *Mental Health and Social Exclusion*' report;<sup>35</sup> the Social Exclusion Task Force's *Reaching Out: An action plan for social exclusion*;<sup>36</sup> and within the DH's vocational services for people with severe mental health problems commissioning guidance.<sup>37</sup>

As part of the socially excluded Public Service Agreement (PSA), the Government has set out its commitment to improving the proportion of adults receiving secondary mental health services who are in paid work.

## Personality Disorder

Some individuals identified by local agencies as having personality disorders may never have had a thorough assessment and formulation. There are now a number of validated

assessment tools and, given the complex needs that many people with personality disorders experience, it is important that their support should be shaped by effective assessment through using these tools.<sup>38, 39</sup>

## History of Violence and Abuse

Childhood experience of sexual and other abuse is known to be more frequent in the histories of individuals with both mental illness and personality disorder (MHNSF, 1999). Research indicates that around 50% of women service users have been sexually victimised as children, notwithstanding further abuse in adulthood and the significant number of men service users who have also experienced abuse.<sup>12</sup> It is now DH policy that, following appropriate training for staff\*\*, exploration of violence and abuse is routinely undertaken in all mental health assessments.<sup>11</sup>

\*\* The implementation of routine exploration is currently being piloted and evaluated in sixteen mental health trusts. From October 2008 Implementation Guidance supported by a one-day training course will be rolled out to all trusts. The training aims to enable professionals of all disciplines to explore sexual, and other abuse, in mental health assessments, and deal appropriately with disclosures.

<sup>35</sup> Office of the Deputy Prime Minister, *Mental Health and Social Exclusion; Social Exclusion Unit Report*. 2004

<sup>36</sup> Cabinet Office, *Reaching Out: An Action Plan on Social Exclusion*. 2006

<sup>37</sup> Department of Health, *Vocational services for people with severe mental health problems: Commissioning guidance*. 2006

<sup>38</sup> The British Psychological Society, *Understanding Personality Disorder*. 2006

<sup>39</sup> NIMHE, *Personality Disorder: No Longer a diagnosis of exclusion: policy implementation guidance for the development of services for people with personality disorder*. 2003

<sup>12</sup> Department of Health, *Women's Mental Health: Into the Mainstream*. 2002

<sup>11</sup> Department of Health, *National Service Framework for Children, Young People and Maternity Services*. 2004

Questions should be asked by suitably trained staff at assessment about the experience of physical, sexual or emotional abuse at any time in a service user's life. The response, with brief details, should be recorded in case records/care plans. If the specific question is not asked, the reason(s) for not doing so should be recorded.

## Carers

Mental illness can have a major impact on carers, families and friends as well as on the person with the illness. It may cause social and financial disruption and restrict educational and employment opportunities for both the carer and the person being supported. The demands of caring can also affect the physical and emotional health of the carer. Young carers can be at risk of social isolation and bullying, under-achievement, absenteeism from school, and physical and mental ill health. Their needs can be overlooked by adult services.

Carers (including young carers) should be identified at the service user's assessment and information provided to them about their right to request an assessment of their own needs. Services should ensure co-ordination of users' and carers' assessments, care and support plans and the exchange of information where agreement has been received to do this.

A service user's own caring responsibilities should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for.



**Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

## Medication

Service users have expressed concerns that medication issues are not always appropriately addressed and reviewed, and information needs not adequately met, in the assessment and care planning processes.<sup>40</sup> Non-concordance with medicines is a high risk-indicator of relapse and as well as lack of insight into illness can be due to: dose/medicine not treating symptoms effectively; intolerable side effects/quality of life issues; inadequate information about medicines; poor communication of the treatment plan with GPs; confusion about how to take medicines or difficulties in accessing medicines.

Greater importance should be given to the assessment and the review of medication issues as indicated above. Specialist mental health pharmacists should be involved in care planning for service users with complex medication needs as their input is recognised as improving outcomes.<sup>41</sup>

<sup>40</sup> Healthcare Commission, *Service User Survey*. 2007

<sup>41</sup> Healthcare Commission, *Talking about medicines. The management of medicines in trusts providing mental health services*. 2007

It is essential that everyone involved in the care of the service user understands who prescribes the medication, where it is obtained from, the instructions for its administration, and what other medications are being prescribed for physical health problems.

In reviewing policies and practice in light of this guidance mental health trusts should:

- > Aim to develop one assessment and care plan that will follow the service user through a variety of care settings
- > Ensure crisis and contingency planning and risk assessment and management are integral to the care planning process
- > Consider the areas highlighted in this Section to make sure that they are adequately addressed as appropriate in individual assessments and care plans
- > Note the PSA targets for settled accommodation and employment



# Section 5: Whole Systems Approach

The care co-ordinator has a pivotal role in helping an individual navigate complicated care systems and provide continuity. But there is also a need for systems and structures to be in place at strategic and organisational level to support this. This whole system approach to care planning and delivery should aim to promote and co-ordinate care, and support activity across the individual's life domains and circumstances. A number of approaches and mechanisms can help with this:

- > **Integrated care pathway** approaches to service delivery
- > Improved **information sharing** between agencies
- > Protocols and arrangements for working between **different assessment and planning systems**
- > Improving **local shared provider agreements**
- > **Commissioning** for a range of services to meet service users' and carers' needs
- > Effective **Local Strategic Partnerships and Local Area Agreements** to facilitate planning across agencies

## Integrated Care Pathways


As systems of treatment and care become more complicated so care pathways are becoming more complex and potentially disjointed. Although the introduction of shared electronic care records between primary and secondary care by 2010 will help, considering service delivery from the viewpoint of service users and their pathways, and how CPA administration systems support this, is critical. Integrated care pathway approaches can:

- > improve quality of care at key points throughout the service user or carer's journey by making it clear how individual component parts fit together as a whole;
- > facilitate closer and integrated working that ensures a co-ordinated approach to care delivery;
- > provide opportunity to compare assessed need and planned care with the care actual given;
- > enable better use of information by ensuring that variation is recorded, analysed and effectively improved and managed;
- > support identification of priorities for skills development and service improvement priorities;
- > reduce bureaucracy – avoiding duplication of record keeping between different professionals or parts of the organisation.

Integrated care pathway approaches can help tackle the potential for disruption to care planning brought about by:

- > **In-patient admission.** Care co-ordination responsibilities will continue while a patient is in hospital. *A Positive Outlook: a good practice guide to improve discharge from in-patient health care*<sup>42</sup> emphasises a whole systems approach to care planning and the need for liaison between in-patient and community teams.
- > **Detention in prison** and other residential criminal justice settings. *Offender Mental Health Care Pathway*<sup>43</sup> documents a number of the requirements around continuity of care co-ordinator involvement and contact. The importance of swift intervention by community teams to ensure continuity of care for those in custody cannot be underestimated.
- > **Out of area placements**, which can lead to service users' care planning becoming detached from any local co-ordination arrangements. Where commissioners agree to out of area placements they must make sure that such care packages adequately take account of the resources required to ensure care co-ordination is carried out effectively.

> Service users that transfer between different services or planning systems (this is discussed more fully below).

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

## Information Sharing

Delivering care to people with mental health problems means bringing together information, skills and resources from a range of public, voluntary and other sectors. Information needs to be shared appropriately between organisations and professionals to make sure that people get the services they need.

A reluctance to share information can arise because of fear or uncertainty about the law or the lack of suitable arrangements to do so. Failure to share information has also been a feature of some public services in recent years and a factor in accounts of untoward incidents, including homicides.

<sup>42</sup> CSIP, *A Positive Outlook, A good practice toolkit to improve discharge from inpatient mental health care*. 2007 [http://changeagentteam.org.uk/\\_library/A%20Positive%20Outlook.pdf](http://changeagentteam.org.uk/_library/A%20Positive%20Outlook.pdf)

<sup>43</sup> Department of Health, *Offender mental health care pathway*. 2005

Mental Health Trusts should ensure they have mechanisms in place to support staff in making appropriate decisions about sharing information.

The Social Exclusion Task Force socially excluded adults PSA and the report *Think Family: Informing the life chances of families at risk*<sup>44</sup> both state the importance of more effective information sharing between local authorities and other agencies working with adults with mental health problems, adults with learning disabilities, ex-offenders, care leavers and families experiencing multiple disadvantage.

## Shared Provider Agreements

As many services users on (new) CPA are likely to need support from a number of providers, it is critical that there is clear local understanding and working arrangements, supported by protocols, so that organisations can work together effectively to meet their needs.

The CPA review highlighted the particular need for better local agreements between secondary mental health care and the following services.

**Primary Care and GP Services** The Quality and Outcomes Framework (QOF) for GPs clearly sets out their responsibilities to have review systems in place in respect of individuals with bipolar disorders and psychosis. However, clear shared agreements between secondary mental

health services and GPs and primary care teams also need to be established for other mental health service users to ensure that they have access to physical health checks and that primary care input to the CPA processes is supported.

Agreements and protocols should be clear about which aspects of healthcare screening and monitoring lie with each agency, and how information on assessment and care planning is shared, including arrangements for, and the responsibilities of, any link workers/graduate primary care workers. Protocols should also include agreements on how mental health service users can be included in local disease prevention and health promotion programmes, e.g. reducing obesity through action on nutrition and exercise, smoking and substance misuse and sexually transmitted infections.

**Housing and Employment services** The inclusion of Public Service Agreement (PSA) targets to improve settled accommodation and employment opportunities for people with severe mental illness in the NHS Operating Framework provides an additional impetus for cross-agency planning for the delivery of these services. Trusts should strengthen links with local housing and employment organisations as part of individual and corporate care assessment and planning processes. Local protocols should be in

<sup>44</sup> Social Exclusion Task Force, *Think Family, Improving the life chances of families at risk*. 2008

place to support good working between agencies. These should include appropriate sharing of information on assessments, including risk, and a common understanding of housing eligibility criteria (for those with unsettled accommodation).

**Drug and Alcohol services** More effective partnerships between general mental health and substance misuse services would improve care and reduce risk. Local strategies and protocols should be in place that agree definitions of dual diagnosis, care pathways and service models.

## Different Assessment and Planning systems

There is a range of assessment and planning frameworks and systems that can have an impact on, and help support, people with mental health problems. Service users may move from one system to another (e.g. CAMHS to CPA in adult services) or may be receiving services concurrently from services that operate different systems (e.g. CPA and the National Offender Management Service (NOMS)).

The principles of all these assessment and planning systems are similar, though they may have subtly differing aims, philosophies and use different terminologies. All strive to adopt a person-centred approach and aim to provide a framework for the assessment, planning and review of an individual in the context of their wider social, health, family and carer needs – usually through working across agencies. Local services and practitioners should aim to emphasise and understand these similarities rather than regard any differences as barriers to service delivery and information exchange.

Local protocols should agree which system/co-ordinator/person is in the lead or, where care is shared, who takes the lead on which aspects. Certainly there should never be a situation where no-one takes the lead because it has been assumed that the other person/service has. Information gained during assessments (including risk assessments) should be shared as appropriate between agencies to avoid duplication.

Annex A contains further information on the links between specific assessment and planning systems.

## Commissioning

If care and support plans for individual service users and carers are detailed and robust enough, aspects of their information can be collated to provide a picture of local need, including any unmet need. This can provide information for commissioning and local service re-configuration. It is particularly important to identify needs that support social inclusion for people with mental health problems as these services may be less developed, or not currently accessible to mental health service users. *Vocational services for people with severe mental health problems: Commissioning guidance.*<sup>45</sup> *From segregation to inclusion: Commissioning guidance.*<sup>46</sup> *Day services Outcomes framework*<sup>47</sup> all provide examples for commissioners on the services that will help with social inclusion.

The importance of supporting and incentivising strategic commissioning is a focus of policy development within the socially excluded adults PSA. Commissioning based on a thorough needs assessment is seen as key to delivering services that will meet needs and improve outcomes.

Explorations of unmet need should also include needs of specific equality or minority groups e.g. single-sex services for women or some ethnic minority groups; language and translation services; specialist support for disabled people.

## Local Strategic Partnerships: Outcomes and Accountability Framework

A new outcomes and accountability framework for Health and Social Care<sup>48</sup> has been developed to support delivery around *better health and well-being for all; better care for all; and better value for all*. The framework is underpinned by a set of around 50 indicators to support the measurement and delivery of outcomes that cover the range of health and adult social care services. The specific mental health indicators (PSA targets) aimed at improving the social inclusion and recovery of adults with mental health problems are:

- > the proportion of adults receiving secondary mental health services in settled accommodation; and
- > the proportion of adults receiving secondary mental health services in paid employment.

<sup>45</sup> Department of Health, *Vocational Services for People with severe mental health problems: Commissioning Guidance*. 2006

<sup>46</sup> Department of Health, *From segregation to inclusion: Commissioning guidance on day services for people with mental health problems*. 2006

<sup>47</sup> CSIP National Social Inclusion Programme, *Outcome Indicators Framework for Mental Health Day Services*. 2007

<sup>48</sup> Department of Health, *Health and Social Care Outcomes and Accountability Framework*. 2007

Additionally there is a PSA to improve the health and wellbeing of children and young people which has indicators on:

- > the development and delivery of CAMHS for children and young people with learning disabilities;
- > appropriate accommodation and support for 16-17 year olds;
- > availability of 24 hour cover to meet urgent mental health needs; and
- > joint commissioning of early intervention support.

Where improving outcomes in these areas is identified as a local priority, it is expected that Local Strategic Partnerships (LSPs) will include relevant improvement targets within their Local Area Agreement to help accelerate progress. The negotiation of LAAs will be led by Government Offices, who will also have a wider role in supporting delivery in specific policy areas. Primary Care Trust (PCT) commissioners will be active partners in this process and should ensure that the needs of people with mental health problems are recognised and understood.

In reviewing policies and practice mental health services should:

- > consider adopting care pathway approaches to service delivery
- > note guidance on information sharing and the need for local protocols for the sharing of information with the police, probation service, local prison (if appropriate) and court liaison; and independent/voluntary sector agencies
- > establish local protocols for working agreements with other service providers (primary care; housing and employment; and drug and alcohol services)
- > note the range of other planning systems and make sure local protocols are in place to ensure sharing of appropriate information and that no service user falls “between” services

PCT commissioners should:

- > note guidance available to support commissioning a wider range of service user needs, including those for social inclusion and to meet equality needs
- > actively participate in Local Strategic Partnerships to ensure that the needs of mental health service users are considered

# Section 6:

## Supporting The Workforce

### The Capable Workforce

All of the workforce in secondary mental health care need a range of competencies, experience and skills to meet the diverse and often complex needs of service users.

The Ten Essential Shared Capabilities (ESC) framework<sup>8</sup>, developed in consultation with service users and carers together with practitioners, provides in one overarching statement the essential capabilities required to achieve best practice for education and training of all staff who work in mental health services. These include:

- > Working in partnership
- > Respecting diversity
- > Practising ethically
- > Challenging inequality
- > Promoting recovery
- > Identifying people's needs and strengths
- > Providing service user centred care
- > Making a difference
- > Promoting safety and positive risk taking
- > Personal development and learning.

The framework is intended to make explicit what should be included as core in the curricula of all pre and post qualification training for professional and non-professionally affiliated staff as well as being embedded in induction and continuing professional/practitioner development for all staff.

To support educators and the workforce consider how the ESC framework can be integrated into practice, a number of educational and workforce development tools have been published. These include:

- > The 10 Essential Shared Capabilities: A Learning Pack for Mental Health Practice<sup>49</sup> (NIMHE 2006). An introductory programme on the use of the 10 ESC in practice.
- > Creating and Inspiring Hope; ESC Recovery (NIMHE 2006)<sup>50</sup> A training resource aimed at understanding the importance of 'recovery' approaches in mental health practice.
- > Capabilities for Inclusive Practice<sup>51</sup> (DH 2007) which explores the skills that all staff need to promote socially inclusive opportunities for people using mental health services.

<sup>8</sup> Department of Health. *Ten Essential Shared Capabilities – A framework for the whole of the Mental Health Workforce*. 2004

<sup>49</sup> NIMHE, *10 Essential Shared Capabilities: A Learning Pack for Mental Health Practice*. 2006

<sup>50</sup> NIMHE/CSIP *Creating and Inspiring Hope: Integrating recovery values and principles into every day practice*. A 2 day training programme for the mental health workforce. (2006) Available from CCAWI – [www.lincoln.ac.uk/ccawi](http://www.lincoln.ac.uk/ccawi).

<sup>51</sup> Department of Health, *Capabilities for Inclusive Practice*. 2007

- > ESC Induction<sup>52</sup> (NIMHE 2007) – A module of the 10 ESC developed specifically for induction programmes in organisations.
  - > Race Equality & Cultural Capability (RECC)<sup>53</sup> (NIMHE 2007) a learning resource which incorporates the ESC in practice and services to deliver race equality.
  - > ESC Dual Diagnosis Training<sup>54</sup> (NIMHE 2007) a training programme reviewing the application of the 10 ESC in offering services for people with substance misuse and mental health problems.
  - > CAMHS Cultural Competence Toolkit covering cultural awareness; cultural knowledge; cultural sensitivity and cultural practice<sup>55</sup> is available from [www.camhs.org.uk](http://www.camhs.org.uk)
- All the above can be downloaded free of charge from [www.lincoln.ac.uk/ccawi](http://www.lincoln.ac.uk/ccawi) following the links to ESC learning resources. In addition a number of supportive initiatives are also in production or planned, such as:
- > Creating Capable Teams Approach<sup>56</sup> (NIMHE 2007) a Workforce Planning resource, which uses the ESC as a foundation in providing best practice guidance to support implementation of new ways of working and new roles in mental health. [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)
  - > Learning and Development Toolkit<sup>57</sup> (NIMHE 2007) a best practice guide on integration of the range of workforce and education initiatives in developing and delivering high quality service user focused education and training at all academic levels and in all educational settings. [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)
  - > The Development of a Knowledge and Understanding Framework which will provide curricula for education and training in relation to forensic and non-forensic Personality Disorder practice.
  - > Proposals to develop additional learning materials using the ESC as a foundation to explore Gender Equality in Mental Health.

<sup>52</sup> The Ten Essential Shared Capabilities Induction Module <http://visit.lincoln.ac.uk/C6/C12/CCAWI/ESC%20Learning%20Materials/Induction%20Module%20October%202007.pdf>

<sup>53</sup> NIMHE, *Essential Shared Capabilities Learning Materials: Race Equality & Cultural Capability*. 2007

<sup>54</sup> NIMHE, *Essential Shared Capabilities Learning Materials: Dual Diagnosis*. 2007

<sup>55</sup> CAMHS cultural competence toolkit

<sup>56</sup> Department of Health, New Ways of Working, *Creating Capable Teams (CCTA): best practice guidance to support the implementation of New Ways of Working (NWW) and new roles*. 2007

<sup>57</sup> Department of Health, *A Learning and Development Toolkit for the whole of the mental health workforce across both health and social care*. 2007



## Setting the Standards for Education

An essential element of all training, whether developed nationally or locally, should be the involvement of service users and carers in its development and delivery. To achieve equitable outcomes the involvement of service users and carers from minority or equality groups should be ensured.

The National Continuous Quality Improvement Tool for Mental Health Education<sup>58</sup> aims to help education commissioners and providers ensure post-qualification mental health education programmes are consistent with the MHNSF. It provides guidance on the meaningful involvement of mental health service users and their carers in the planning, design, delivery and evaluation of education programmes. This includes user and carer involvement in course management and the selection and assessment of students.

## Care Co-ordinator Role and Competences

The role of care co-ordinator is pivotal to the success of (new) CPA. To strengthen the role, and to reduce local variation, work has been undertaken to identify care co-ordinator principles of practice, core functions and competences (linked to associated National

Occupational Standards and the Knowledge and Skills Framework). These are set out in CPA competences outline report.<sup>59</sup> These aim to support service planners and managers to:

- > review and redesign care co-ordinator roles and responsibilities within services;
- > consider and review the distribution of a practitioner's workload and caseload, in the light of care co-ordination responsibilities;
- > agree local protocols for the delegation of specific tasks associated with care co-ordination, where the care co-ordinator remains both responsible and accountable for the appropriate and effective delivery of the care co-ordination function;
- > inform supervision and appraisal;
- > inform training and development;
- > inform service governance processes;
- > develop information for people who use services, and people who support them.



**Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

<sup>58</sup> Brooker, Readhead and Curran 2005/2006 available from CCAWI <http://www.lincoln.ac.uk/ccawi/>

<sup>59</sup> CPA competencies outline report available from <https://www.nimhe.csip.org.uk/cpa>

## Who Can Be a Care Co-ordinator?

The role of the (new) CPA care co-ordinator should usually be taken by the person who is best placed to oversee care management and resource allocation and can be of any discipline depending on capability and capacity. The care co-ordinator should have the authority to co-ordinate the delivery of the care plan and ensure that this is respected by all those involved in delivering it, regardless of the agency of origin. It is important that they are able to support people with multiple needs to access the services the need.

However, it is not the intention that the care co-ordinator necessarily is the person that delivers the majority of care. There will be times when this is appropriate, but other times when the actual therapeutic input may be provided by a number of others, particularly where more specialist interventions are required. This approach supports the principles of New Ways of Working, which aims to use the skills of all in the most appropriate, effective and efficient manner.<sup>60</sup>

For people who have had damaging experiences of sexual abuse or violence, choice of gender of the care co-ordinator may be a crucial factor in establishing trust and a therapeutic relationship.

Services users should also be afforded a choice of care co-ordinator which takes account of any cultural or religious needs. Local workforce strategies should ensure appropriate team skill mix and diversity to accommodate this.

## Implementing CPA: National Learning Materials

Successful care assessment and planning is a multi-disciplinary and multi-agency endeavour, although the role of the care co-ordinator is critical. To support individuals, teams and organisations implement this guidance, and to improve integrated approaches to risk and safety management, a national learning and development package for the range of staff working in mental health services is being commissioned. This will build on the 10 ESC framework and guidance on Best Practice in Managing Risk. Further details on this will be made available on [www.nimhe.csip.org.uk/risk](http://www.nimhe.csip.org.uk/risk) in 2008.

<sup>60</sup> Department of Health, *New Ways of Working for Everyone*. 2007

## Capacity and Effectiveness

Capacity can be measured at organisation, service, team or individual level. The capacity of a team is taken to mean the amount of quality-assured care which can be delivered to service users and carers by that team. It can be optimised by:

- > Having skills and capabilities available in the team which match the population needs. The Creating Capable Teams Approach (CCTA) provides a means to produce a team level workforce plan which can then contribute to the organisation's overall plan<sup>61</sup>
- > Using those skills in the most effective way, utilising the principles of New Ways of Working and a model of distributed responsibility.<sup>55</sup>
- > Establishing efficient processes which minimise wasted, or non-value-adding, effort. Process redesign and the principles of Lean thinking (references appended) can assist with the production of easily understood and negotiated care pathways which minimise bureaucracy.
- > A truly person-centred approach to working with service users and carers.

- > The availability, and creative use, of sources of support outside the secondary service to contribute to care plan delivery.
- > Efficient communication processes and clinical information systems, aided by the use of technology.
- > Effective team leadership and management, including readily available supervision, advice and support.

The Policy Implementation Guide for Community Mental Health Teams<sup>62</sup> gives general guidance on caseloads but the opportunities afforded by New Ways of Working, technological change, and choice mean that a national blueprint for local teams is not appropriate. Trusts should agree appropriate levels of service capacity with commissioners, taking account of local needs.

Some organisations use modelling tools to work out the effect on capacity of changing skills mix or team organisation. These still use judgement to determine appropriate workloads, and must factor in time for supervision, advice and support, as well as direct contact, to ensure service quality is maintained. Others have developed 'care packages' for different types of need, which can then be used to describe the capacity and capabilities required of the team.

<sup>55</sup> Department of Health, *New Ways of Working, Creating Capable Teams (CCTA): best practice guidance to support the implementation of New Ways of Working (NWW) and new roles*. 2007

<sup>61</sup> Department of Health, *Creating Capable Teams Approach (CCTA): Best practice guidance in the implementation of New Ways of Working (NWW) and New Roles*. Available at [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk)

<sup>62</sup> Department of Health, *Mental Health Policy Implementation Guide: Community Mental Health Teams*. 2002

At practitioner level, tools which profile a caseload according to the time and intensity of the interventions required to meet the needs, can assist with maintaining focus and throughput, avoiding the creation of waiting lists and ensuring practitioners have doable jobs. Again, there are several such tools being used. Although their scales have face validity they have not yet been subjected to rigorous trials.

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

In reviewing policies and practice in light of this guidance mental health services should:

- > note the range of guidance and training available to ensure all staff are competent to delivery evidence and values-based, service-user and recovery focused services
- > use the national statement of care co-ordinator competences to strengthen the role locally and inform workforce planning developments
- > note the development of national training on CPA and Risk and Safety: further information in 2008
- > consider how capacity and effectiveness can be improved

# Section 7:

## Measuring and Improving Quality

All services need to understand and assess their impact on achieving positive outcomes for clients or service users. How well CPA is implemented can provide an overview and an indicator of quality for secondary mental health services. Commissioners acknowledge this. This guidance, building on other frameworks and guidance, aims to describe what implementing efficient, effective and service user focused CPA means.

Auditing and monitoring the quality of care will remain essential components of secondary mental health services for all service users and carers, whether needing the support of (new) CPA or not.

The need for systems to measure the impact of quality and outcomes for tackling inequalities has been included here. An approach to improving the quality of services that does not pay due attention to equality issues is unlikely to deliver equitable improvements to all.

### Recording Management Information

Trusts will need to continue to capture information about individuals receiving their services for monitoring and information purposes whether they are on (new) CPA or

not. Trusts should have an appropriate central record of all service users receiving treatment, care and support provided by them. This system, alongside electronic systems, will provide reports to managers and staff concerning caseloads and other relevant information. Alternative local methods for manually collecting information will continue until such time as a full electronic record is available to provide a comprehensive list of all activity.

All providers of specialist mental health services for adults and older adults are mandated to collect information for the Mental Health Minimum Dataset<sup>63</sup> (MHMDS). There will be a continuing requirement to complete MHMDS returns on every individual receiving secondary mental health care, even those not on (new) CPA. Dataset descriptors of “standard” and “enhanced” CPA will be amended to non-CPA and CPA in due course.

Management information systems should routinely collect data on service users' race, ethnicity, gender etc, so that the impact and accessibility of service delivery for these groups can be measured and action taken to address inequalities, where necessary.

<sup>63</sup> NHS, Mental Health Minimum Dataset

<http://www.ic.nhs.uk/ourservices/imposing-patient-care/mental-health/mental-health-minimum-dataset>

## Regulation Across Health and Social Care

Regulatory bodies recognise the importance of agreeing indicators that can be used as part of the annual performance assessment of all partners involved in the provision of secondary mental health care. If indicators only apply to either the health or social care organisations this will not help to lever change across all the agencies with a central role to play in delivering better outcomes for mental health service users.

The Healthcare Commission and the Social Care Inspectorate undertook a joint review of community mental health services in 2005/6,<sup>64</sup> which looked at aspects of CPA. There is scope within existing systems to develop a more integrated approach to how integrated approaches such as CPA are assessed and the community review was testimony to this. The Government's wider review of regulation plans to bring together the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission, which will provide a further opportunity to develop this approach.

## Local Audit

Local audit and monitoring will continue to be essential components of measuring the quality of service provision and CPA. A number of audit tools and guidance exist:

- > *An Audit Pack for Monitoring the Care Programme Approach*<sup>65</sup> includes guidance on reporting into clinical governance and local council scrutiny committees and a section for development of audit from a service user focus by service users;
- > the CPA Association (CPAA) standards and protocol for CPA;<sup>66</sup>
- > the CPA Brief Audit Tool (CPA-BAT)<sup>67</sup> developed for assessing the quality of CPA care planning for service users who have been more than one compulsory admission to hospital in a period of three years.

<sup>64</sup> Healthcare Commission & Commission for Social Care Inspection, *No Voice, No Choice: A joint review of adult community mental health services in England*. 2007

<sup>65</sup> Department of Health, *An audit pack for monitoring the care programme approach*. 1996

<sup>66</sup> <http://www.cpaa.co.uk>

<sup>67</sup> Sainsbury Centre for Mental Health & Mental Health Act Commission, *The CPA Brief Audit Tool (CPA-BAT) for assessing the quality of CPA care planning for service users who are frequently detained*. 2005

The CPAA, as part of the CPA review, carried out a survey of its members to examine the current process of audit of CPA within mental health services. In the short timescale allowed 28 trusts responded. Although it is not possible to draw conclusions for all trusts, from this sample there was sufficient information to be able to draw some general conclusions, which are that for local audits:

- > most trusts have developed local tools and methods, based on the tools and guidance described above;
- > under half include risk issues;
- > only half include carers' views;
- > audit reviews and reports generally feed into management and governance review systems and help to influence change;
- > opinion varied on the impact of CPA audit between very negative, feeling it had no or little impact, to very positive, feeling it had a great impact (impact was viewed as often depending on the commitment of managers, and in particular medical staff);
- > the majority welcomed the proposal to update local audit guidance in light of policy and practice developments

As a result of this survey, and general CPA review feedback, DH is commissioning a review of local CPA audit tools and methods to judge if they meet the requirements of updated policy and good practice. Guidance will be available in 2008. Key elements the review is likely to cover include:

- > a focus on service user and carer satisfaction and engagement rather than system processes;
- > use of outcome measures, including user-defined outcomes, to measure success;
- > improved attention to issues around housing, employment and other social inclusion and recovery needs;
- > better integration of risk management into CPA systems;
- > consideration of equality issues.

Until the review is undertaken and further guidance provided, trusts should continue with current local audits, include findings from the National Patient Survey, to review performance and drive improvement within local teams.

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

### Action Points

In reviewing policies and practice in light of this guidance mental health trusts should:

- > note the continued need to collect management information on all services users in secondary mental health care, including: MHMDS and HoNOS
- > note that review of Regulators will consider how a more integrated approach can be developed
- > note the review of local audit tools – further guidance in 2008



# Annex A: CPA and Other Assessment and Planning Frameworks

This Annex is for information and aims to provide an overview of a number of key assessment and care and support systems that can interlink with assessment and care planning systems for adults in secondary mental health care.

## Long-Term Conditions Common Assessment Framework (Adults)

The Common Assessment Framework for Adults (CAF) with longer term support will aim to deliver a more person-centred and integrated approach to assessing people's need for support from health and social care services and the support needs of their carers. A (adults') CAF would be designed to support independent living through better integration of community support services, although the proposals would also extend to the interface between support received in hospitals, intermediate care and longer-term support in the community and in residential care settings. A consultation document with detailed proposals on the CAF is due to be published in 2008.

Although the (adults') CAF will provide a generic framework for assessment for all people with long-term conditions, it is intended that CPA will be the framework for specialist multi-disciplinary assessment and planning for people with complex support needs in secondary mental health care. As with other frameworks,

services should ensure that information on assessments, plans and care co-ordination responsibilities for individuals who have the potential to benefit from both systems are shared and made clear as the (adults') CAF develops locally.

## Child and Adolescent Mental Health Services

The importance of having a system similar to CPA for children and young people with mental health needs is increasingly recognised. In the Report on the Implementation of *Standard 9 of the National Service Framework for Children, Young People and Maternity Services*,<sup>68</sup> in delivering good practice for young people it is noted that "The Care Programme Approach, modified to meet the needs of younger people, is used to plan transition, and transition is supported by agreed protocols."

A similar point is made in Standard 9 of the NSF for Children, Young People and Maternity Services, namely "When children and young people are discharged from in-patient services into the community and when young people are transferred from child to adult services, their continuity of care is ensured by use of the care programme approach."

<sup>68</sup> Department of Health, *Promoting the mental health and psychological well-being of children and young people: report on the implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services*. 2006

However, it is important that where CPA is considered relevant for children and young people it is tailored to their requirements. Guidance on how this can be achieved is set out at Annex B.

### Framework for the Assessment of Children in Need and their Families

Adults who have parenting responsibilities for a child under 18 years may require help with these responsibilities. In such cases, councils may also have a duty to provide services under Section 47 of the Children Act 1989<sup>69</sup> to safeguard and promote the welfare of children in their area. Where appropriate the 'Framework for the Assessment of Children in Need and their Families'<sup>70</sup> should be used to explore whether there are any issues relating to children in need and their parenting. Under the Children Act<sup>66</sup> a service may be provided to any member of a child's family, if it is provided with a view to safeguarding or promoting the child's welfare.

Adult services have a continuing role of supporting parents when children's services carry out their responsibilities under the Children Act. It is important that adults' and children's services work together to provide adequate support for parents.

### Single Assessment Process (Older People)

Older people with mental health needs may be involved with two assessment processes: the Single Assessment Process (SAP) and the Care Programme Approach (CPA). The aim of SAP is to ensure a person-centred approach to assessment and care planning for older people, regardless of organisational boundaries. Services are at different positions in integrating the specialist CPA and the more generic SAP methodologies. Some are maintaining the CPA as a separate specialist assessment and care planning framework, others are trying to incorporate key elements of the CPA as an integral part of specialist assessment and care planning under SAP. Annex C provides further guidance on the relationship between CPA and SAP.

<sup>66</sup> Sainsbury Centre for Mental Health & Mental Health Act Commission, *The CPA Brief Audit Tool (CPA-BAT) for assessing the quality of CPA care planning for service users who are frequently detained*. 2005

<sup>69</sup> Children Act 1989 [http://www.opsi.gov.uk/acts/acts1989/Ukpga\\_19890041\\_en\\_1.htm](http://www.opsi.gov.uk/acts/acts1989/Ukpga_19890041_en_1.htm)

<sup>70</sup> Department of Health, *Framework for the Assessment of Children in Need and their Families*. 2000

## Person Centred Planning (Learning Disabilities)

The MHNSF standards and guidance apply to people with learning disabilities as much as anyone else. While there are some excellent examples of positive practice, it is acknowledged that many people with learning disabilities still find it difficult to access mainstream mental health services.

Since 2004, the 'Green Light Toolkit'<sup>14</sup> has helped mental health services judge progress and plan action. A national programme of support is available to help with this. Individuals with a learning disability should access annual health checks which inform the Person-centred Health Action Plan (HAP). Any assessment undertaken by secondary mental health services should form part of this plan and not be seen as separate. If the individual does not have a HAP on referral to the secondary mental health services it would be the time to initiate one with the learning disability services and GP.

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

 **Positive practice** (available at [www.nimhe.csip.org.uk/cpapp](http://www.nimhe.csip.org.uk/cpapp))

## Criminal Justice

Movement of offenders between prisons (often at very short notice and to different areas and regions) and movements between prison, hospital and community can lead to lack of continuity of care due to poor exchange of information. There can be a lack of understanding on the part of mental health professionals regarding the criminal justice system and of Offender Managers regarding the mental health and social care systems.

This lack of understanding can lead to discontinuities in care and to offenders with mental health needs not receiving the care and support they need. In some circumstances this may lead to increased risk of re-offending and increased risk of harm to the public.

It is therefore vital that relevant information accompanies the offender/service user during transition through the offender pathway and that both CPA care co-ordinators and Offender Managers have a sound understanding of both the health and criminal justice systems. As there is a high population of people with learning disabilities in prisons there is also a need to ensure that assessments for these individuals are linked with the Person-centred Health Action Plan (HAP) (see above).

<sup>14</sup> NIMHE/CSIP Delivery Race Equality Programme  
<http://www.csip.org.uk/about-us/about-us/equality-and-diversity-.html>

## National Treatment Agency

The National Treatment Agency (NTA) endorses the CPA framework as an approach to co-ordinating the care of people with a severe mental disorder and substance misuse problems within mental health services.<sup>71, 72, 73</sup>

It acknowledges that substance misuse treatment providers should contribute to the CPA process where appropriate.

NTA guidance also indicates that people receiving treatment within substance misuse services who have co-existing mild to moderate mental health problems should have their care co-ordinated by the allocated key worker in the substance misuse service. The substance misuse key worker has the responsibility to develop a comprehensive care plan addressing the full range of needs in partnership with the service user and carers.

<sup>71</sup> National Treatment Agency for Substance Misuse, *Models of care for treatment of adult drug misusers*. 2002

<sup>72</sup> National Treatment Agency, *Care planning guidance*. 2006

<sup>73</sup> Department of Health, *Drug Misuse and Dependence: Guidelines on Clinical Management*. 2007

# Annex B: CPA and Child and Adolescent Mental Health Services

An approach such as CPA can particularly add value for those children and young people with more complex needs, such as those which need help from specialist multi-disciplinary Child and Adolescent Mental Health Services (CAMHS). The value of CPA in enabling transparency of care and treatment and promoting accountability of clinicians needs to be enhanced by linking with other planning and assessment frameworks (see below). Teams and individuals working in a given locality will need to be clear about where the threshold lies for use of CPA. If a criterion of complexity of need is applied, there should arguably be no lower age limit for the use of CPA.

It is vital that local protocols are used to agree which system, co-ordinator, or person is in the lead in the overall care of a child or young person. Where care is shared across agencies it must be clear who takes the lead on which areas. This is especially important for children and young people who may have a Lead Professional appointed across agencies. The risk, if this is not clarified and agreed, is that professionals might assume that others are taking responsibility e.g. for child protection or mental health, when they are not.

## Adapting CPA for CAMHS

When using CPA for children and young people, health professionals need to take appropriate account of:

- > The fact that the needs of children and young people vary and change over time to a possibly greater extent than adults. The environment experienced by a child or young person may be changing, for example, because of progress through the educational system or changes in fostering arrangements for those children in care. CPA will be particularly important when a child or young person is in a secure setting or leaving a secure setting. Reviews may need to be more frequent for children and young people compared to adults.
- > The more complex inter-agency issues that often affect the care management and planning for children and young people. For example, a child or young person in contact with the Youth Justice System.
- > The need to ensure that the child or young person's family are involved in the care plan decision making process and have a good quality relationship with the care co-ordinator. CAMHS typically works from a family centred orientation rather than a person centred approach and care must be taken to ensure all relevant family members are included, as appropriate to the child or young person's age, developmental level and taking into account their choice.

- > The educational needs of children and young people.

Children, more than adults, are likely to be subject to multiple care plans and review mechanisms from multiple agencies e.g. Looked After Child Reviews, Special Educational Needs reviews, (children's) Common Assessment Framework (CAF). All professionals and agencies need to work together to ensure minimum duplication of information, meetings and clarity of roles (especially who is leading) to avoid confusion and risk. CPA needs to be seen in the context of other planning mechanisms for children with complex needs and agreement must be made locally on how to co-ordinate multi-agency care planning.

To ensure continuity of care the care co-ordinator should follow the transition protocols at their Trust for CAMHS to adult services.

## Children and Young People's Involvement

Young people's involvement brings advantages in terms of promoting user empowerment and choice. However, to make young people's involvement in CPA a reality rather than an aspiration careful attention needs to be paid to, for example, the design of paperwork so that service users do not feel excluded. Children and young people need communication to be tailored to them, to recognise their process of cognitive development and, for those under 16, the extent of their competence to give consent.

Key issues in relation to the involvement of young people are that:

- > The review and other meetings should be young-person friendly (including the language used, timing of meetings, location of venues, who is in attendance, the possible need for interpreters); information leaflets and paperwork should be age-appropriate; staff should be competent in managing meetings in such a way as to ensure young people's views are heard and taken into account.
- > Young people should be supported in this process, using advocates as necessary, and assisted in developing skills to voice their views; the views of their parents and carers should also be incorporated, and where appropriate, distinguished from those of the young person.
- > Agencies in a given locality need to have protocols for working together in this process, for example in the duty to cooperate, and information sharing processes.

Local teams are likely to have experience of cross-agency meetings for Looked After Children (LAC) and family group conferences and should draw upon this expertise in developing care plans for children and young people.

## CAMHS CPA and other Planning/Assessment Frameworks

As CPA is not the only care planning method for children and young people, its use needs to be coordinated with the other systems e.g. the (children's) CAF, and any local systems for Looked After Children. Practitioners need to be clear about which approach to use in a given situation and how the (children's) CAF would capture issues about the psychological well-being of children and young people who were not subject to CPA. It will be important that young people are not overloaded with assessment and review meetings. In addition, there is a need to consider the interplay between the CPA care co-ordinator role and that of the (children's) Lead Professional.

It will be important to minimise different approaches, to avoid duplication and to work towards a situation where there are clear and agreed links between the different frameworks.

CPA should be modified for children and young people at a local level and decisions on what framework to use should be decided across agencies on a case by case basis. Issues to be considered locally between mental health services and partner agencies when developing CPA for children include:

> how CPA can facilitate the management of those young people in out-of-area placements, including those with long-term needs;

- > the extent to which IT systems are compatible with those partner agencies;
- > the extent the (children's) CAF is being implemented locally;
- > how consent will be given for information sharing;
- > clarity about the respective roles of the CPA care co-ordinator and (children's) Lead Professional, and who has ultimate responsibility;
- > clarity about which young people CPA should be used for, consideration of any risks inherent in using CPA must be considered and minimised;
- > how to ensure user involvement in CPA;
- > clarity about how CPA works alongside other planning and assessment frameworks.

## Annex C: CPA and Older Adults

This part of the guidance sets out some of the key issues in relation to the assessment, care planning and care co-ordination of older adults with mental health needs who receive secondary mental health services. It is informed by current thinking, policy and responses to the CPA review consultation. It builds on the advice set out in the documents *Everybody's Business*<sup>16</sup> and *Securing Better Mental Health for Older Adults*.<sup>74</sup>

### Background

The range of mental health problems experienced in later life is wide and includes depression, anxiety, delirium, dementia, schizophrenia and other severe and enduring mental health problems, and drug and alcohol misuse.<sup>75</sup> Older adults and their carers should not be subjected to age-based discrimination in terms of the health and social care service they receive.<sup>76</sup> They may have particular health and social care needs associated with ageing, including complex physical and mental health co-morbidity. These needs must be met within and across services that currently often have age-based exclusion criteria.

Older adults much like everyone else want to have choice and control over how their mental health care is managed and have a say in how their problems are understood. Carers also require their needs to be understood and have involvement in care plans which affect them.

Assessment of these needs must attend to the broader health and social care needs in addition to those associated with mental health, or there will be a danger that aspects of care may be missed and remain unmet. An older person's combined mental health, physical health and social care needs can be highly complex and involve several assessments, necessitating a co-ordinated and focused service response across disciplines and agencies. Any one of those agencies may already be managing that person's care and the person does not necessarily always require a lead co-ordinator from mental health services although others may (see below).

Older adults want to experience assessments that translate into action rather than further and repeated questioning. Staff need to be able to gather only the additional information they require to deliver and direct care without unnecessary duplication or repetition. The

<sup>16</sup> Department of Health, *Everybody's Business*. (Nov 2005)

<sup>74</sup> Department of Health, *Securing better mental health for older adults*. (2005)

<sup>75</sup> Age Concern England, *Improving services and support for older adults with mental health problems – The second report from the UK inquiry into mental health and wellbeing in later life*. (August 2007)

<sup>76</sup> Department of Health, *Human Rights in Healthcare – A Framework for Local Action*. (March 2007)



generic assessment framework provided by the Single Assessment Process (SAP), with its tiered model of contact, overview, specialist and comprehensive assessment, and the sharing of information from these assessments with appropriate agencies and professionals, provides a platform to reduce unnecessary duplication or repetition.

### Single Assessment Process and CPA

The use of the Single Assessment Process (SAP) and CPA for older adults has to a large extent been locally defined in response to the DH 2002 Guidance.<sup>77</sup> The effect has often been one of unhelpful variation in practice within and across agencies, increasing duplication and not always achieving the integrated approach necessary to best meet the needs of older adults. We have aimed to clarify some of the issues below. Table 2 (Section 3) of this guidance clearly sets out the characteristics and circumstances under which individuals should receive (new) CPA.

### Single Assessment Process

Ordinarily SAP would be the primary method of assessment for all older adults<sup>78</sup> and some older adults referred to specialist mental health services will already have been assessed and their care planned using SAP. When an older

person's needs are met and managed predominantly in primary and social care, and they have a mental health need which is not complex or which is without significant risk, secondary mental health care will form part of the overall assessment and care plan and care management will be co-ordinated through existing SAP Care Managers. (New) CPA would not be required. Mental health assessments, care plans and reviews will be communicated to the identified person taking the lead in management. The SAP care manager should also ensure that an identified lead in mental health services is informed of the overall plan of care and ensure ongoing dialogue.

Some older adults, however, may not have had an assessment using SAP prior to their referral to secondary mental health services. In these circumstances, locally agreed arrangements for health & social care assessments should be initiated (where the Trust is SAP compliant this would normally be the SAP overview assessment) and where needs are predominantly well-managed, without significant risk and will primarily be managed in health or social care, SAP will also provide care planning and co-ordination as described above.

<sup>77</sup> Department of Health, *Care management for older adults with serious mental illness*. (2002)

<sup>78</sup> Department of Health, *National Service Framework for Older Adults*. (2001)

## When to use (new) CPA

When a person's mental health and social care package is complex, predominantly mental health related and the characteristics in section 3 of this guidance on (new) CPA are present, their care will normally require care co-ordination using CPA and a mental health lead care co-ordinator should be allocated. SAP can provide information and inform assessment – the (new) CPA will provide the specialist care planning, review and health and social care provision that is required to meet this person's needs.

## Transfer from adult to older adult's services

Current policy makes clear that care should be offered on the basis of need and not age or service configuration. Transfer of care from adult (working age) services to older adult services is no exception. Transfer should only occur when the needs of a person will be better met by professionals working with older adults, and not just because an individual reaches a certain age. When transfer to another service lead is appropriate it will necessitate a transfer of care co-ordinator and care plan. If the person has formerly required the support of secondary mental health services then this should continue

following reassessment at transfer, with the SAP forming the assessment framework.

Under Mental Capacity Act (2005) legislation, some older adults may have an Independent Mental Capacity Advocate (IMCA) instructed to support and represent the person in particular circumstances. It is essential that the lead co-ordinator communicates with and assists the IMCA to carry out their role.

A person's needs change over time, and from time to time, and can move up and down in terms of degree of risk and complexity of need. The appropriateness (new) CPA must be reviewed in line with these changes.

# Annex D: Glossary

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<b>Advance Decision</b>	A statutory right to refuse treatment, including life sustaining treatment, that if valid and applicable, is binding and cannot be overridden by anybody at a time when the person lacks capacity, having been made when they had capacity.
<b>Carer</b>	The term carer is used in this guidance to describe an individual who provides or intends to provide practical and emotional support to someone with a mental health problem. They may or may not live with the person cared for. They may be a relative, partner, friend or neighbour. They may be young people who find themselves in the position of needing to support an unwell person. A person may have more than one carer.
<b>Common Assessment Framework (CAF)</b>	The term Common Assessment Framework (CAF) is used to describe assessment systems in adult health and social care and in children's services. To differentiate in this guidance we have indicated (adults') or (children's) CAF.
<b>Dual Diagnosis</b>	The term dual diagnosis is used in the document to mean a dual diagnosis of mental health and drug and alcohol misuse problems unless otherwise specified.
<b>Homeless or Unsettled Accommodation</b>	The reference to homeless people in this guidance refers to people not in settled accommodation, this includes: rough sleepers; people living in insecure accommodation e.g. hostels, night shelters, squats, or living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the homelessness duty.
<b>Lead professional</b>	The term lead professional is used in this document in its ordinary sense, i.e. the professional who has lead responsibility for an individual's treatment and care. Where it refers to the Lead Professional, i.e. the specific role in Every Child Matters and the Common Assessment framework for Children, capital letters are used.

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<b>Person-Centred Care</b>	<p>The key principles of person-centred care are:</p> <ul style="list-style-type: none"><li>&gt; it is a continuous process not a product;</li><li>&gt; it is a dynamic process of discussion, negotiation, decision making and review that takes place between the individual and the professional – who have an equal partnership;</li><li>&gt; the process should be led by the individual with them at the centre, based upon their strengths, goals, aspirations and lifestyle wishes;</li><li>&gt; the person should be encouraged to have an active role in their care, be offered options to allow informed choices, and empowered to make their own decisions with adequate information or signposting – all within a framework of managed risk;</li><li>&gt; self care and self management is an essential element of good care/support and should always be supported.</li></ul>
<b>Recovery</b>	<p>Recovery is a concept that has been introduced primarily by people who have recovered from mental health experiences and has grown considerably around the developed world. Now many people are talking about and using the word 'recovery'. However, in England, people have differing views of what recovery means, whilst the word is being included in common usage in mental health services, a clear understanding of what this means remains limited. NIMHE has produced a <a href="#">brief statement</a><sup>79</sup> on the emerging view of mental health recovery to contribute to the development of recovery-oriented services nationwide.</p>
<b>Social Inclusion</b>	<p>Social inclusion can be defined as people having the same opportunities to participate in, and contribute to, society and community as the rest of the population. This includes improving access to health and social care services but also to community services to enable people to participate. It involves increasing options and empowering people to have confidence in their own abilities and aspirations. Key areas are education, employment, housing, family and relationships, financial security, leisure, arts, cultural and religious opportunities and participation in civic life.</p>

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<sup>79</sup> <http://www.personalitydisorder.org.uk/assets/Resources/32.pdf>

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<b>Statement of Wishes</b>	Statements of wishes and preferences, including written statements, are those that are non-binding but which have to be taken into account by those making best interests decisions on a person's behalf at a time when the person lacks capacity having been made when they had capacity.
<b>Unsettled Accommodation</b>	The reference to people in unsettled accommodation includes: rough sleepers and people living in insecure accommodation e.g. hostels, night shelters, squats, or living with friends or in bed and breakfast accommodation; and individuals or families living in temporary accommodation who are owed the main homelessness duty.
<b>Young Carer</b>	Around 3 million children in the UK have a family member with a disability. Not all take on a caring role that is inappropriate to their age. Few parents want their children to be carers but it can happen for many reasons, such as families being isolated, afraid of outside interference or lack of other support.

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