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The History of the Care Programme Approach in England: where did it go wrong?

Short Title: History of the CPA

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Abstract

Background: The Care Programme Approach (CPA) was introduced in England in 1991 as a form of case management to improve community care for people with severe mental illness. It helped services maintain contact with users but failed to provide comprehensive, co-ordinated care and is associated with increased bed use.

Aim: To describe and evaluate the introduction, implementation and development of the CPA and identify reasons for its relative failure.

Method: A critical review of key events, audits, reports, research and policies that shaped the CPA.

Results: Reasons for the relative failure of the CPA included the socio-political and financial context, clinicians' resistance to political and managerial interference, and the bureaucratic, complex and time-consuming nature of the policy. This reduced face-to-face contact whilst contributing to an emergent 'blame culture' and defensive psychiatric practice. The CPA also presumed levels of community resources and interprofessional teamwork that were frequently absent.

Conclusions: The CPA was a flawed policy introduced insensitively into an inhospitable environment. It was destined to fail and after more than a decade remains ineffectively implemented. Changes introduced recently may have contradictory influences on the ability of services to provide effective case management but remain to be evaluated.

Declaration of interests: This paper is derived from work undertaken by Alan Simpson under the supervision of Carolyn Miller and Len Bowers, as part of a

Introduction

The Care Programme Approach (CPA) was introduced in England in 1991 to provide shape and coherence to what had often been haphazard, uncoordinated attempts to provide support in the community for people with severe mental illness. This paper explores the history and development of the CPA and identifies the key events, audits, evaluations and initiatives that shaped this policy and concludes by identifying possible explanations for the continued under-performance of this English version of case management.

A brief background to the introduction of the CPA

The Audit Commission (1986) called for radical changes in the organisation and management of community services in the mid-1980s. Community care appeared to be failing patients and families (Wallace, 1986) and worrying numbers of mentally ill people were becoming homeless (Belcher, 1988). The killing of a social worker by a mentally ill woman added to concerns when it transpired that the patient had been able to 'drop out of sight' of mental health services whenever she was discharged from hospital. The '*Spokes Inquiry*' recommended that health authorities set up a register of vulnerable mentally ill patients living in the community and appoint keyworkers (DHSS, 1988).

In response, the *'Griffiths Report'* recommended targeted care packages and the appointment of case managers who would assess the needs of the mentally ill person, co-ordinate the input of various agencies and work closely with the family (Griffiths, 1988). These recommendations formed the backdrop to the White Paper, '*Caring for People'* (Department of Health,

1989a). But specific proposals concerning mental health were dwarfed and delayed by the NHS and Community Care Act, 1990, which contained extensive measures to reorganise all hospital and community services (Hadley, Muijen, Goldman, & Shepherd, 1996; Reynolds & Thornicroft, 1999).

Nonetheless, local authority social services introduced a care management system, in which social worker care managers assessed social needs, designed 'packages of care' and purchased services for vulnerable people (Department of Health, 1989b). A directive followed that advised psychiatrists not to discharge patients from hospital without an individual care plan agreed with the local authority (Department of Health, 1989a). A second circular required health and local authorities to implement the CPA by April 1991 for *all* people with mental illness referred to specialist psychiatric services (Department of Health, 1990).

The Care Programme Approach (CPA)

The CPA was based on the principles of case management, developed in the USA to target resources at those considered most in need (Intagliata, 1982; Ovretveit, 1993; Stein & Test, 1980). Different models of case management stressed different characteristics (Mueser et al., 1998), but in England these could be determined locally, provided that the fundamental features of the CPA were implemented (See Table 1). The relationship between different case management approaches and the CPA is discussed elsewhere (Simpson, Miller & Bowers, in press). Names of those subject to the CPA

were recorded on 'CPA registers', introducing paperwork that became the

leitmotif of the new policy (Simpson, 1998).

[INSERT FIGURE 1 HERE]

Things were not getting better

The ability of 'community care' policies to provide humane, safe support for

severely distressed people remained in doubt (Hogman, 1992). Unkempt and

disturbed men and women were sleeping rough in apparently increasing

numbers (Craig et al., 1993; Craig & Timms, 1992; Scott, 1993). Mental

health was now a key policy area in the government's '*Health of the Nation'*

strategy (Department of Health, 1992) but when the media reported and

arguably exploited a series of tragic incidents involving people with mental

illness pressure mounted on the government to do more (Coid, 1994). Most

influential was the case of Christopher Clunis, a man with mental illness, who

killed Jonathon Zito (Hallam, 2002). This rare incident involved the death of a

total stranger and fuelled the public's anxieties, leading the government to

introduce independent inquiries whenever a mentally ill person committed

homicide (NHS Executive, 1994). The ensuing rash of inquiries and reports

(with attendant publicity) repeatedly highlighted breakdowns in

communication between agencies and individuals (Shepherd, 1996). People

were still 'falling through the net'.

Further guidance signalled the government's determination to prioritise the

needs of people with '*severe* mental illness' (Department of Health, 1993;

1994). Unfortunately, the failure to publish a definition of severity created

disagreement and confusion (Powell & Slade, 1996; Walker, 1998).

Initial evaluations of the CPA

Initial evaluations identified many difficulties affecting implementation of the

CPA (See Table 2). Psychiatrists in particular perceived it as an

encroachment on their clinical judgement and practice. They believed the

basic requirements of good practice were already in place and that the CPA

was bureaucratic and over-structured (North et al., 1993). Staff were also

concerned that with the introduction of CPA registers they would be involved

in a more explicit form of surveillance or social control (May, 1996).

Consequently, the CPA was being implemented selectively and was not

applied to all mentally ill patients (Schneider, 1993).

[INSERT FIGURE 2 HERE]

Supervision Registers and Supervised Discharge

The '*Ten Point Plan*', aimed at tightening procedures, introduced supervision

registers for patients considered most at risk and in need of increased support

(Secretary of State for Health, 1994). Supervision registers were more often

seen as another controlling response to the needs of mentally ill people,

rather than being designed to improve quality of care (Godin & Scanlon,

1997; Kingdon, 1996; Nolan et al., 1998; Ryan, 1994) and were rarely

employed (Bindman et al., 1999; Turner et al., 1999). Together with homicide

inquiries, many suspected they pointed towards an emerging 'blame culture' with clinicians being held responsible for untoward incidents (Peck & Parker, 1998). The aim of providing community mental health care in the least restrictive environment (House of Commons, 1985) was being lost, with mentally ill people now being treated with different rather than fewer restrictions (Ryan, 1994).

Supervised discharge was also flagged up and eventually introduced in April 1996 under the Mental Health (Patients in the Community) Act, 1995. This required certain patients to adhere to an agreed care plan but there was little enthusiasm amongst clinicians for yet another modification to the CPA (Burns, 2000). 'Designated supervisors', most likely the CPA keyworker, now had powers to 'take and convey' patients to where their care plan specified they should reside or receive treatment. Many thought such measures would impinge on their therapeutic relationships with users (Coffey, 1997; Rogers, 1996). Others argued that such a position was naïve or dishonest and created a 'pernicious split' within mental health services between those directly involved in restricting the liberty of service users and those not (Godin & Scanlon, 1996). Others saw the increased supervision of service users as validating early concerns that the CPA would foreground the 'medical model' and enable the extension of coercive psychiatric practices into the community (Onyett, 1998b).

Building Bridges

The continued failure to properly implement and monitor the CPA was
severely criticised by politicians who identified fragmentation of services and
poor inter-disciplinary co-ordination. They also criticised the lack of detailed
data that would enable proper evaluation of the CPA (Health Committee
Report, 1994). Suitable information technology was still treated with some
suspicion within the health service (Ferguson, 1996). This damning report,
coupled with the '*The Report of the Inquiry into the Care and Treatment of
Christopher Clunis'* (Ritchie & Lingham, 1994) led to the publication of
'*Building Bridges'* (Department of Health, 1995). Alongside sister publication
'*Building on Strengths'* (NHS Training Division, 1995), this re-emphasised the
importance of good multidisciplinary working and inter-professional
communication for the effective implementation of the CPA and stressed the
government's determination to prioritise the needs of those most vulnerable
and at risk. *'Building Bridges'* also contained the first official attempt to define
severe mental illness. However, providing a 'framework definition' and
continuing to recommend locally agreed operational definitions ensured that
confusion and disagreement remained (Huxley et al., 1998).

Tracking the tiers of the CPA

Localities developed different grades of the CPA, depending on the users'
severity of illness or complexity of need, in order to target restricted resources
at those in most need and to reduce administration required for those seeing
one worker (Wells, 1997). Some introduced a 'continuum' that allowed a more

individualised response to changing needs, others introduced 'levels' where each person was placed on a particular 'tier' of the CPA (Margerison, 1998). Again, solutions were decided locally (NHS Training Division, 1995) ensuring little consistency, with patients allocated according to different criteria including diagnosis, number of professionals involved, and severity of illness (Margerison, 1998; Marlowe et al., 1999; Sone, 1992). As a result, social service and health employees working alongside each other could end up employing separate and contradictory systems (Miller & Freeman, 2003).

Still Building Bridges

Tiers, supervision registers and supervised discharge deepened the confusion surrounding the CPA (Department of Health, 1995; Hamilton & Roy, 1995). A survey of all 180 English NHS mental health trusts reported widespread variation in the number of people allocated to the CPA and different tiers, not explained by variations in population need (Bindman et al., 1999). *'Still Building Bridges'* (Department of Health, 1999) confirmed the continuing uneven implementation of the policy. Few authorities provided holistic inter-disciplinary assessments and assessment systems "varied significantly between different professional groups, different agencies and within agencies", making appraisal of needs difficult (ibid: 6). Attempts to develop joint recording systems encountered major problems reconciling different computer systems. There were few agreed procedures for risk assessments, care plans were often found to be ineffective and some areas had difficulty keeping up with regular reviews. Service users and carers were more likely to be invited to reviews but often found them formal and

intimidating and arranged at the convenience of medical staff. Written information on the CPA and other services was seldom available.

[INSERT FIGURE 3 HERE]

Increased contacts, admissions and costs

The Cochrane systematic reviews of various case management programs in the USA, Australia and Europe concluded that such approaches increased patient contact but approximately doubled the numbers admitted to psychiatric hospitals, with no significant advantages over 'standard care' on psychiatric or social variables (Marshall et al., 2001). Increased bed use was highest in studies in England where the impact of the CPA, risk management and concerns about untoward incidents may have fuelled figures (Turner et al., 1999). Psychiatric hospitals faced enormous pressures; admission rates rose with bed occupancies exceeding capacity, compulsory admissions soared and additional use of non-NHS inpatient facilities escalated costs (Gould, 2002; Simpson, 2000). Consequently, the CPA was dismissed as an ineffective approach beyond maintaining contact with patients and providing "useful administrative functions" (University of York & NHS Centre for Reviews and Dissemination, 2000:p1). Assertive community approaches were recommended as more beneficial than 'standard' CPA (Marshall & Lockwood, 1999). However, evaluation of case management programs is a highly complex and contentious issue (Brugha & Glover, 1998; Burgess & Pirkis, 1999; Rosen & Teesson, 2001; Ziguras & Stuart, 2000) and is explored by the

authors in relation to the CPA elsewhere (Simpson, Miller & Bowers, in press).

'Community care has failed': the risky shift

Claims persisted that 'community care' had failed. '*Learning the lessons',* produced by the Zito Trust (established by Jayne Zito, a psychiatric social worker and the widow of Jonathan Zito), summarised the findings and recommendations of 54 mental health inquiry reports published in England and Wales (Shepherd, 1996). The Zito Trust argued that mental health policy was too often "a disaster" and that the chances of efficient communication taking place appeared negligible given the failure to implement the CPA and the dreadful state of basic services (ibid: p10). Others were adamant that rather than more supervision there needed to be an improvement in the level of engagement, care and support provided to mentally ill people, especially those from black and other minority ethnic groups (Francis, 1996; Morgan & Hemming, 1999).

Suggestions were also made that the same pressures that had produced the focus on risk assessment and management, now central to the CPA (Busfield, 2000), had encouraged 'defensive' psychiatric practices (Burns Tom & Priebe, 1999; Deahl et al., 2000; Smyth & Hoult, 2000), resulting in 'reinstitutionalisation' within services (Turner & Priebe, 2002). The frequently implied association between mental illness and homicide led Taylor and Gunn (1999) to conduct a detailed review of criminal statistics between 1957 and 1995 in England and Wales. They found little fluctuation in the numbers of

people with a mental illness committing homicide over the 38 years, and a 3%

annual decline in their contribution to official statistics despite the enormous

increase in the number of people being cared for in the community. Whilst

society had witnessed an increase in murders, there had been an annual fall

in the number committed by those with a mental illness. Similar findings have

been reported internationally (Walsh & Fahy, 2002). A separate review of 14

homicide inquiries involving mentally ill people did however emphasise

inadequacies in the planning of care (Parker & McCulloch, 1999). These

findings were given further weight by the National Confidential Inquiry into

Suicide and Homicide by People with Mental Illness in *'Safer Services'*

(Appleby et al., 1999). Considerable failings were described, particularly in the

care of people recently discharged from hospital, the very target group the

CPA was originally introduced to support. Any clinical value of the CPA was

reputedly "in danger of being undermined by its administrative demands"

(ibid: p86).

Users' experiences of the CPA

Service users' experiences of the CPA have been consistently disappointing.

Relatively small studies repeatedly reported little awareness of the policy,

patchy allocation and identification of keyworkers, limited involvement in care

planning, poor use of care plans, and mixed experiences of CPA review

meetings (Lawson et al., 1999; McDermott, 1998; Phillips, 1998; Simpson,

1999a; Wolfe et al., 1997).

A CPA audit in 1998 surveyed 503 patients across five NHS trusts (Webb et al., 2000) and confirmed that key policy components were not being implemented, with wide variation between trusts. Research conducted across England by user researchers reported similar results (Rose, 2003; Rose, 2001). Rose (2001) lamented the lack of transparency in the CPA process and outlined the serious implications of these findings, describing the failure to provide comprehensive care plans as "almost a dereliction of duty" (ibid: p48). The impression gained from staff was that the CPA was seen as "just a paper exercise, which increases their workload with no benefit to care" (ibid: p49). Yet where CPA arrangements are more successfully administered and where service users experienced greater involvement in their care, greater levels of satisfaction are expressed (Beeforth et al., 1994; Webb et al., 2000). This suggests a paradox in which workers complain of the 'bureaucracy' of the CPA but service users value the written care plans and information that care co-ordinators are mandated to deliver.

Carers' experiences of the CPA

The limited research on carers' experiences of the CPA consists mainly of relatively small qualitative studies (Allen, 1998; Carpenter & Sbaraini, 1996; Huang & Slevin, 1999; Simpson, 1999a). Carers commonly reported having little or no knowledge of the CPA, keyworker details or emergency arrangements, and of rarely being involved in the care planning process with their views seldom sought or listened to. Carers' concerns often overlapped with their experiences of mental health services generally.

What went wrong? Money, managerialism and the CPA

The CPA was introduced against a socio-political backdrop that included a concerted effort to reduce public spending across government departments (Onyett, 1998a). No direct funding accompanied the CPA and special project funding required complex arrangements with social services (Peck & Parker, 1998). Additionally, two-thirds of resources for mental health services continued to be allocated to inpatient care with less than a quarter spent on day and community care (Audit Commission, 1994). Lack of suitable community resources was estimated to account for between 24% and 58% of psychiatric bed use (Department of Health, 2000b). The woeful under funding and diversion of mental health funds during this period have since been acknowledged (Appleby, 2000; Department of Health, 1999; Dobson, 2000; Leff & Knapp, 2000).

Reorganisation under the NHS and Community Care Act, 1990, and the establishment of NHS trusts also had an impact by increasing the confidence and authority of trust managers (Peck & Parker, 1998). Pertinently, the introduction and subsequent amendments to the CPA were addressed via circulars addressed to managers within health and social services, creating resentment and resistance amongst many clinicians who viewed managerial attempts to comply with the requirements as "cumbersome and bureaucratic" (Peck & Parker, 1998). There was a failure to sufficiently motivate the workforce and ensure the policy was integrated into everyday practice (Bonner, 2000). Psychiatrists in particular often ignored the CPA and

supervision registers because they saw them as centralised bureaucratic systems, imposed with little consultation and offering little benefit to the service user (Norman & Peck, 1999).

Alongside the rise of managerialism in the NHS came the introduction of targets, standards, performance measures and financial incentives. The percentage coverage of the CPA for eligible users became a measure of performance, with success linked to increased funding of local services. Such initiatives added to the suspicion and resentment of clinical staff faced with implementing the CPA when managers were keen to emphasise 100% coverage 'regardless of the reality of service provision that such statistics masked' (Peck, 1997; Peck & Parker, 1998). An unforeseen effect, perhaps, of a healthcare policy managed by outcome measures (McCartney & Brown, 1999).

Sectorisation and community mental health teams (CMHTs)

Successful execution of the CPA was also dependent on the development of multi-disciplinary CMHTs (Shepherd, 1995). In 1994 there were just over 500 CMHTs in England, by 1996 almost 900 (Onyett et al., 1997). The *'Spectrum of Care'* guidance (Department of Health, 1996) made explicit their role as the cornerstone of specialist mental health service provision and by 1997 CMHTs operated in 82% of trusts in England and Wales (Brooker & White, 1997). Each CMHT provided mental health services to the population of a geographical catchment area but the sectorisation of mental health care had developed without central planning, unlike in other European countries, and

with little evaluation (Johnson & Thornicoft, 1993). Consequently, sectorised teams were engulfed with conflicting demands from referrers and policy makers and struggled to provide a service focused on the needs of people with severe mental illness (Galvin & McCarthy, 1994; Onyett et al., 1994). They also tended not to offer out-of-hours services, relying on inpatient services (Johnson & Thornicoft, 1993).

Despite these and other difficulties, a Cochrane systematic review concluded that the CMHT management of people with severe mental illness increased the maintenance of contact, reduced suicides, reduced the length of hospital admissions, reduced costs and increased patient satisfaction (Simmonds et al., 2001). No significant differences in clinical symptomatology or social functioning were detected. However, these conclusions were drawn from just five eligible studies, just two of which related to typical CMHTs in England (Holloway, 2001). Numerous factors are likely to impact on the effectiveness of teams providing CPA-style community care (Burns & Priebe, 1996). These include bed availability (Tyrer et al., 1998), caseload size and content of therapeutic interventions (Burns et al., 2000), quality of the therapeutic relationship (McCabe & Priebe, in press) and a complex interrelationship between personal/social and psychiatric factors (Wakefield et al., 1998).

Teamwork and the CPA

The effective discharge of individual CPA responsibilities can only occur in the context of a 'well-functioning team' under good leadership (NHS Training Division, 1995; Shepherd, 1995). Key principles identified included the need

to clarify goals and procedures, improve leadership skills, clarify roles, address issues of responsibility and accountability, and to support the team. But CMHTs have been the focus of tensions and difficulties and many of these prerequisites are rarely in place. This has led to high workloads, role ambiguity, stress and low morale for many CMHT staff (Brooker & White, 1997; Chalk, 1999; Edwards et al., 2000; Onyett et al., 1997). Team leadership is often fraught as most CMHT managers lack the knowledge, expertise and support to effectively manage teams that contain professionals with different levels of status, remuneration and power and conflicting educational, cultural and philosophical backgrounds (Norman & Peck, 1999).

Many of the difficulties faced in implementing the CPA and executing the keyworker role related to problems encountered in working as part of a team (Miller et al., 2001; Simpson, 1999b). The CPA lacked a unifying philosophy of care (Norman & Peck, 1999) whilst presuming inter-professional collaboration, but often served only to intensify pre-existing tensions and rivalries amongst team members (Miller & Freeman, 2003). Sharing of professional knowledge, skills and philosophies can create more integrated, collaborative working within teams (Miller et al., 2001) but clinicians within CMHTs often see moves towards greater role overlap as threatening and respond by employing defensive manoeuvres and inflexible role demarcation (Peck & Norman, 1999). Staff may hold contradictory attitudes towards role boundaries, either seeking to remove boundaries in order to facilitate closer teamwork or fearing that the erosion of boundaries would result in role confusion (Brown et al., 2000). Such are the 'messy realities' of mental health care (Warne et al., 2000).

[INSERT FIGURE 4 HERE]

New Labour, new CPA

Despite evidence of the continued struggle to implement many aspects of the CPA, the new Labour government announced a further reform of the CPA as an integral part of the National Service Framework for Mental Health (NSFMH) (Department of Health, 1999a). The CPA would continue to be "*the* framework for care co-ordination and resource allocation in mental health care" and a "model for good practice" (Department of Health, 1999b). Changes included the complete integration of the CPA with social services' care management system, with a single point of referral for the two agencies. The similarities, differences and co-existence of these two systems had been the source of enormous confusion throughout the existence of the CPA (Burns, 1997; Hadley et al., 1996; Holloway, 1991; Marshall et al., 1995; Schneider, 1993). Other changes are detailed in Table 3. The NSFMH also aimed to address the needs of carers, adding more responsibilities to hard-pressed CMHT staff.

Further initiatives including assertive outreach and early intervention teams were contained within the NHS Plan (Department of Health, 2000a), with promises of significantly increased funding for mental health services. But, in light of ongoing difficulties in achieving effective co-ordination and communication, some were concerned that additional teams and extended working hours could create new gaps through which patients might slip (Deahl

et al., 2000). There are also worries that just as CMHTs are beginning to find their feet, staff will escape the excessive responsibilities and overwork of CMHTs to join the new, better-resourced teams. CMHTs may be undermined just as we begin to understand what makes them work (Burns & Catty, 2002). Whether the increased funding of services will bolster and improve CMHTs and the latest manifestation of the CPA remains to be seen. In 2002, Health Minister Jacqui Smith admitted that still just 85% mentally ill patients received a CPA care plan when discharged from hospital (Smith, 2002).

[INSERT FIGURE 5 HERE]

Conclusion

The CPA has improved the ability of services to maintain contact with people with severe mental illness but overall the CPA has not been effectively implemented and the following factors contributed to its failure. The policy was introduced at a time when health and social workers felt under attack from unsympathetic political leaders. No additional funding accompanied the CPA at the same time as health and social service budgets were being cut. Little or no training was provided. The imposition of the policy by politicians and managers was associated with charges that community care had failed whilst there was no acknowledgement of the good work that was often being undertaken within a seriously under-funded and complex area of healthcare. The CPA failed to explicitly build on the knowledge, skills and abilities of the workforce so was seen as a largely bureaucratic and superfluous addition to a

hectic workload, symbolised by carbon-copied assessment and registration forms. The introduction of 'registers' and other measures of close supervision for service users, coupled with inquiries following homicides, created the perception that the CPA was part of a 'blame culture' and that individual workers would be held responsible for often systemic and organisational failures. Staff felt targeted not supported and responded with defensive clinical practice that has increased bed use. No particular model or philosophy appeared to underpin the CPA, thereby failing to unite staff around a common approach whilst the CPA required effective teamwork to succeed. Fledgling CMHTs were characterised by conflicting philosophies and work practices and led by inexperienced managers, operating within organisations often faced with competing and contradictory policy demands. The CPA did not stand a chance.

words/ 3,900

Acknowledgements

References

Allen, C. (1998). The care programme approach: the experiences and views of carers. Mental Health Care, 1(5), 160-162.

Appleby, L. (2000). A new mental health service: high quality and user-led. British Journal of Psychiatry, 177, 290-291.

Appleby, L., Shaw, J., Amos, T., & McDonnel, R. (1999). Safer Services: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. London: Department of Health.

Audit Commission. (1994). Finding a Place. London: HMSO.

Audit Commission. (1986). Making a Reality of Community Care. London: Audit Commission.

Beeforth, M., Conlan, E., & Graley, R. (1994). Have we got views for you: User evaluation of case management. London: Sainsbury Centre for Mental Health.

Belcher, R. (1988). Defining the service needs of homeless mentally ill persons. Hospital and Community Psychiatry, 39(11), 1203-1205.

Bindman, J., Beck, E., Glover, G., Thornicroft, G., Knapp, M., Leese, M., & Szmukler, G. (1999). Evaluating mental health policy in England: Care Programme Approach and supervision registers. British Journal of Psychiatry, 175, 327-330.

Bonner, G. (2000). The CMHN and change. Mental Health Nursing, 20(6), 8-12.

Brooker, C., & White, E. (1997). The Fourth Quinquennial National Community Mental Health Nursing Census of England and Wales. University of Manchester: University of Manchester & University of Keele.

Brown, B., Crawford, P., & Darongkamas, J. (2000). Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. Health and Social Care in the Community, 8(6), 425-435.

Brugha, T., & Glover, G. (1998). Process and health outcomes: need for clarity in systematic reviews of case management for severe mental disorders. Health Trends, 30(3), 76-79.

Burgess, P., & Pirkis, J. (1999). The currency of case management: benefits and costs. Current Opinion in Psychiatry, 12, 195-199.

Burns, T. (1997). Case management, care management and care programming. British Journal of Psychiatry, 170, 393-395.

Burns, T., & Priebe, S. (1996). Mental health care systems and their characteristics: a proposal. Acta Psychiatrica Scandinavica, 94(6), 381-385.

Burns, T. (2000). Supervised discharge orders. Psychiatric Bulletin, 24(11), 401-402.

Burns, T., Fiander, M., Kent, A., Ukoumunne, O. C., Byford, S., Fahy, T., & Kumar, K. R. (2000). Effects of case-load size on the process of care of patients with severe psychotic illness. Report from the UK700 trial. British Journal of Psychiatry, 177, 427-433.

Burns, T., & Priebe, S. (1999). Mental health care failure in England. British Journal of Psychiatry, 174, 191-192.

Burns T., & Catty, J. (2002) Mental health policy and evidence. Psychiatric Bulletin, 26, 324-327.

Busfield, J. (2000). Introduction: Rethinking the sociology of mental health. Sociology of Health and Illness, 22(5), 543-558.

Carpenter, J., & Sbaraini, S. (1996). Involving users and carers in the care programme approach. Journal of Mental Health, 5(5), 483-488.

Chalk, A. (1999). Community mental health teams: reviewing the debate. Mental Health Nursing, 19(2), 12-14.

Coffey, M. (1997). Supervised discharge: concerns about the new powers for nurses. British Journal of Nursing, 6(4), 215-218.

Coid, J. (1994). Failure in community care: psychiatry's dilemma (Editorial). British Medical Journal, 308, 805-806.

Craig, T., Hepworth, C., Klein, O., Manning, P., & Ratcliffe, M. (1993). Homelessness and Mental Health Initiative: Second Report to the Mental Health Foundation . London: RDP.

Craig T., & Timms, P. W. (1992). Out of the wards and onto the streets? Deinstitutionalisation and homelessness in Britain. Journal of Mental Health, 1, 265-275.

Deahl, M., Douglas, B., & Turner, T. (2000). Full metal jacket or the emperor's new clothes? The National Service Framework for Mental Health. Psychiatric Bulletin, 24(6), 207-210.

Department of Health. (1995). Building Bridges: A guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. London: HMSO.

Department of Health. (1990). The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services. HC(90)23/LASSL(90)11. Joint Health and Social Services Circular: DoH.

Department of Health. (1989a). Caring for People: Community Care in the Next Decade and Beyond. London: HMSO.

Department of Health. (1989b). Discharge of Patients from Hospital. Health Circular HC(89)5. London: Department of Health.

Department of Health. (1999b). Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. A Policy Booklet. London: HMSO.

Department of Health. (1992). The Health of the Nation: A strategy for health in England. London: HMSO.

Department of Health. (1993). The Health of the Nation Key Area Handbook, 1st Edition. London: HMSO.

Department of Health. (1994). The Health of the Nation Key Area Handbook, 2nd Edition. London: HMSO.

Department of Health. (2001). The journey to recovery - the Government's vision for mental health care. London: Department of Health.

Department of Health. (1995). Mental Health (Patients in the Community) Act. London: HMSO.

Department of Health. (1999a). National Service Framework for Mental Health: Modern Standards and Service Models. London: HMSO.

Department of Health. (2000a). The NHS Plan: a plan for investment, a plan for reform. London: Department of Health.

Department of Health. (2000b). Shaping the future NHS: long term planning for hospitals and related services. Consultation document on the findings of The National Beds Inquiry. London: Department of Health.

Department of Health. (1996). The Spectrum of Care: local services for people with mental health problems. London: HMSO.

DHSS. (1988). Report of the Committee of Inquiry into the Care and Aftercare of Sharon Campbell. (Chairman: J.Spokes) . London: HMSO.

Dobson, R. (2000). NHS accused of diverting money. Community Care, (4-10 May), 4-5.

Edwards, D., Burnard, P., Coyle, D., Fothergill, A., & Hannigan, B. (2000). Stress and burnout in community mental health nursing: a review of the literature. Journal of Psychiatric and Mental Health Nursing, 7(1), 7-14.

Ferguson, B. (1996). Principles of computers in care management and the care programme approach. British Journal of Hospital Medicine, 56(9), 466-469.

Francis, E. (1996). Community care, danger and black people. OpenMind, 80(April/May), 4-5.

Galvin, S. W., & McCarthy, S. (1994). Multi-disciplinary community teams: clinging to the wreckage. Journal of Mental Health, 3, 157-166.

Godin, P., & Scanlon, C. (1996). Community supervision. Nursing Management, 3(5), 12-13.

Godin, P., & Scanlon, C. (1997). Supervision and control: a community psychiatric nursing perspective. Journal of Mental Health, 6, 75-84.

Gould, M. (2002). Private beds for psychiatric care cost NHS £200m a year. The Independent on Sunday, 15th September, 2.

Griffiths, R. (1988). Community care: agenda for action. London: HMSO.

Hadley, T. R., Muijen, M., Goldman, H., & Shepherd, G. (1996). Mental health policy reform and its problems in the UK: deja vu. Current Opinion in Psychiatry, 9, 105-108.

Hallam, A. (2002). Media influences on mental health policy: Long-term effects of the Clunis and Silcock cases. International Review of Psychiatry, 14(1), 26-33.

Hamilton, I., & Roy, D. (1995). The care programme approach at work in mental health care. Nursing Times, 91(51), 35-37.

Health Committee Report. (1994). Better off in the community? London: HMSO.

Hogman, G. (1992). Window Dressing, The Care Programme Approach and the Mental Illness Specific Grant April 1991-1992 - the First Year. Kingston upon Thames: National Schizophrenia Fellowship.

Holloway, F. (1991). Case management for the mentally ill: Looking at the evidence. The International Journal of Social Psychiatry, 37(1), 2-13.

Holloway, F. (2001). Invited commentary on: Community mental health team management in severe mental illness. The Community Mental Health Team: What we know and what we do not know. British Journal of Psychiatry, 178, 503-505.

House of Commons. (1985). Second Report from the Social Services Committee Session 1984-85. Community Care with special reference to adult mentally ill and mentally handicapped people ('The Short Report'). London: HMSO.

Huang, M.C., & Slevin, E. (1999). The experiences of carers who live with someone who has schizophrenia: a review of the literature. Mental Health Care, 3(3), 89-93.

Huxley, P., Reilly, S., Mohamad, H., & Harrison, J. (1998). Severe mental

illness: comparing CPNs' and social workers' input. Mental Health
Nursing, 18(3), 14-17.

Intagliata, J. (1982). Improving the quality of community care for the
chronically mentally disabled: The role of case management.
Schizophrenia Bulletin, 8(4), 655-674.

Johnson, S., & Thornicoft, G. (1993). The sectorisation of psychiatric services
in England and Wales. Social Psychiatry & Psychiatric Epidemiology ,
28, 45-47.

Kingdon, D. (1996). Supervision registers: caring or controlling? British
Journal of Hospital Medicine, 56(9), 470-472.

Lawson, M., Strickland, C., & Wolfson, P. (1999). User involvement in care
planning. Psychiatric Bulletin, 23, 539-541.

Leff, J., & Knapp, M. (2000). The TAPS Project: A report on 13 years of
research, 1985-1998. Psychiatric Bulletin, 24(5), 154-168.

Margerison, N. (1998). Care Programme Approach in practice. Hospital
Medicine, 59(2), 130-133.

Marlowe, M. J., White, C., & White, K. J. (1999). Mental health needs of
populations and the burden of secondary care: An audit of patients
assessed under the Care Programme Approach in South East Kent.
Journal of Mental Health, 8(5), 533-538.

Marshall, M., Gray, A., Lockwood, A., & Green, R. (2001). Case management
for people with severe mental disorders (Cochrane Review). In The
Cochrane Library (4). Oxford: Update Software.

Marshall, M., & Lockwood, A. (1999). Assertive community treatment for
people with severe mental disorders (Cochrane Review). The
Cochrane Library, Oxford, (3).

Marshall, M., Lockwood, A., & Gath, D. (1995). Social services case-
management for long-term mental disorders: a randomised controlled
trial. The Lancet, 345, 409-412.

May, P. (1996). Joint training for mental health key workers: Part 1. Nursing
Standard, 10(43), 39-42.

McCartney, S., & Brown, R. B. (1999). Managing by numbers: using outcome
measures in the NHS. International Journal of Health Care Quality
Assurance, 12(1), 6-12.

McDermott, G. (1998). The Care Programme Approach: A patient
perspective. NTresearch, 3(1), 47-64.

Miller, C., & Freeman, M. (2003). Clinical Teamwork: the impact of policy on
collaborative practice. In A. Leathard (Editor), Interprofessional
Collaboration: From Policy to Practice in Health and Social Care.

London: Routledge. pp 121-132.

Miller, C., Freeman, M., & Ross, N. (2001). <u>Interprofessional Practice in Health and Social Care: Challenging the shared learning agenda</u>. London: Arnold.

Morgan, S., & Hemming, M. (1999). Balancing care and control: risk management and compulsory treatment. <u>Mental Health Care, 3</u>(1), 19-21.

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. <u>Schizophrenia Bulletin, 24</u>(1), 37-74.

NHS Executive. (1994). <u>Health Service Guidelines HSG (94) 27.</u> London: Department of Health.

NHS Training Division. (1995). <u>Building on Strengths: Developing the Care Programme Approach</u>. Bristol: NHS Executive.

Nolan, P., Oyebode, F., & Liburd, M. (1998). A survey of patients placed on the supervision register in one mental health trust. <u>International Journal of Nursing Studies, 35</u>, 65-71.

Norman, I. J., & Peck, E. (1999). Working together in adult community mental health services: An inter-professional dialogue. <u>Journal of Mental Health, 8</u>(3), 217-230.

North, C., Ritchie, J., & Ward, K. (1993). <u>Factors Influencing the Implementation of The Care Programme Approach.</u> London: HMSO.

Onyett, S. (1998a). <u>Case Management in Mental Health</u>. Cheltenham: Stanley Thornes (Publishers) Ltd.

Onyett, S. (1998b). An exploratory study of English community mental health teams (Unpublished PhD: University of Liverpool).

Onyett, S., Hepplestone, T., & Bushnell, D. (1994). A national survey of community mental health teams. Team structure and process. <u>Journal of Mental Health, 3</u>, 175-194.

Onyett, S., Pillinger, T., & Muijen, M. (1997). Job satisfaction and burnout among members of community mental health teams. <u>Journal of Mental Health, 6</u>(1), 55-66.

Onyett, S., Standen, R., & Peck, E. (1997). The challenge of managing community mental health teams. <u>Health and Social Care in the Community, 5</u>(1), 40-47.

Ovretveit, J. (1993). <u>Co-ordinating community care: multi-disciplinary teams and care management</u>. Buckingham: Open University Press.

Parker, C., & McCulloch, A. (1999). <u>Key Issues from Homicide Inquiries</u>.

London: MIND.

Peck, E. (1997). Ethics Man - at odds with truth. Health Service Journal, 5542, 104.

Peck, E., & Norman, I. J. (1999). Working together in adult community mental health services: Exploring inter-professional role relations. Journal of Mental Health, 8(3), 231-242.

Peck, E., & Parker, E. (1998). Mental health in the NHS: Policy and practice 1979-98. Journal of Mental Health, 7(3), 241-259.

Phillips, P. (1998). The care programme approach: the views and experiences of service users. Mental Health Care, 1(5), 166-168.

Powell, R., & Slade, M. (1996). Defining severe mental illness. In G. Thornicroft, & G. Strathdee (Editors), Commissioning mental health services . London: HMSO.

Reynolds, A., & Thornicroft, G. (1999). Managing Mental Health Services. Buckingham: Open University Press.

Ritchie, D. J., & Lingham, D. R. (1994). The Report of the Inquiry into the Care and Treatment of Christopher Clunis. London: HMSO.

Rogers, B. (1996). Supervised discharge: implications for practice. Mental Health Nursing, 16(2), 8-10.

Rose, D. (2003). Partnership, co-ordination of care and the place of user involvement. Journal of Mental Health, 12(1), 59-70.

Rose, D. (2001). Users' Voices: The perspectives of mental health service users on community and hospital care. London: Sainsbury Centre for Mental Health.

Rosen, A., & Teesson, M. (2001). Does case management work? The evidence and the abuse of evidence-based medicine. Australian and New Zealand Journal of Psychiatry, 35, 731-746.

Ryan, T. (1994). The risk business. Nursing Management, 1(6), 9-11.

Schneider, J. (1993). Care Programming in Mental Health: assimilation and adaptation. British Journal of Social Work, 23, 383-403.

Scott J. (1993). Homelessness and mental Illness. British Journal of Psychiatry, 162, 314-324.

Secretary of State for Health. (1994). Letter to the President of the Royal College of Psychiatrists. Psychiatric Bulletin, 18, 387-388.

Shepherd, D. (1996). Learning the lessons - mental health inquiry reports published in England and Wales between 1969 and 1996 and their recommendations for improving practice (Second Edition). London:

Zito Trust.

Shepherd, G. (1995). Multi-disciplinary team-working: The essential background to the Care Programme Approach. In NHS Training Division <u>Building on Strengths: Developing the Care Programme Approach</u>. Bristol: NHS Executive.

Simmonds, S., Coid, J., Joseph, P., Marriott, S., & Tyrer, P. (2001). Community mental health team management in severe mental illness: a systematic review. <u>British Journal of Psychiatry, 178</u>, 497-502.

Simpson, A. (1998). <u>Creating Alliances: the development of the community mental health nurse in supporting people with severe and enduring mental health problems in the community</u>. Eastbourne: Sussex Education Consortium.

Simpson, A. (1999a). Creating Alliances: the views of users and carers on the education and training needs of community mental health nurses. <u>Journal of Psychiatric and Mental Health Nursing, 6</u>(5), 347-356.

Simpson, A. (1999b). Focus on training. <u>Nursing Times, 95</u>(47), 67-68.

Simpson, A. (2000). Taking a pounding. <u>Health Service Journal, 110</u>(5710), 26-27.

Smith, J. (2002). Written answer to Paul Marsden, MP. <u>Hansard, 7th November.</u> Column 524W.

Smyth, M. G., & Hoult, J. (2000). The home treatment enigma. <u>British Medical Journal, 320</u>, 305-308.

Social Services Inspectorate. (1999). <u>Still Building Bridges: The report of a national inspection of arrangements for the integration of Care Programme Approach with Care Management</u>. London: Department of Health.

Sone, K. (1992). The luck of the draw. <u>Community Care, </u>(30th January), 29-31.

Stein, L. I., & Test, M. A. (1980). Alternative to Mental Hospital Treatment 1. Conceptual model, treatment program and clinical evaluation. <u>Archives of General Psychiatry, 37</u>(April), 392-397.

Taylor, P. J., & Gunn, J. (1999). Homicides by people with mental illness: myth and reality. <u>British Journal of Psychiatry, 174</u>, 9-14.

Turner, T., & Priebe, S. (2002). Forget community care - reinstitutionalisation is here. <u>British Journal of Psychiatry, 181</u>, 253.

Turner, T., Salter, M., & Deahl, M. (1999). Mental Health Act reform: Should psychiatrists go on being responsible? <u>Psychiatric Bulletin, 23</u>, 578-581.

Tyrer, P., Evans, K., Gandhi, N., Lamont, A., Harrison-Read, P., & Johnson, T. (1998). A randomised controlled trial of two models of care for discharged psychiatric patients. British Medical Journal, 316, 106-109.

University of York & NHS Centre for Reviews and Dissemination. (2000). Psychosocial interventions for schizophrenia. Effective Health Care, 6(3), 1-8.

Wakefield, P., Read, S., Firth, W., & Lindesay, J. (1998). Clients' perceptions of outcome following contact with a community mental health team. Journal of Mental Health, 7(4), 375-384.

Walker, L. B. P. (1998). The required role of the CPN: uniformity or flexibility? Clinical Effectiveness in Nursing, 2, 21-29.

Wallace, M. (1986). A caring community? The plight of Britain's mentally ill. Sunday Times Magazine, 3rd May, 25-38.

Walsh, E., & Fahy, T. (2002). Violence in society: Contribution of mental illness is low. British Medical Journal, 325, 507-8.

Warne, T., Skidmore, D., Stark, S., & Stronach, I. (2000). Implications of current mental health policy for the practice and education of the mental health workforce. Mental Health and Learning Disabilities Care, 4(2), 48-52.

Webb, Y., Clifford, P., Fowler, V., Morgan, C., & Hanson, M. (2000). Comparing patients' experience of mental health services in England: a five-Trust survey. International Journal of Health Care Quality Assurance, 13(6), 273-281.

Wells, J. S. G. (1997). Priorities, 'street level bureaucracy' and the community mental health team. Health and Social Care in the Community, 5(5), 333-342.

Wolfe, J., Gournay, K., Norman, S., & Ramnoruth, D. (1997). Care Programme Approach: evaluation of its implementation in an inner London service. Clinical Effectiveness in Nursing, 1, 85-91.

Ziguras, S. J., & Stuart, G. W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. Psychiatric Services, 51(11), 1410-1421.

Figure 1: Key features of the CPA (1991)

- Systematic arrangements for assessing health and social needs
- Provision and regular review of a written care plan
- Close monitoring and co-ordination by a named keyworker
- Involvement of users and carers in planning and provision of care
- Inter-professional and inter-agency collaboration
- CPA Register
  (From Department of Health, 1990)

Figure 2: Factors undermining initial implementation of the CPA

- Confusion with social services' care management system
- Shortage of resources
- Insufficient training
- Disagreement over aspects of the policy
- Time restraints
- Lack of agreed standards
- Varying levels of motivation and awareness amongst staff
- Resistance and resentment
  (Summarised from North et al 1993 and Schneider, 1993)

Figure 3: Key amendments and additions to CPA

- Tiers - to target resources and limit administration

- Supervision registers - to identify and target patients at most risk

- Supervised discharge - designated supervisors can 'take and convey' patients to where care plan specifies they reside or receive treatment

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Figure 4: Key changes to the CPA introduced in 1999

- Complete integration with care management
- Tiers replaced by 'standard' and 'enhanced' CPA
- Supervision registers abolished
- Review of care plans relaxed and clarified
- Care plans to include crisis and contingency arrangements
- Enhanced care plans to include employment, accommodation and finances - extended to all by March 2004 (Department of Health, 2001)
- Care co-ordinator replaces keyworker at preference of users (Social Services Inspectorate, 1999)
  (From Department of Health, 1999b)

Figure 5: Timeline illustrating history of the CPA and related events			
1986	Audit Commission '*Making a reality of community care*' calls for reorganisation of community care.	Sunday Times Magazine articles, '*The plight of Britain's mentally ill*' by Marjorie Wallace, highlights lack of support for users and carers.	
1988	'Spokes Inquiry' following killing of mental health worker by patient, recommends care plans, register of mentally ill and keyworkers.	'*Community Care: Agenda for Action*' (Griffiths Report) recommends care packages, case managers, 'ring-fenced' funding and ministerial responsibility for community care.	
1989	White Paper '*Caring for People*' largely incorporates Griffiths report but no protected funding.	'*Community Care: in the next decade and beyond*' includes plans to introduce care management in social services.	
1990	NHS & Community Care Act - massive NHS reorganisation, includes 'internal market', NHS trusts and GP 'fund-holders'. Dwarfs and delays proposals for reform of community care.	Guidance issued on discharge from hospital of mentally ill patients.	**CPA** guidance issued – to be implemented by April 1991 for all people under care of specialist psychiatric services.
1991	CPA introduced: assessments, care plans, keyworkers and regular reviews.		
1992	Mental health key policy area in '*Health of the Nation*' strategy.	Christopher Clunis murders Jonathan Zito.	
1993	Early evaluations of CPA report difficulties and resistance (North, *et al;* 1993; Scheider, 1993*)*.	Ben Silcock filmed climbing into lion's den at London Zoo.	'*Health of the Nation Mental Illness Key Area Handbook*'.
1994	'*Ritchie Report*' into care and treatment of Christopher Clunis reports woeful lack of inter-agency communication.	NHS Executive plan inquiries for all homicides involving mentally ill people.	Audit Commission – two-thirds of mental health funding still spent on inpatient care.
	House of Commons Committee report, '*Better off in the community?*' describes fragmented services and failure to implement or evaluate CPA.	Secretary of State for Health issues '*Ten Point Plan*' that aims to improve community care for mentally ill people: includes supervision registers, supervised discharge (from April 1996) and better training for keyworkers.	
1995	'*Building Bridges*' and '*Building on Strengths*' outlines need for inter-agency working for effective CPA, acknowledges tiers and loosely defines 'severe mental illness'.	'*Mental (Patients in the Community) Act, 1995*' - CPA becomes statutory.	'*Carers (Recognition and Services) Act, 1995*' – family carers entitled to needs assessment.
1996	Zito Trust '*Learning the Lessons*' reviews 54 homicide inquiries and finds continued failure to implement the CPA.	'*Spectrum of Care*' CMHTs key to community mental health services.	900 CMHTs in England (up from 500 in 1994) (Onyett, et al 1997).
1999	Review of criminal statistics reveals rise in homicides in society but decrease in proportion due to mentally ill people (Taylor & Gunn, 1999).	'*Safer Services*' suicides and homicides report suggests focus on admin undermines CPA aftercare.	Review of mentally ill homicides finds inadequacy in care planning with CPA not implemented (Parker & McCulloch, 1999).
	'*National Service Framework for Mental Health*' and '*Effective Care Co-ordination*' **CPA reformed and re-affirmed as key mental health policy framework**.		
2000	National Beds Inquiry - lack of community services account for 24%-58% psychiatric bed use.	Mental health director acknowledges mental health funds diverted in the past (Appleby, 2000).	NHS Plan includes promises of significantly increased funding for mental health services.
2001	'*Users' Voices*' reports user-led research in which continued failure to fully implement CPA described as "almost a dereliction of duty" (Rose, 2001).		
2002	Government health minister acknowledges that only 85% mentally ill patients discharged from hospital with CPA Care Plan (Smith, 2002).		