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Editorial: considering metrics for nursing

by John Butler – Chair of Editorial Group

Within the landmark document, High Quality Care for All – the NHS Next Stage Review, there is an explicit focus on safety and quality, with quality improvement as the key organising principle for the NHS (DH 2008a). Setting out the future development of the NHS and building on the NHS Plan, staff are viewed as agents of change, empowered to improve services through innovation. This Review included a commitment to developing quality measurement for nursing that reflects the compassion (the patient experience), safety and effectiveness (the positive contribution to well-being) of nursing care.

Nursing is viewed as ‘fundamental to high quality healthcare….’ being ‘in a strong position to improve the care that patients experience’ (DH 2008b: 5). Demonstrating how the quality of care is being enhanced will require a consideration of different methods of assessing the nursing contribution to care, with a focus upon outcomes rather than processes. In fact, we can only be sure to improve what we can measure: measurement is therefore viewed as the backbone of quality improvement.

Deciding which indicators are most meaningful, of course, is a significant challenge for nurses, though one which merits active consideration and involvement. Commissioned by the Department of Health, Griffiths et al (2008) conducted a rapid appraisal of the state of the art in developing meaningful ‘metrics’ for nursing (Griffiths et al 2008), with the aim of developing a set of measures or indicators that identify and quantify the quality of nursing care.

Griffiths et al (2008) highlighted four key components of meaningful nursing metrics:

- the indicator must be measurable, with easily accessible data;
- the indicator must evidence the quality or quantity of nursing, that substantially contributes to the changes that are measured;
- the indicator must be recognised as important – to the public, managers and nurses;
- the nursing contribution must be recognised, by nurses and others.
In their review of what would represent a practical, valid and useful indicator of nursing practice, Griffiths et al (2008: 18-19) identified a number of front runners – those with stronger evidence of an association with the variation in the quality of nursing. These included:

- indicators of safety: failure to rescue; healthcare associated pneumonia and infections; pressure ulcers; falls
- indicators of effectiveness (known to be associated with the quality of practice): staffing levels and patterns; staff satisfaction; staff perception of the practice environment
- indicators of compassion / the patient experience: the direct experience of care (patient satisfaction); communication / involvement.

However, they emphasised that much of the available information about nursing metrics had thus far been based upon general nursing care, rather than mental health or learning disability nursing. So the question remains: what would be a set of meaningful metrics for the quality of nursing practice in mental health / learning disability services? It seems that individual organisations will have some scope to select which metrics to apply, making this question all the more important. I wonder what nurses and other practitioners within the Trust would consider meaningful indicators of their work.

Thinking about the practice of those practitioners who are providing psychosocial intervention (PSI), as an example, through the Department of Talking Therapies we are actively encouraging practitioners to monitor outcomes, which involve: (1) use of the OQ45.2 and HoNOS outcomes questionnaires; and, (2) use of a personalised problem severity and goal attainment tool with the service-user / client. Early findings show that 2/3rds of service-users receiving PSI are achieving positive outcomes – this is a very positive finding. Establishing metrics as part of routine practice is an important challenge for us all.

Department of Health (2008b) Framing the Nursing and Midwifery Contribution: driving up the quality of care. London: DH
Specialist Healthcare Inclusion Group

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Service-User Involvement

Introduction

My name is Mark Crearer – I live in a flat independently in the community where I am supported by staff from Papworth Trust for 20 hours a week, and by TARMO twice a week. I am a member of the Specialist Health Care Inclusion Group. My role within this group is to look at what life is like for people using the Specialist Health Care Services and to help improve the services on offer.

This is the first project that I have done myself for the inclusion group and I was supported by Miranda MacGowan, a staff member on the Inclusion Group, to visit the Assessment and Treatment Units within the Specialist Health Care Service:

1. Wood Lea Clinic
2. The Willows
3. In-patient Intensive Support Team (IST)

What I found out

For the most part, the people I saw where welcoming, friendly and happy to answer the questions I had pre-prepared.

- **Wood Lea Clinic** – I was pleasantly surprised, as I am aware that Wood Lea Clinic is a secure service, as to how welcoming the environment is given that you cannot enter or leave the service without being let in / out.
Many of the service users where happy to inform me they had organised day activities. Only a handful could pop out to the shops either with or without staff, for example, but this was planned. I was also informed by the service users that they held weekly meetings where they had the opportunity to discuss and review responses / actions from requests made by them to improve their time at Wood Lea Clinic.

The only drawback was that some service users who cannot access community facilities would have liked more space to do activities such as cooking, social skills training and educational work, as it can get overcrowded and noisy.

- **The Willows** – Prior to my visit, I was informed about protected meal times. Staff at the Willows said I could visit before 12 noon or after 1.30pm. I thought this was a good idea as it respected the individual’s choices to not be interrupted. I was made very welcome at the Willows and I thought it was very different to Wood Lea Clinic. It was more homely and the service users I did speak to informed me that they went out to the cinema and shopping, for example, though needed staff support for reasons such as being unsteady on their feet. The in house day activities, I observed, were more social activity based, rather than educational and skills based.

- **IST (In-patient Service)** – I was made welcome and had the opportunity to speak to one service user. Although I would have liked to have talked to other service users, the staff felt that I would perhaps not gain a response as they didn’t communicate well. Though I did not question this, I was aware from the staff response to my question, ‘are individuals involved in developing their own care plans?’, that most are but some can cause difficulty for them as they have not been given training to use sign language. The service user I did speak to said they were able to express their ideas about what they could do with their time whilst at the unit and were involved in developing their care plan. The service user did express that staff were not always available to take them out and this therefore prevented them from doing activities such as going to the cinema. The staff member supporting the service user did say that all efforts to take individuals out were made, but staff shortage was an issue.
I was shown, by staff, where the in house activities were held and thought it was brilliant that it was separate to the main living environment. The service user reported that this facility was really good as it could get noisy in the main living area. The service user informed me that they could choose activities and attend a set social skills training group.

When asking about meetings, the service user told me that a service user meeting was held weekly (similar to Wood Lea Clinic) and that he could attend ward round, which I was told by staff was a review of an individual’s progress and recommendations involving all who support the service user. The service user said this was good as they knew what was going on.

**Conclusion**

I felt that my visits to the unit’s were really useful as I got to meet individuals who access the service and to see if ‘Valuing People’ is really occurring. Most of the people I spoke to in the Assessment and Treatment Units thought that it was important that there was support for them and that they could make own choices – this I heard and observed was happening.

Some of the service users asked why I was asking questions and, when I told them about my role, they felt that this could be something they could do, and I agreed. I think more individuals with learning disabilities should review the services.

*Finally, just one niggling thought: I am a bike rider, but on my visits there was no place to chain my bike to. I am aware it’s the same when I go to Twinwoods.*
Best Interests Assessment Process under the Deprivation of Liberty Safeguards (MCA 2005 / MHA 2007): a brief overview

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Case Study

Introduction
The Deprivation of Liberty Safeguards (DOLS) were introduced to provide a legal framework from the lessons learnt in the case of HL v the United Kingdom (2004 Application No: 00045508/99) to prevent breaches of the European Convention on Human Rights (ECHR). HL, an autistic man with a learning disability was admitted to Bournewood Hospital on an informal basis under common law, in his best interests. This decision was challenged by his carers. The European Court of Human Rights (ECtHR) held that this it constituted a deprivation of liberty in breach of Article 5(1) of the ECHR, and there had also been a contravention of Article 5(4) of the ECHR. This is because HL had no means to apply to the court to see if the deprivation of liberty was lawful (MCA 2005 Code of Practice). To prevent further similar breaches of the ECHR, the Mental Capacity Act 2005 was amended through the Mental Health Act 2007, in order to provide safeguards for people who lack capacity, and this would be implemented from the 1st of April 2009.

The principles of the Mental Capacity Act 2005 (MCA 2005), Deprivation of Liberty Safeguards (DOLS) and the respective Codes of Practice (CoP) will be referred to through a case study exercise, within which I will explore, account for and establish the whole range of factors, such as type, duration, effects and manner of implementation, to either restrict or deprive of liberty. This will provide an illustration of how DOLS will affect the professional in practice. Furthermore, I will explore the key criteria used by the Department of Health Deprivation of Liberty Standard Authorisation Forms Nos. 5 – 10 and 24 to record the decision, conditions and recommendations for the Managing Authority and the Supervisory Body to establish and authorise DOLS.
Brief Scenario
For the purpose of this exercise, the service user will be known as John Carter (JC), who is 41, suffers from a moderate learning disability and has suffered brain injury after a road traffic accident that resulted in epilepsy. His epilepsy is controlled by medication. Over the past few years, he has been living in a residential home where he was able to go out by himself to the local shops and parks. He enjoys his freedom of doing these activities daily. He is also able to manage small amounts of money for his daily needs.

Family History
He is one of two siblings: his younger sister Sally has two children. His father had died ten years ago. Very recently his mother had been diagnosed with dementia and is cared for in a residential care home. Until recently, his sister Sally had been visiting him regularly and had been attending to his affairs, though she has not recently been able to visit him due to her own children’s illnesses.

Recent Events
JC was taken by the staff to visit his mother and during the visit she became agitated and began to shout at JC. JC’s carers had to terminate the visit. Recent observations made by staff are that: JC isolates himself; he has lost his appetite and thus has lost weight; and, that he has not been his usual self. On several occasions, he had returned to the home without his sweets and money. JC has been found wandering, confused and distressed in the middle of the road, and was brought back on two occasions by Police Officers. When JC was accompanied by staff to the park, JC became agitated, shouting at children and was reluctant to return. JC continued requesting to see his mother and he has not been out for four days.

Management Plan
Decisions were made that JC has to be accompanied on any outings by two members of staff. They expressed that they are unable to guarantee that JC can be taken out at least once or twice a week. The Managing Authority, ‘the care home’ (Care Standards Act Part 2, 2000), has applied to the Supervisory Body, ‘the Local Authority’ (National Assistance Act 1948), for standard authorisation and have appointed a Best interest Assessor (Mental Capacity Regulations 2008). The Managing Authority should inform the relevant person’s (Mental Capacity Regulations 2008) family...
and friends about the application to the Supervisory Body (CoP DOLS 2008: 34).

Identifying Restriction or Deprivation of Liberty

**Fig. 1: Rating Scale**

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I have considered JC’s circumstances and behaviours within and outside the care home. The facts remain that he is unable to go out to the shops, parks or visit his mother without an escort as and when he wishes. Under these circumstances he is restricted of his liberty, and if JC is unable to go out at all, JC is deprived of his freedom of movement (Mental Capacity Act 2005: Sec 6(4)). His past history of activities shows that he had been enjoying the daily outings and had been semi independent for some years. Now JC is unable to go out and constraints have been imposed due to the fact that the staffing levels cannot be adjusted and practicable steps are not considered to resolve these issues, in a least restrictive manner, to maximise his choices. This impact on JC is not considered in his best interest (Principles of Mental Capacity Act 2005). Therefore, it would be considered that JC is subject to *Deprivation of Liberty*. The above rating scale (**Fig. 1**) is a useful tool for analysing weighting scores, that will assist the assessor in making decisions.

While investigating the issue around restriction and deprivation of liberty, it is vital to have access to all his care plans, daily records about his behaviour, weight charts, daily activity charts, medical records, risk assessments and management plans. Interviews will be arranged (Mental Capacity Act 2005: Sec 4(7)) to see JC’s Registered Care Manager of the care home, the carers, his sister Sally, whilst also accessing any other assessments and reviews that have been carried out by other significant professionals who have been involved in his direct care over the last twelve months (CoP DOLS: 40). For this process of Best Interest Assessment, should his sister Sally agree, she would be appointed as the relevant person’s representative by the Best Interest Assessor (Mental Capacity Regulations 2008: 77). If Sally is unable, then the Best Interest
Assessor will refer to the Supervisory Body in appointing a relevant person’s representative. The Best Interest Assessor explains the role to the relevant person’s representative and informs the Supervisory Body. It may be necessary to consider a Section 39A Independent Mental Capacity Advocate (IMCA) to act in JC’s best interest.

The types of interventions in JC’s care plans and the lack of extra staff in the duty roster does not reflect that it is in the best interest of JC. As JC is not allowed out alone, indirectly he is physically prevented which indicates that he is restrained. JC has not been out for the duration of four days, and with no definite arrangements being put in place for him to go out, this leads me to believe that the score on the rating scale (Fig. 1) has moved to 8 and above. The psychological impact may be a causal link to his behavioural changes. Furthermore, JC’s curtailed outdoor activities could exacerbate disturbed behaviour. The fact that he is going up to the front door and asking for his mother is indicative of his desires and wishes and may have a negative effect on his thoughts and behaviour. It is necessary that JC engages and participates in the management and decision making process as the relevant person (Mental Capacity Regulations 2008: 77).

He may also feel traumatised by his sister’s absence, as she has been a support to him. It is required that Sally is aware of JC’s situation and the application of standard authorisation and such needs to be clarified: whether she accepts or objects to the measures proposed by the Managing Authority. If these restrictions are to continue, the cumulative effect and the risk of psychological and physical harm would be detrimental to his quality of life. This cumulative effect would constitute deprivation of liberty even though the individual actions may not. In JC’s case, Deprivation of Liberty is established and the actions proposed are not permitted under the Mental Capacity Act 2005, therefore it is necessary to proceed with a DOLS assessment.

**DOLS Assessment Process** (CoP DOLS 2008: 4.23 – 4.76)

The regulation for England specifies that all assessments required for standard authorisation must be completed within 21 calendar days. As the appointed Best Interest Assessor (BIA), the Supervisory Body has to be satisfied with the requirements under the Mental Capacity Act 2005 and Regulations 2008 and be protected against any liabilities. The DOLS assessment process requires that all six assessments are completed before
the authorisation is approved by the Supervisory Body. It is necessary for the Best Interest Assessor to coordinate the six assessments before recommending authorisation.

1. **Age Assessment**
DOLS only applies to those aged 18 years and over (CoP DOLS 2008: 1.12). If the age is in doubt, it should be established by a birth certificate or other evidence that the assessor considers reliable. This assessment can be conducted by a Best Interest Assessor. In JC’s case, he is 41 and this can be verified with his sister and the care home manager.

2. **No Refusal Assessment** (Mental Capacity Act 2005: Sec 24-26; CoP DOLS 2008: 4.26 – 4.28)
From the information gathered from JC’s records, there is no evidence of advance decisions to refuse treatment. JC is compliant with prescribed medication for his epilepsy and staff have not raised any concerns. This assessment can be carried out by the Best Interest Assessor.

3. **Mental Capacity Assessment**
The purpose of this assessment is to establish whether JC (the relevant person) has the capacity to make decisions for specific tasks or activities at specific times. Section 1 to 3 of the Mental Capacity Act 2005 guides anyone who is competent to carry out the capacity assessment. The regulations for England specify that the mental capacity assessment can be undertaken by the Mental Health Assessor and the Best Interest Assessor. Alternatively, in some cases, the Supervisory Body can consider asking the eligible assessor, who may have known the relevant person, to carry out this assessment, which may be easier for the relevant person and for the purpose of DOLS.

For JC, the capacity assessment commenced by asking the following questions as the preliminary stage (Mental Capacity Act 2005: Sec 2 & 3):

- Does JC have impairment or a disturbance in his brain or mind? JC has impairment and a disturbance due to the fact he has an acquired brain injury, a moderate learning disability and epilepsy.

- Does the disturbance or impairment affect his decision making process? The second stage (Mental Capacity Act 2005: Sec 2 & 3) test
was to find out whether JC can understand, retain the information given to him, be able to weigh the pros and cons of that information, and be able to communicate his decisions. He has capacity to make decisions for specific tasks and at specific times. He is unable to make decisions to manage himself when he is out of the care home, as he has been found to be distressed, confused and wandering. Therefore, JC does lack capacity to be safe and to remember to return to his accommodation. He also did not know how and where he spent his money, but he knows that he wants to visit his mother though he would not know where she lives.

A patient may be so agitated or overactive in his or her behaviour that it may be impossible to impart relevant information…. Mood may be very important in determining capacity. Anxiety may also have some effect on the assessed level of capacity……. Disorientation is usually a marker of brain dysfunction, for instance in delirium or dementia and in these conditions capacity is commonly impaired... (Mental Capacity Guidance 2004: 155-7).

JC lacks capacity in certain areas of his activities and at certain times. This could be temporary and fluctuating. The change observed in JC’s behaviour has been since the visit to his mother. This behaviour could be either responsive or reactive to his mother’s behaviour. This could be different from the knowledge he may have retained of her normal behaviour, and the change in his mother’s behaviour could have been traumatic. It is possible for him regain capacity to the level he was prior to this episode. Reviewing the possibility of his regaining capacity to this level should be a priority, and regarded as in his best interest. This means that specialist services need to assess and establish his ability to communicate, and his level of understanding of the use of simple language and pictorial aids.

- Does he understand the information about the choices he has (CoP DOLS 2008: 45)? Does JC need to continue to live in the care home at this relevant time? This needs to be clarified by consulting with his sister Sally, an IMCA and the Care Coordinators, in considering their points of view.
4. Mental Health Assessment

This assessment is conducted to establish whether JC has a mental disorder, as defined in the Mental Health Act 2007. That means any disorder or disability of the mind, apart from dependence on alcohol or drugs, which includes all learning disabilities. This is not to determine whether JC requires mental health treatment. The objective of this assessment is to medically diagnose JC as being of ‘unsound mind’, within the scope of Article 5 of the ECHR (CoP DOLS 2008: 46-7). The Supervisory Body has to appoint a doctor, who is Section 12 approved (Mental Health Act 1983), or a registered medical practitioner with at least three years post registration experience in the diagnosis or treatment of mental disorder and has completed the standard training (RCP 2008). Most importantly, the mental health assessor is required to consider how JC’s mental health would be affected following the deprivation of his liberty, and this information should be passed on to the Best Interest Assessor (CoP DOLS 2008: 47). In JC’s case, he has a brain injury, learning disability and suffers from epilepsy. But does this affect his decision making process and would the deprivation of liberty have any ill or adverse effects on his personal welfare? The Best Interest Assessor would clarify this information with the mental health assessor.

5. Eligibility Assessment (CoP DOLS 2008: 47)

This assessment can only be carried out by a Section 12 approved doctor and an approved mental health professional. This is to validate JC’s status or potential status and Deprivation of Liberty. This would apply if he is not detained under the Mental Health Act 1983 and JC is not subject to guardianship or a community treatment order or conditional discharge under this act.

If JC (the relevant person) is unable to state an objection (CoP DOLS 2008: 48), or where persons are unable to communicate or only to a limited extent, the assessor would need to consider JC’s current and past behaviour, feelings, wishes, beliefs and values (Mental Capacity Act 2005). In JC ‘s case, he wants to see his mother and his behaviour indicates that he wishes to go out by wandering to the front door of the care home. Is this behaviour reasonable or not? There is no proposed treatment or specialist care for JC.
6. **Best Interest Assessment** (CoP DOLS 2008: 4.58)
The purpose of this assessment is to establish whether deprivation of liberty is occurring or is going to occur. This raises the following questions:

- Is it in the best interest of JC to be deprived of his liberty?
- Is it necessary for JC to be deprived of his liberty in order to prevent him from harm?
- Is the deprivation of liberty a proportionate response to the likelihood of JC (the relevant person) suffering harm and the seriousness of that harm (CoP DOLS 2008: 51)?

The Best Interest Assessor is appointed by the Supervisory Body under the guidance and the required criteria set by Department of Health (CoP DOLS 2008: 4.60). The ‘best interests’ principles and the check list are set within the Mental Capacity Act 2005 and the main Code of Practice (Mental Capacity Act 2005: Sec 4; Code of Practice: 5.13). These principles and guidance apply equally to working out a person’s best interests for the purpose of the DOLS.

The additional factors to consider when JC’s deprivation of liberty does not take place, include: whether there is sufficient evidence to show from the risk assessments that JC had been found to be confused and wandering aimlessly when returned by Police; whether he is vulnerable to being injured, bullied by children or by their parents, or being exploited financially; whether there is a risk of retaliation from the parents of children in response to his verbal abuse of children.

There is a risk of applying DOLS, as it may encourage frustration, isolation, may escalate physical aggression, exacerbate a loss of autonomy, self determination, self esteem, confidence and loss of regular physical exercise. There is a risk of boredom and lack of mental stimulation resulting in mental health deterioration and it may lead to challenging behaviours. Involving JC and the relevant professionals, including JC’s relevant representatives, would boost his morale and mood.
Conclusion
To provide a meaningful assessment report after examining all of the reports and assessment forms, having explored JC’s position and considered his capacity to make decisions (temporary or able to regain?), having considered his preferences and wishes / lifestyle (he was able to go out daily to local parks and shops, managing small amounts of money, and maintaining contact with the sister), and the risks of depriving his liberty and of applying DOLS, it is necessary that JC is Deprived of his Liberty and for DOLs to be established in his best interest. This is a proportionate response to the likelihood of JC (the relevant person) suffering mental and physical harm. The seriousness of the harm may impact on JC’s short term and long term welfare.

Therefore, in relation to this case, I would recommend standard authorisation to the Supervisory Body, with conditions:

- to recommend standard authorisation of Deprivation of Liberty Safeguards for two months, with the conditions that two members of staff are available to accompany JC out of the care home for at least one our per day.

Recommendations:
- For specialist needs assessments to be carried out and to set up positive risk management plans, involving JC and his relevant representatives (Sally, IMCA, Psychologist).
- To encourage staff to engage him within structured activities within the care home.
- For the Supervisory Body to agree the level of staffing in meeting JC’s needs.
- To arrange a time and date for a review meeting to monitor progress within the specified two months.

The decisions take by the Best Interest Assessor were necessary to reduce harm, being practicable and least restrictive in order to enable JC to progress in his best interest.
References
Department of Health (2009) The Mental Capacity (Deprivation of Liberty; Monitoring and Reporting; and Assessments – Amendment) Regulations. London: DH
Reasons why people use drugs: exploring the supersensitive model, the bio-psycho-social model and the self medication model

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Literature Review

Introduction
The rising incidence of drugs may be the result of a combination of bio-social and psychological factors. It is stated that people use drugs for various reasons. Some may enjoy themselves, whilst for others it may be an escape from too much pressure (Graham et al 2003). However, using to escape can, in itself, create more problems and hence an even greater need to escape (Hawkings and Gilburt 2004). Rassool (2002) reported that drugs are used to relax, attain euphoria or because drugs have become increasingly available or acceptable. Gafoor & Rassool (1998) concurred that the increased social acceptance of drug use has coincided with the advent of de-institutionalisation and consequent increase in the opportunity for people with mental health problems to acquire illegal substances. Banerjee, Clancy & Crome et al (2002) argued that the reasons are varied, for example, some people who are socially excluded may find a sense of belonging within a community of other drug users. Additionally, Philip and Johnson (2001) showed in their study that drug taking may be an escape from too much stress, boredom and peer pressure, and that people with mental health problems are introduced to drug and alcohol by others who attend mental health services.

According to Muesser et al (1998), individuals with poor social skills tend to be attracted towards other deviant young people who are using psychoactive substances and alcohol and drug use become the norm within this group. On the other hand, further studies have shown that people with severe mental illness are prone to dysphoric experience that makes them also prone to use psychoactive substances (Pristach & Smith 1996). Leishner (1998) reported that these people use substances to mask
bad feelings before the process of addiction supervenes. The reasons for drug use have been further explored by the following models.

The Super Sensitive Model

According to Muesser et al (1998), individuals who suffer from mental illness have biological and psychological vulnerabilities, which are caused by genetic and early environmental events in their life. These individuals are ‘supersensitive’, as they cannot sustain moderate use over time without experiencing negative symptoms. Watkins et al (2001) further support the supersensitive model, as shown in their statement that even a casual use of alcohol or street drugs may bring on transient psychiatric problems in drug abusers while they are actively using or have just stopped it. In a study conducted by Knudsen and Vilmar (1984), it was reported that the conditions of those patients suffering from schizophrenia were much aggravated as a result of using drugs, despite being compliant to their antipsychotic medication. Similarly, it has also been found that among those with combined severe mental health and drug problems, there was greater use of emergency services (Salloum, Moss & Daley 1991) and incidents of self-harm (Howland 1990; Lyons & McGovern 1989). Watkins et al (2001) further suggested that any type of non-prescribed drug in a person who already has some abnormalities of the brain creates significant problems.

Lieberman, Kane & Alvir (1987) equally confirmed in their study that patients with schizophrenia and a substance misuse problem were found to be highly sensitive to low doses of amphetamine that produce a lesser response in patients without substance use. Various research supports the supersensitive model. A study carried out by Drake, Osher & Wallach (1989) highlighted that various amounts of psychoactive substances have been found to produce symptoms in clients with severe mental illness. Menezes et al (1996) concurred by stating that alcohol and drug misuse may interact with the symptoms of psychotic illness, causing slower recovery than from a psychotic episode uncomplicated by substance misuse. Therefore, it could be implied that the supersensitive theory provides a good explanation as to why individuals with severe mental illness who use relatively low levels of substance use often experience negative consequences (Mueser, Drake & Wallach 1998).
The Bio-psycho-social Model
The term ‘Bio-psycho-social Model’ comes from combining the individual factors that contribute to the model: biological, psychological (thoughts, feelings, behaviour), and social (Donovan & Marlatt 1988). The biological dimension refers to brain chemistry problems which may be genetic. The brain chemistry of people with mental illness is fragile, so that even social use of alcohol or drugs can destabilise them and cause psychotic episodes, which could result in unnecessary hospitalisation (Watkin et al 2001).

Rigglewicz and Pepper (1992:12) suggested that psychoactive drugs affect the ego function because ‘a person with mental / emotional / personality disorder has by definition some impairment of ego functions involving one or more of the capacities for judgement, reality testing, impulse control, affect modulation, memory, mastery, competence and so forth’.

Relating to the social aspect of drugs, Gorski et al (1994) referred to factors such as poor social skills, poverty and family dysfunction that may contribute to the aetiology of mental illness, substance abuse and problems that may develop within relationships as a result of abusing drugs. In a study carried out by Philip and Johnson (2001), it was reported that social isolation, boredom, difficulty coping with everyday interactions and lack of meaningful activity all support explanation as possible factors in the development of drug and alcohol problems among those with schizophrenia. The social network and social life were also contributory factors. Furthermore, Mueser et al (1998) supported the view that there are multiple risk factors, which could explain why people with severe mental illness use street drugs. These include: poverty; lack of structured daily activity; living in an environment with high drug availability; and, mixing with other drug users.

Self Medication Model
The self medication hypothesis of addictive disorder was initiated by Khantzian in 1985. He suggested that people with mental illness use a particular substance for the relief of a specific set of symptoms and to counter the negative effects of psychotic medication. The examples given are that opiate, cannabis or alcohol may reduce the agitation and anxiety associated with mental illness, while stimulants (amphetamine, cocaine) may be used as self-medication for depression. Psycho-stimulants may be used to counteract akathisia, which is one of the extra-pyramidal side
effects of antipsychotic medication (Smith & Hucker 1994). However, Solomon et al (1993) argued that this does not take into consideration the role of biological genetic factors and socio-cultural factors that contribute to substance use.

In a study investigated by Addington and Duchak (1997), it was found that in patients with mental illness, such as schizophrenia, the use of street drugs was to relieve dysphoria and anxiety, to alleviate stress and increase pleasure. It was not used for any direct effect on positive symptoms. The subjects interviewed reported that they used drugs to ‘get high’, to deal with depression rather than to medicate symptoms of their illness. Noordy et al (1991) reported similar findings, which showed that the use of drugs improves their social anxiety, tension and apathy and did not help with psychotic symptoms. Furthermore, in self-report studies of patients with dual diagnosis, they rarely report that specific substance use relates to specific symptoms of a particular mental disorder (Dixon et al 1991). On the other hand, Mueser, Yarnold & Bellack (1992) reported that substance use is related to availability and market forces. According to Philip and Johnson (2001), drugs were used for the same reasons given by the general population, for example, recreational use and not as a coping mechanism to relieve symptoms of psychiatric disorder.

Additionally, the findings of a study by Cooper et al ((2007) showed that two fifths of people reported that they did not want to take their prescribed medication or think it necessary. Side effects of prescribed medication was found to be an common reason for not taking prescribed medication. Nevertheless, it has been argued by Mueser et al (1998) that though there is minimal support for self-medication, there is an accumulation of risk factors related to mental illness, including dysphoria that may increase the risk of substance use disorder.

**Conclusion**
The nature of addiction has not been explained adequately by one theory. However, understanding the various reasons why people use drugs is vital in ensuring that the right treatment intervention is provided. This therefore explains the different approaches used to treat addiction.
References


Delayed Discharge: personal reflections on a one year service project

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Personal Reflection

‘Delayed Discharges disrupt the therapeutic potential of the ward, create dependence in service users and waste scarce resources’ (CSIP 2007: 3).

Introduction
A certain doctor in learning disability services influenced this article. We were sat contemplating the project before a review meeting, one of many I was welcomed to over the course of the project, when he suggested that an article in this journal would be a good idea - thank you very much!!

First of all, let me just clarify a few things: this is a personal account representing my views, as opposed to those of colleagues or of the Trust as an organisation; I will not be referring to specific case examples as there is a danger of breaching confidentiality, but to stress that my passion for this project has been driven by a wish to improve the experience of service users who come to stay in any of our Units; I will also not refer to individual workers or establishments (although you may know who you are!), instead talking about service areas (namely, People of Working Age (POWA), Services for People with a Learning Disability (SPLD), and Older Peoples’ Mental Health Services (OPMH)).

This article will commence with an historical perspective, then focus upon the national context and origins of ‘Delayed Discharge’ within the national legislation and guidance, before considering local policy and the project itself – how it started, the key objectives, and the initial work that was carried out.

As an optimist, I will then reflect upon what I consider to have been the project highs, beginning with my favourite, statistics, and then moving onto some of the key challenges which remain ongoing. Finally, I’ll offer
some thoughts about future opportunities, which I hope will stimulate
plenty of debate!!

Historical Perspective
I thought it important to start with some history, as we can easily forget
the pace of change.

In 1954, there were 154,000 ‘psychiatric’ in-patient beds, amounting to
350 per 100,000 population. In 1961, Enoch Powell announced his vision
for services which included a closure and re-provision programme for the
‘water tower hospitals’. In 1982, there were 151 beds per 100,000
population. In 1987, the beds had reduced further to 67,000, and in 2003-4
this was merely 32,400 (SCMH 2005: 37).

‘In 1985, someone looking for help with a mental health problem would
expect to be treated in a psychiatric hospital. In 2005, someone with that
same mental health problem could expect a very different approach to be
offered by a range of Crisis Resolution and Home Treatment Teams
(CRHTs), crisis houses, partial hospitalisation, Early Intervention Services
(EI), Assertive Outreach Teams (AOTs), and multi-disciplinary Community
Mental Health Teams (CMHTs) provided by a combination of health, social
care and voluntary sector organisations’ (SCMH 2005: 37).

So my point here is that we have mainly institutionalised people with
mental health problems until 20 years ago, perhaps explaining why we are
taking some time to shift in our attitudes and ways of working. Alongside
this, consider the continuing stigma surrounding mental ill health and the
preoccupation with risk.

So how does this relate to delayed discharge? I think it explains why there
is still a tendency to view admission as an outcome as opposed to part of a
process in a service user’s journey.

It is also worth taking note of some research conducted by the Sainsburys
Centre in 1998 across 38 hospital sites, which involved interviews with 112
service users. The findings were that 1 in 10 service users had been
admitted for the wrong reasons, mainly relating to social factors or for
respite. Nearly three quarters of these service users who were on the ward
some two months later did not need to be there (SCMH 2005).
The question I would like to pose is this: *if you walked into your local acute unit today, how different would you find the picture to be for service users?* I suggest not dissimilar. The reduction in acute beds and rehabilitation placements has, I would argue, just exposed delays and prompted a need for early resolution due to the impact on admissions.

**National Context**

In 2003, the Department of Health published a policy document with the aim of improving ‘local hospital discharge policy and practice’ (DH 2003).

*‘Discharge from hospital is not an isolated event. It should involve the development and implementation of a plan to facilitate the transfer of an individual from hospital to an appropriate setting. The individuals concerned and their carer(s) should be involved at all stages and kept fully informed by regular reviews and updates of the care plan’* (DH 2003: 2).

Doesn’t that sound simple and obvious? What the rest of the report goes on to unpick however, are the complexities of discharge planning, and particularly the interface between health and social care.

The Community Care (Delayed Discharges) Act came into force in October 2003. It brought in a process of reimbursement for hospitals by Social Services Departments when a delay was registered. Trusts providing mental health services, intermediate care or rehabilitation services were excluded from this financial process but were asked to prepare procedures.

In April 2006, Mental Health Trusts were required to start to complete weekly reports (called SITREP reports), which passed data onto the Department of Health: numbers of delayed discharges, their location and the cause of each delay.

There has been no further specific legislation around delayed discharge though its profile has grown due to related policy and guidance which has focused on recovery and social inclusion, moving even further away from institutional care. To mention just a few: the National Service Frameworks for Mental Health / Older people; Valuing People; Supporting People.
Acute care beds have been reduced nationwide with Crisis Resolution and Home Treatment Teams offering an alternative to hospital admission and facilitating early discharge. Rehabilitation projects have become recovery focused, offering short term programmes as opposed to the former ‘slow stream rehabilitation’ which had become, quite frankly for many service users, a stagnant pond.

Locally this translated, in 2006, into a 20% reduction in acute adult mental health beds, a 50% reduction in rehabilitation beds, 12 beds across two older peoples’ units, and fewer beds in the SPLD acute care.

Local Context
Within the Bedfordshire & Luton Partnership NHS Trust (BLPT), we are currently working to a Policy for the Management of Delayed Transfers of Care, dated 18th July 2007.

The purpose of the policy is: ‘To ensure that people who are medically / psychiatrically fit for transfer of care do not experience unnecessary delays. Where the delay exceeds an agreed acceptable period, the process will be actively managed to resolution by the Trust, Social Services and Health Commissioners.’

This policy offers a definition of a delay as: ‘A delayed transfer of care occurs when a patient is ready for transfer from an acute hospital bed, but occupying such a bed. A patient is ready for transfer when: a clinical decision has been made that a patient is ready for transfer AND a multi-disciplinary decision AND the patient is safe to discharge / transfer.’

A care pathway is set out for service users across service areas, which requires a treatment plan to be in place from admission, if not prior to admission. This care plan should be reviewed regularly, directly involving the service user and all relevant parties, including the advocate, carer and others, which should include discussing readiness for discharge. The Care Programme Approach is central to this, and particularly the role of the allocated Care Coordinator.

If a service user is transferring into another care setting, be it the one they were admitted from or a new one, then a delay will be recorded if the discharge is later than 3 days from the planned date. Otherwise, delay
begins when an agreed care plan for discharge has been completed and
the planned date for discharge has passed.

As regards the reporting of delays, the policy requires this to happen
weekly from Units / Projects, in accordance with Department of Health
reporting guidelines. These cases should then be subject to weekly reviews
with recorded action plans. The policy sets out plans for a fortnightly
delayed discharge meeting to discuss cases and an escalation process for
delayed cases which exceed 30 days through the Chief Executive.

Finally the policy sets out the key criteria for discharges being delayed:
1. Completion of assessment
2. Public funding
3. Further non-acute NHS care ( including rehabilitation)
4. Care home placement – residential or nursing
5. Care package in own home
6. Community equipment / adaptations
7. Service user / family choice
8. Disputes
9. Housing – service users not covered by NHS and Community Care Act

Establishing the Project
The Delayed Discharge Project commenced in September 2007 and
involved myself as Project Lead, a Line Manager, and we were lucky to
have, even if only for one day a week for the first few months, a Discharge
Coordinator from the Luton and Dunstable Hospital, who really helped
with setting up systems and offering lots of ideas about addressing key
causes of delays.

The project was launched widely using Trust communications, including
Trust Today, Staff Matters, and the Team Brief, but also by meeting with all
the Unit / Team Managers and Medical staff over the first month to
introduce the project, gather information about positive practice and
ongoing challenges. This led in many cases to invitations to team meetings
and to provide some presentations.
Project Objectives

These were agreed as follows:

- To support multi-disciplinary teams to address delayed discharges, to include individual support for care coordinators / attending reviews;
- To work with teams in identifying the causes of delays and agreeing action plans;
- To collate statistics on a weekly basis for the DH, and then monthly for the Trust Board;
- To coordinate the delayed discharge meetings, providing summary reports of delayed cases for discussion and using this forum to highlight issues for the Trust and its partner organisations;
- To escalate cases where the delay exceeds 30 days and ensure the development of appropriate action plans;
- To focus initially on the process and management of delayed discharges, then moving to more proactive work around discharge planning in preventing delays.

Project Highs

Fortunately, the project has had many high points, although that is my opinion – let’s see if I can convince you.

Let’s start with numbers. When the project commenced, 24 service users were identified as delayed discharges for long periods of time, and some for several years. Of those cases, only two remained as delayed discharges by the end of the project: one in POWA and another in SPLD (the good news is that both service users have now moved on, as at January 2009).

I do need to clarify those Units / Projects that were included in this count. They included: all three POWA Acute Units; all four OPMH Acute Units; two adult rehabilitation projects; and, 2 SPLD Acute Units.

Between August 31st 2007 and August 31st 2008, there have been a further 106 delayed service users registered with the project and subsequently monitored, with support being offered to care teams and reported to the DH. As regards the service areas, of these 106 service users, 29 were in POWA; 4 in rehabilitation projects, 59 in OPMH, and 14 in SPLD.
The causes of delay have often been complex but for the purpose of statistical reporting, the key reason has to be recorded. It is also important to realise that the cause of delay can change a number of times during the delay process. I have therefore grouped funding and placement as a reason for delay, as the two tend to be inextricably linked.

In POWA, the reasons for delays were: housing = 11; placement / funding = 13; care package = 3; awaiting rehabilitation place = 2. In the rehabilitation projects: placement/ funding = 3; housing = 1. In OPMH: nearly all of the delays, some 58 of the 60, were the consequence of placements / funding and, of these, approximately one quarter involved issues of family choice at some point in the delay process; care package = 1; housing = 1. In SPLD: placement / funding = 9; care package = 4; housing = 1.

So what is significant about these figures? The number of service users being delayed has reduced considerably over the past 12 months. At the end of August 2007, 28 service users were delayed as compared to 14 in August 2008. More important, however, is the reduction in the length of delay for those service users (as shown in Chart 1). At the end of August 2007, some 1,158 bed days were attributable to delayed discharges, which breaks down to an average of 37.4 per day that month, as compared to 476 bed days at the end of August 2008, which breaks down to 15.3 per day that month.

So how did this relate to the national targets for delayed discharges? During the period of the project, Monitor (for Foundation Trusts) set a target of 7.5%. The Trust achieved 6.1% overall for the last financial year (2008-09), and as the project ended this was continuing to improve (as shown in Chart 2).

In April 2009, a new single set of 198 national indicators was launched for Local Authorities, following on from the comprehensive spending review in Oct 2007. N131 is the indicator for Delayed Transfers of Care, which has further heightened the profile of Delayed Discharge.
Chart 1: Trends in Delayed Discharges

Chart 2: Achieving Targets for Delayed Discharges
Changes & Improvements in Practice

So what made such a difference? Obviously I would like to say the project but, if I’m honest, that was merely a catalyst and what this was really about were changes / improvements in practice. Let’s consider some examples.

- In OPMH, I observed considerable improvements. Service user delays were generally promptly reported and lengths of delay reduced dramatically. Factors contributing to this included attention to the quality of funding applications, with the funding process becoming less complex in many cases, due mainly to good relationships with our partners in the Local Authority and Primary Care Trust (PCT) / Continuing Health Care Panels.

- One Acute Unit stood out particularly in that a discharge date was set, often within a week of admission, and attention to a delayed service user’s case, once registered, was reviewed regularly.

- Family choice often featured in the reason for delay in this service area, and mainly around placement in nursing / residential care, so I worked with the Trust solicitor who agreed a preferred choice letter which is now available for care coordinators to use as appropriate.

- In SPLD, I was struck by the quality of service user reviews that I attended, as a forum to address a service user’s delay. Service users were mainly fully involved in the review, usually with an advocate and good attendance by the whole multi-disciplinary team. I attended many reviews to facilitate the development of action plans to address the cause(s) of delay, setting realistic timescales and then maintaining the momentum through regular CPA reviews.

- Another development was the establishment of a local forum between SPLD, the PCT, Local Authority and BLPT which just focuses on delayed discharge. This has already had a positive impact on those service users delayed for a long period of time, including two service users having a house re-opened for them, with a specialist care team to meet their complex needs.

- In rehabilitation services, there were only a few reported cases, but I was actively involved in those cases and the impact was that staff started to realise the importance of long term planning with service users to prevent delay at the end of their six month stay. One success
to be highlighted has to be the offer of a flat to one service user in one day, following a meeting with housing that was facilitated by the project.

✓ In POWA, progress was more gradual, though there was movement and examples of improvements in practice. I therefore spent more time during the project in this service area, both in terms of direct work with care teams and with proactive work that included training, audit, work around care pathways and housing.

✓ To start with direct work, I called into the Acute Units regularly, meeting with care coordinators individually, attending reviews, offering support with funding applications, and assisting with finding suitable placements.

✓ Listening to care teams, the funding application process to Local Authority Panels was felt to be hugely frustrating, and particularly in Luton. This led to the Project Manager developing a new form to ensure that all information was collated to avoid documentation simply moving back and forth. He then met the community teams with a representative from the Local Authority to discuss the funding process.

✓ Housing / homelessness was the next area requiring a proactive approach. I had already been involved in setting up a protocol with housing services in Luton, and so I sought to re-activate this and the local mental health housing forum. Briefly, the process involves Unit staff referring a service user with any housing needs to the council upon admission, whether the reason is for homeless prevention or homelessness or a need to consider housing support. The housing forum then meets with care coordinators to see how identified housing needs can be met. This forum has continued to develop, with service users in the community now able to be referred, as addressing housing need can also prevent unnecessary hospital admission and hence delay.

✓ In Bedford, I became a member of the Mental Health and Homelessness Task Group and, as part of that, carried out a pilot to launch a direct access form from the acute ward into housing options. In South / Mid Bedfordshire, work commenced and the new unitary Central Bedfordshire Authority should present as an opportunity to develop relationships further.
Care pathways in POWA have become more complex over the past few years, which was quickly evident when I started this project: with three strands of care (the Crisis Resolution and Home Treatment Teams, the Community Mental Health Teams, and the Acute Unit Teams) teams all trying to pull together, in addition to a functional model that separated in-patient care from community care – complications!! I therefore agreed to take part in some work focusing on care pathways in trying to focus on the need for joined up working. Key points included communication between all teams, prompt care coordinator allocation, and discharge planning from day one – all of these factors often contributed to the potential for delay.

Finally in POWA, I felt a need to undertake some work around service user reviews. Many I attended, as part of the project, lacked service user / carer involvement, nor involved any use of advocacy, showed poor preparation and were often rushed, resulting in confusion about the care plan and so compounding the cause of delay. I subsequently teamed up with the Nurse Consultant who had undertaken extensive work in this area, and we offered three educational sessions – one for each POWA Acute Unit, entitled ‘Meaningful Admissions’. These proved to be really fascinating, with each one proving to be very different. Briefly, the session consisted of role-playing a service user review and then using this as a basis to debate practice and identify key learning points. Attendance was multi-disciplinary and feedback was very positive. Highlights included an administrator role-playing a Consultant and loving every moment!!

Other highs that I have noted, have included: improved data collection, the setting up of a folder on the Trust’s computer hard drive (G drive) to ease access to all information about delayed discharge; launching a delayed discharge advice form to encourage early reporting and multi-disciplinary agreement; the escalation of cases involving delayed service users, which has brought about plenty of attention and interaction with relevant partner organisations.

Key Challenges
When talking about the project, above, I have already alluded to some of the challenges faced in addressing delayed discharges, though in a wider sense – for example: the culture of institutionalisation; the poor
streamlining of care pathways. Let’s now consider a few of these very real local issues that I have faced over the past 12 months.

- A lack of joint commissioning, such that there is no one point to direct deficiencies in service provision in seeking solutions.
- Finding suitable placements for some service users has been a particular challenge – for example, older people who present suicidality and or challenging behaviour; those with dual diagnosis (both with substance misuse / learning disability and mental health); those with early onset dementia; service users with a learning disability alongside dementia and physical health needs; adults in mental health services who require longer term detention under the Mental Health Act within a registered nursing setting.
- Geographical inequalities in service provision – South / Mid Bedfordshire has fewer Adult Mental Health Services, though the good news is that the Assertive Outreach Team has now arrived in South Bedfordshire (2009), in addition to a new supporting people provider.
- Age discrimination – service users in older peoples services are unable to access Crisis or Assertive Outreach Services.
- Section 117 – there is no local forum for discussing service users with complex needs. Continuing Health Care Panels are not the appropriate forum, but we have not created an alternative to resolve funding disputes.
- Rehabilitation services – there are a lack of vacancies locally and an inability to use some available resources.
- Supported housing – there is a need to look at increasing the range of provision. There is a glaring gap between having a tenancy with floating support and residential care, whereas some service users could benefit from a variation of this provision with housing / health and social care support being adjusted according to need.
- Social crisis house – there is as yet no local provision, though this could be a real alternative to admission for some service users.
- Care Pathways – to re-iterate some of the points made earlier: there is a lack of clarity about the purpose of admission; there is often a lack of involvement of the service user / carers; communication between Units / Projects and community teams is highly variable; there are delays in allocating a care coordinator; though service user reviews are so important, these are often ill prepared, rushed, and lack the full involvement of all parties.
There are intricacies in navigating funding application processes. The new Continuing Health Care Panels commenced in October 2007, as this project commenced. There has been new paperwork to negotiate and there is still the occasional dispute with the Local Authority, although I have observed less of this as workers have become more accustomed to the Decision Support Tool. The Local Authorities operate quite differently, with panels in Bedfordshire across all services but none in Luton, where, instead, the paperwork goes up for scrutiny, which can prolong decision making.

Linked to this, there is an ongoing issue about the quality of assessments, including risk assessment and care planning. This can complicate the funding process if the outcomes are unclear.

Future Opportunities
As usual, Mental Health Services and the rest of the public sector continue to be on the move. I thought it would be useful to finish by outlining some of the changes on the horizon which will impact further on delayed discharge.

- Delayed discharge is now a key performance indicator, and so will be subject to scrutiny both within the Trust and with our partner organisations. This will hopefully facilitate better partnership working, with regular forums being established, as has happened in SPLD, to focus on delays.
- Mental Health Act 2007 – Community Treatment Orders should limit the use of lengthy periods of Section 17 leave, and Independent Mental Health Advocates will support detained service users through their inpatient stay.
- Transforming Social Care – personalisation is coming and the hope is that it will lead to service users having greater choice and control of their care plans and more creative support plans being possible, contributing to less need for hospital admission and to earlier discharge.
- Mental Capacity Act 2005 / Deprivation of Liberty Safeguards – giving greater attention to capacity and human rights. This should ensure provisions are made so that the service user’s best interests are considered, including discharge planning, and ensure access to
Independent Mental Capacity Advocates to assist with residential placements.

- Housing – accommodation is moving up the agenda and will become a key performance indicator. We need to consider having a local housing strategy that involves all key agencies, including supporting people providers.

References


The Changing Lifestyles Group

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Practice Initiative

Introduction
This is a joint venture between TARMO and Occupational Therapy, within Services for People with a Learning Disability (SPLD), which aims to develop the maintenance element of the offender’s treatment programme. It builds on the original ideas of the maintenance programme of support, which followed attending an offender’s treatment group within SPLD and includes elements that try to introduce the concepts of healthy balanced lifestyles in supporting non-offending behaviour and group members taking increasing responsibility for themselves.

It has been seen that many individuals who complete the main treatment programme with TARMO remain in the contemplation stage of change (thinking about change but not actually doing it). At this point, they need additional support and treatment in order to progress on towards the possibility of developing these fragile ideas into a real lifestyle change.

The Changing Lifestyles Group
The Changing Lifestyles Group is bringing together ideas from elements of rehabilitative practice, psychiatric recovery models and personal goal planning, in a similar way to the work of Bird, Sperry and Carrera (1998). Their programme focused on applying psychiatric rehabilitation principles and behaviour support strategies through goal setting, social skills training, positive reinforcement, crisis intervention and competency based skills teaching. Their research showed significant reductions in the individual’s targeted behaviours, maintained community placements, the development of effective and adaptive social skills, more secured job placements and a reported increase in satisfaction with the quality of life.

The Changing Lifestyles Group has now been run for twelve months offering this support and implementing these principles for individuals who
have already attended the TARMO treatment programme but who need ongoing support to either prepare them for leaving the clinic or for supporting them in making the transition to a community setting. During this time, the group has clarified its aims and is working towards them. It has grown from two to six members and now has three members who have moved into community supported placements. It has become an integral part of the treatment within the clinic. It has proved a valuable way to help members in the clinic increase their realism over the difficulties with community living. At present, the whole group meet once a fortnight on a Wednesday, from 10.00AM until 12.00 noon, at Wood Lea Clinic, with small group work or individual sessions on the alternate Wednesday.

Aims of the Group
The aims of the group are:

- To further develop relapse prevention plans and personal coping strategies in order to develop individualised lifestyle plans.
- To provide a forum for members to work towards taking increasing responsibility within aspects of their life and responsibility for implementing their lifestyle plan.
- To work towards individuals setting personal goals and working towards them, as part of their desired lifestyle plans.
- To provide a self directed forum that is designed to facilitate members to take individually appropriate levels of responsibility for planning and co-ordinating the group sessions and self evaluating progress.

The group will also act as a point of contact, in order to:

- Support members with difficult situations offending thoughts or feelings that arise, reinforcing problem solving strategies and coping strategies within their lifestyle plan.
- Work with carers and others who are involved in support packages to provide training, advice and a contact point for concerns as necessary, and particularly considering how best to support group members in implementing their lifestyle plan.

The group will liaise with members of the multi-disciplinary team at Wood Lea Clinic to ensure the continuity of treatment plans for group members at the clinic.
The Changing Lifestyles Group Team
The core team membership consists of:

- Senior Occupational Therapist (1 session per fortnight)
- TARMO Specialist Treatment Tutor (1 session per week)
- TARMO Treatment Tutor (1 session per week)

It is hoped that in the future this service could be extended to allow for the group to meet more regularly and accept more members. Further ideas that could be pursued as resources become available are: community based support groups for ex offenders; and, community based rehabilitation programmes.

References


Personalised Care Planning: a practice guideline for Trust practitioners

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Practice Guideline

Why Plan Care?
A care plan is what we have agreed to do within an agreed timescale. It is a core communication document that is:

- the written record of a plan of action negotiated with the service user to meet their mental health and social needs
- a record of needs, actions and responsibilities;
- a tool for managing risk;
- a plan which, in the event of a crisis, can be used and understood by the service user, his/her carer(s) and other agencies, as well as by colleagues;
- based upon a thorough assessment of need;
- a multi-professional, multi-agency endeavour;
- produced in the most appropriate forum;
- shared effectively with those who are part of it.

A care plan is not:
- a bureaucratic exercise – rather it is an essential element in engaging service users and communicating what the service can and will do, and what responsibilities the service, informal carers and the service user will have.

Types of Care Plan:
There are generally the two main types of care plan used within this Trust:

- **CPA Care Plan**: This is mainly used in community settings by a care coordinator when the client is subject to CPA (Care Programme Approach). It provides an overview of all the care provided and by whom.
Supplementary Care Plan: This is mostly used in in-patient settings by the key professional. It is a valuable tool for use or reference by other multidisciplinary team members when needing to plan for specific, time limited interventions. These can be used by Community Support Workers, Occupational Therapist and Named Nurse, for example.

The principles for developing plans are the same for both types.

Statement of Care
Clinical and practice records (however recorded) that contribute to the care of the service user must be accessible to all clinical and practice staff who are involved in the care of the service user, and should be written from a person centered perspective.

Clinical and Practice Records:
- that contribute to the care of the service user must be accessible to service users, as appropriate to their circumstances;
- must contain a complete set of personal identification data (CPA 1);
- must be contemporaneous, up-to-date and chronological (daily diary / progress records);
- must be legible;
- must be dated, timed, and signed (daily diary / progress records);
- must be maintained in such a way that ensures accuracy of information;
- must include a record of known allergies and adverse reactions (CPA 1).

In addition, the Clinical and Practice Record:
- must contain all relevant clinical information, be of high quality, and be complete;
- must contain information about children who are in regular contact with the service user, clearly identifying any safeguarding concerns (CPA 1);
- must include clear evidence of all service user and carer involvement (CPA1);
- must contain discharge / transfer / leave information.
Assessment

Needs are recorded upon the completion of a comprehensive assessment. The level of the assessment undertaken will depend upon the individual’s needs, though the aim is to ensure that the assessment process is as straightforward as possible for the service user and their family / carers.

One or more assessment tools may be used in undertaking the assessment—the tools most commonly used within this Trust include (this is not a comprehensive listing):

- Camberwell Assessment of Need (CAN) OR Camberwell Assessment of Need Short Appraisal Survey (CANSAS);
- Model of Human Occupation Screening Tool and Single Assessment (MOHOST);
- Employment Questionnaire;
- Risk Assessment Tools e.g. CPA Risk Profile, BHS, HCR-20;
- Symptom Severity Scales e.g. KGV(M), PANSS, BAVQ, DASS, HRSD/A, BDI, BAI, Robson Self-concept Questionnaire;
- Medication Side-effect Assessment Tools e.g. LUNSER S, Barnes Akathisia Scale, AIMS;
- Outcomes Questionnaires e.g. OQ45, CORE-OM, HoNOS.

Summary of Need

‘Personalised care planning is essentially about addressing an individual’s full range of needs, taking into account their health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognises that there are other issues in addition to medical needs that can impact on a person’s total health and well being’ (DH 2009).

Once the initial assessment has been completed, a summary of need will be drawn up, recording the needs that have been discussed and agreed with the service user and their family-members during the assessment process. This tends to take the form of a problem list, which should include the individual’s strengths as well as family / personal issues that are affecting the service users overall well-being.
Goal Setting
SMART goal-setting will help all involved in ensuring that goals are:

SPECIFIC: a specific goal identifies exactly what the issue is, and what you and the service user would like to outcome to be.

MEASURABLE: you will need to identify a baseline measure of the issue, and what the outcome should be using measurable terms—for example: Fred sleeps for two hours each night now, and feels he needs 7 hours each night. The measure is the number of hours.

ACHEIVABLE: only write things that can be achieved, rather than necessarily the ideal situation, which may not be attainable. This will require negotiation with the service user about what is achievable, given the available resources, interventions and their desires / wishes.

REALISTIC: each goal must be realistic in its expectation. There is little point in agreeing a clearly unrealistic goal—for example: that Simon will become a pilot, when he dropped out of school when he was 12 years old.

TIMED: by agreeing a time limit for when the goal will be reviewed, you are focusing the individual upon progressing towards their goal and encouraging ‘hope’. In the event of little progress, you can use the collaborative process to help the service-user to consider whether the goal was realistic or whether it needs to be modified.

There are three types of goals that support the care process:
1. Improvement for the service user: ‘will this problem get better?’ If ‘YES’, then ‘where is this likely to lead?’
2. Where the optimum outcome is stabilisation to maintain their current functioning: ‘can we keep this from getting any worse, or developing
complications? If ‘YES’, then consider stabilising & maintaining factors.

3. Where the illness is degenerative and there is no hope for improvement: ‘what can we do to provide optimal quality of life, comfort and dignity for this person?’

Planning Process
To assist the planning of meaningful interventions, consider the following:

• agree with the service user and their family about what intervention, if any, has been useful to meet their needs in the past
• is this still available now and, if so, in what form?

Consider:
• who can provide this?—advise the service user on the wider availability of resources within the community
• where is most convenient for the service user and their family?
• is there a need to develop skills to be able to access this service e.g. using public transport?
• is there a referral process and, if so, who are referrals accepted from and how long does the process take?
• how will an agreement from others involved in the service-user’s care be gained?
• what specific pathways can be followed to ensure that the care coordinator is kept informed of how the service-user progresses?
• in collaboration with the service user, what is the likely expected outcome?

It is important to be MINDFUL of:
• literature related to best practice to meet the needs of the service user
• national reports and guidelines on best practice interventions
• the role of the family and social support networks in meeting the service user’s needs
• social and economic circumstances that may impact upon the service user’s ability to access support
• identifying the need for actions in the case of disengagement
• knowledge and practice that underpins the holistic, person centred approach which will enable you to:
focus on the individual’s preferences and best interests;
provide active support for the individual;
empower the person to take responsibility to communicate their own decisions about their lives, actions and risks when developing implementing and reviewing care plans.

Review Process
Preparation for review is essential, not only for the professionals involved in care but also for the service user and their family, friends or carers. We have a duty to support this process of preparation and this is an integral part of the CPA process and documentation (as shown in Fig. 1).

Effective preparation provides for effective and efficient care planning that meets the needs of the individual.

**Fig. 1: the Review Cycle**

As shown, the review cycle is an ongoing process, where you will review actions undertaken to date against the goals set, then deciding as a group (either multi-disciplinary, and/or with the service users and carers) or with the individual, the effectiveness of the interventions carried out.
The review can result in the following actions:

- the review reveals something new and more pressing which currently needs to become the focus of care;
- the review identifies that either there has been an improvement, stabilisation or deterioration of the presenting care need which will require a (1) continuation of planned care, (2) modifying the care intervention approach, (3) planning further intervention, or (4) phasing out care interventions as goals are achieved.

**Working in Collaboration**

The collaborative process of developing and implementing care plans, moving from assessment through to review, is summarised in Figs. 2 & 3.

There are several ways of ensuring collaboration:

- Service users can write their own care plans if they so wish. The care coordinator / key professional will need to collaboratively work with the service user to include operational issues, if required.
- Service users should be given a copy of their care plan and have an opportunity to sign it, indicating their agreement with the plan. If the service user refuses to be involved, then this should be recorded.
- Care plans should reflect the needs of the service user.
- Though writing care plans can be challenging, it is essential in enabling all those involved to be aware of what has been agreed, areas where it has not been possible to reach agreement, and agreeing a specific measure for assessing the effectiveness of planned interventions.
- A fundamental ingredient of a care plan is the stated time frame – that is, the time by which a goal / objective is expected to be achieved (Rutter 1989). This will help the service user identify where they are going, how they are progressing and what they can expect from the services.

*In practice, it may be useful to write:*

- statements of need rather than actions that are instructional and able to be followed in your absence;
- care plan statements which begin with phrases such as ‘I need.....’, in encouraging the service user to think about what s/he needs.
**Fig 2: Collaborative Assessment & Care Planning**

**Collaborative Working**

**Assessment**

**MDT**

Any one who is involved in delivering care to the service user and their families.

**The Whole Person**

To include all aspects of need: social, psychological, physiological, spiritual

**Who**

**What**

**Where**

**How**

**Planning**

**The people who assessed!**

By everyone who is going to be involved, which will include community workers.

**Needs of the individual identified from the assessment**

Focus on the needs of the clients in enabling them to recover their functioning

**Variety of Places**

Anywhere that is appropriate for care delivery—e.g., at their home, at the GP practice or within a Unit/Centre.

**Variety of Places**

**Tools**

By using the generic CAN needs assessment and specialist assessment tools (see page 5)

**A combination of**

What you can offer as a Service alongside what the service user feels would help.
Fig 3: Collaborative Implementation & Care Review

Collaborative Working

**Implementation**

*The best placed person to provide the service*

These can be carers, social networks, volunteers, human resources if working, nurses, social workers etc...

**Review**

*The plan signed up to by everyone*

Implementation is delivering the interventions with service user agreed in the plan.

*MDT*

Any one who has been involved in delivering the care to the service user and their family.

*The Whole Person*

The whole interventions and the impact on the identified needs.

*Variety of Places*

Anywhere that is appropriate for care delivery e.g. in the bank (if budgeting issues).

*Tools*

Reviews can take place anywhere, including in the client’s home, GP practice and hospital unit.

*Using evidenced care, alongside the desires of the individual*

In a consistent manner as agreed in the plan, in the place agreed in the plan and for as long as has been planned for.

*How*
Multi-disciplinary Involvement

As a care coordinator, it is important to ensure that:

- all involved parties are invited to regular review and, if they cannot attend, that they provide information about:
  - their contact with the service user / family
  - how long they have been / will be involved for
  - what they are hoping to aim for
  - the impact of the intervention, if known

- the meeting is held on time and in the place stated;
- a written account of the review is made;
- that the outcomes of the review are disseminated to all involved;
- a new review date and venue is agreed and indicated in the review record.

Remember that:

the ultimate purpose of the care plan is to guide all who are involved in the care of the person to provide the appropriate treatment in order to ensure the optimal outcome during their stay within the service.

A care-giver unfamiliar with the service user should be able to find all the information needed to care for this person in the care plan.

Illustrating the Care Plan

A visual guide to the completion of the Supplementary Care Plan (referred to locally as CPA5s), together with a worked example (shown in two parts), is shown on the following pages. This is followed by a visual guide to the completion of the main CPA Care Plan (referred to locally as CPA5), again with a worked example (shown in four parts)
**GUIDE to the Supplementary Care Plan (CPA5s)**

**Area of Need,** identified through assessment.

Describe circumstances of area of need.

**Goals,** which should be **SMART:**
- Specific,
- Measurable,
- Achievable,
- Realistic, and
- Timed

Agree with the service user where possible.

This must be clear, and describe in words that any member of the team implementing the plan AND the service user can understand.

It needs to be explicit: **who**, is going to do **what** and **when**.

There must be clear timescales of when the plan needs to be reviewed.

It must describe the measurement being used to identify success.
DO NOT use this section as an assessment. Any information here must be found within a documented assessment.

This Care Plan is ‘supplementary’ to the main CPA Care Plan (CPA5).

Where possible, the identified need will be one of a number that have been identified in the CPA5.

This plan should be reviewed regularly and if any member of staff implementing it identifies a problem with the plan (e.g. a change in circumstances), they must report this to the person organising the individuals care.

Ask the service user to sign and if unable or unwilling to sign, record this in the box.

Sign here, using black or blue permanent pen.
(computer printed signatures are not sufficient)
## EXAMPLE: Supplementary CARE PLAN—part a

**Care Plan** for use in in-patient settings / recovery units, by support workers and others

This care plan is to be used for specific interventions as prescribed by the CPA care plan and should be used by support workers, recovery unit, support workers etc.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Gary Turner</th>
<th>NHS No:</th>
<th>NH34 7653 M</th>
</tr>
</thead>
</table>

**Care Plan Description: Summary of Area of Need**

Gary is a 25-year old fireman, who has been working for the fire service for 8 years after leaving school. Gary has recently broken up with his long term girlfriend, reportedly because of her unsocial working hours, and is now living with his parents at home. Gary has two sisters, whom is close to, and both have young families with whom he is very close.

Gary had been taken to the Accident & Emergency Department by his father, following an impulsive suicide attempt that involved an overdose of 40 paracetamol tablets. Gary was reluctant to receive treatment and continues to express suicidal ideation, stating that he has ‘nothing to live for’, and that ‘he can’t go on’. Gary had his stomach pumped in the A&E Department after his father persuaded him, but he found this very distressing and tried to run out of the Unit into oncoming traffic. He was placed on a Section of the Mental Health Act and brought to the acute in-patient ward.

Gary’s father states that Gary was involved in putting out a fire in a family home, when three children and their parents were killed last week, and since this time he has talked of how he had felt them, that he was not worth it. He was sent home from work early today and was advised that he should not return until he had been cleared by the Occupational Health Department. His father thinks that this acted as the trigger to his overdose.

Gary is very agitated, pacing around and pulling out his hair, and shouting that he wants to leave as he wishes to kill himself.

**What are your Goals? (what do you want to achieve?)**

S/T: For Gary to be less agitated and less preoccupied with suicidal ideas, such that therapeutic observation levels can be reduced to level 2 (intermittent), as described in supplementary care plan 1, within 5 days. His level of intent will be measured by using the suicide intent scale, which will be reviewed daily (score to be within the minimum range of 4 – 10 before considering a reduction in the therapeutic observation level), as he is currently scoring 13.

S/T: For Gary to be offered oral medication for agitation, with staff monitoring for medication side effects on a daily basis and reporting such to medical staff. As Gary is drug naïve, to ensure that any medication side effects are kept to a minimum within the first five days.

M/T: Gary would like to go home and have access to housing, psychological care, and an assessment of employment and family support needs within 7 days, being referred to other required services within 10 days.

L/T: Gary does not wish to receive care from the CMHT for long, and would like to be discharged within 8 weeks.

S/T = short term goals; M/T = medium term goals; L/T = long term goals
**EXAMPLE: Supplementary CARE PLAN—part b**

**How are you going to achieve this and by when?**

Gary is currently subject to a Section of the Mental Health Act, and thus ward staff must ensure that he is made aware of his personal and legal rights, which will need to be discussed with him on a daily basis initially and reviews once he is able to sign to confirm that he has understood these rights.

Gary needs to have his dietary needs met and thus the shift leader must ensure that Gary has access to and is encouraged to have three meals and eight drinks each day, promptly reporting to the team if this is not being achieved.

Gary needs a daily assessment of his mental state, an assessment for medication effects and side effects, which must involve a review with Gary by the nursing and medical staff.

Tracy, Gary’s key professional whilst on B ward, will liaise with the CMHT to ensure that goals 3 & 4 are progressed, and that a care coordinator is appointed.

The CMHT will offer a family carers assessment and sign-post Gary’s main carers to RETHINK for continuing support.

Tracy, Gary’s key professional, will ensure that his family are involved in ward care reviews or, if they are unable to attend, to receive feedback following review meetings.

<table>
<thead>
<tr>
<th>When do you expect to achieve this? (date):</th>
<th>4-3-09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date for Review:</td>
<td>Daily</td>
</tr>
</tbody>
</table>

**I have received or seen a copy of this care plan, which has been explained to me.**

<table>
<thead>
<tr>
<th>Signature of Service-User</th>
<th>Gary Turner</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25-2-09</td>
<td></td>
</tr>
</tbody>
</table>

**Signature of Named Nurse or Support Worker (please circle):**

<table>
<thead>
<tr>
<th>Tracy Lambert</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25-2-09 / 12:00PM</td>
</tr>
</tbody>
</table>

**Record date of distribution to the following:**

<table>
<thead>
<tr>
<th>Case-notes / File</th>
<th>CPA Care Coordinator</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-2-09</td>
<td>25-2-09</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service-User</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-2-09</td>
<td></td>
</tr>
</tbody>
</table>
GUIDE to the CPA Care Plan (CPA5)

Area of Need, identified through assessment.

Describe circumstances of area of need.

Goals, which should be SMART:
Specific, Measurable, Achievable, Realistic, and Timed

Goals should reflect what the service user views as important. If these are presently unrealistic or unattainable, then use the boxes below to describe what can be achieved.

from the Summary of Need

What is going to happen?
Who is going to do it?

What is the planned outcome for the service user?
When will we have achieved this outcome?
GUIDE to the CPA Care Plan (CPA5)

Who is involved and what is their role in the care plan?

What have the people listed agreed to do?

Include all medication (both physical and mental health).

This must be completed! If you write the ICD10 code, then a description is also needed.

Sign here, using black or blue permanent pen. (computer printed signatures are not sufficient)

Ask service user to sign and if unable or unwilling to sign, record this in the box.
EXAMPLE: CPA CARE PLAN—part a

<table>
<thead>
<tr>
<th>CPA Care Plan CPAP 5</th>
</tr>
</thead>
</table>
This CPA care plan has been completed following our meeting where we discussed your needs at the current time, along with the help/support you may require to help you to meet these needs.

<table>
<thead>
<tr>
<th>Name: Ethel Shakespeare</th>
<th>NHS No: 12345670</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your CPA Care co-ordinator is:</td>
<td>Emma Smith</td>
</tr>
<tr>
<td>They can be contacted on telephone no:</td>
<td>01234 334455</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need to talk to your CPA care co-ordinator and they are not available, please contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Team</td>
</tr>
<tr>
<td>Dr Jones</td>
</tr>
</tbody>
</table>

Care Plan: Summary of Areas of Need

Ethel was admitted into the assessment unit on 20-01-09. There have been a variety of needs identified to enable Ethel to be able to return home, as recorded within her needs assessment. Her main needs are: to assess her physical health in her home environment, to ensure she can return home and manage all activities of daily living safely, to increase care agency duties so that they can prompt Ethel to take medication, and to reduce social isolation – Ethel would like to go to the local bingo hall. Medical staff need to monitor and review the new medication that Ethel has started. Her key worker will need to make a safeguarding of vulnerable adults referral to explore her safety and well-being, as she is vulnerable and may be at risk of exploitation.

What are your Goals? (What do you want to achieve?)

The fundamental aims identified are that Ethel would like to return home and the care team need to assess both Ethel’s physical, mental health and environment to explore whether Ethel will be able to return home and live in a safe environment with adequate support provided by the care team and care agency, within 6 weeks.

Ethel has expressed an interest in going to the local bingo hall, and the care team should support Ethel to achieve this, within 6 weeks.

How are you going to achieve this and by when?

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Intervention/ Responsible (who will do what)</th>
<th>Outcome (what you expect to achieve and when)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding of Vulnerable Adults referral to be made re allegation of theft by carer.</td>
<td>Emma Smith</td>
<td>26-01-09: referral to be made after this meeting.</td>
</tr>
<tr>
<td>Monitor for symptoms on new medication. Complete LUNSERs side effects assessment.</td>
<td>Jo Wild, CMHN, to monitor and report to Dr Jones in next ward round.</td>
<td>For next 3 weeks; To minimize side effects, if identified through LUNSERs, within 3 weeks.</td>
</tr>
</tbody>
</table>
### EXAMPLE: CPA CARE PLAN—part b

<table>
<thead>
<tr>
<th>Identified Need</th>
<th>Intervention / Responsible (who will do what)</th>
<th>Outcome (what you expect to achieve and when)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapist to undertake home assessment prior to Ethel being discharged from assessment unit.</td>
<td>Kelly Field to complete Activities of Daily Living assessment.</td>
<td>To be completed by 6-2-09, which will determine if adaptations are required to enable Ethel to live at home, and to ensure adequate support / equipment is provided on discharge.</td>
</tr>
<tr>
<td>Support worker to be identified to focus on reducing social isolation and identifying local bingo halls. Support worker to support Ethel in attending bingo.</td>
<td>Emma Smith to identify support worker from within the CMHT.</td>
<td>To be explored on discharge from the assessment unit.</td>
</tr>
<tr>
<td>Care Agency to be informed that they should prompt Ethel to now take her medication and to record this.</td>
<td>Emma Smith to contact care agency in ensuring that systems are in place.</td>
<td>Care plans to be shared and tasks to be completed by 6-2-09.</td>
</tr>
<tr>
<td>For Emma Smith to obtain information and advice on Continence Service for Ethel, to enable her to be more comfortable.</td>
<td>Kelly Field, Occupational Therapist to contact service and liaise with them.</td>
<td>To be completed by 6-2-09.</td>
</tr>
<tr>
<td>Another review meeting to be held weekly with updates of actions from this review.</td>
<td>Emma Smith to coordinate review.</td>
<td>Arranged for 13-2-09, to be held at same location.</td>
</tr>
</tbody>
</table>

**Date for Review:** 27-1-09

**Have direct payments been discussed?** NO

**Could any of the identified needs be met by a direct payment?** NO

If yes specify details:

Not at this stage, however in future, when Ethel is less anxious about going out, this could be considered.

### Accessing support in a Crisis: (Names of people who may help - please include names / contact details of other people including voluntary organisations, friends or family who may help)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Contact details</th>
<th>Hours of Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark Shakespeare</td>
<td>01234 777888</td>
<td>Shift work</td>
</tr>
<tr>
<td>Mavis Barker</td>
<td>No phone. She is my next door neighbour and has a key to my house</td>
<td>She does not work</td>
</tr>
</tbody>
</table>

59
### Example: CPA Care Plan—Part C

#### Summary of Multi-disciplinary / Multi-agency Care

<table>
<thead>
<tr>
<th>People involved in providing care</th>
<th>Summary of agreed interventions / support</th>
</tr>
</thead>
<tbody>
<tr>
<td>(provide the following details: name, position, agency, tel. no.)</td>
<td>(provide the following details: intervention, start date, frequency OR number of sessions agreed)</td>
</tr>
<tr>
<td>Emma Smith</td>
<td>Emma started working with Ethel when she was admitted into the assessment unit on 20-1-09. Emma will coordinate and work with the care team to ensure that Ethel's identified needs are met. Emma will have contact with Ethel on a fortnightly basis and will increase contact when Ethel is discharged from the assessment unit.</td>
</tr>
<tr>
<td>Central CMHT</td>
<td></td>
</tr>
<tr>
<td>Central Road</td>
<td></td>
</tr>
<tr>
<td>Town Centre</td>
<td></td>
</tr>
<tr>
<td>Tel: 01234 334455</td>
<td></td>
</tr>
<tr>
<td>Dr Jones</td>
<td>Dr Jones will liaise with the named nurse to assess whether Ethel experiences any symptoms or side effects of the new medication. This will be discussed at the next review on 13-2-09.</td>
</tr>
<tr>
<td>Riverview Hospital</td>
<td></td>
</tr>
<tr>
<td>Riverview Lane</td>
<td></td>
</tr>
<tr>
<td>Outskirts Town</td>
<td></td>
</tr>
<tr>
<td>Tel: 01234 110011</td>
<td></td>
</tr>
<tr>
<td>Kelly Field</td>
<td>Kelly will carry out an Occupational Therapy assessment with Ethel at her home to ascertain if it is possible for Ethel to return home to live there safely.</td>
</tr>
<tr>
<td>OT Wing</td>
<td></td>
</tr>
<tr>
<td>Riverview Hospital</td>
<td>Kelly will liaise with the Continence Service to provide information to them about maintaining good physical health and continence.</td>
</tr>
<tr>
<td>Riverview Lane</td>
<td></td>
</tr>
<tr>
<td>Outskirts Town</td>
<td>Care Agency provision will be put on hold until the outcome of the Safeguarding of Vulnerable Adults investigation is made.</td>
</tr>
<tr>
<td>Tel: 01234 110000</td>
<td>To discuss with Ethel, if no concerns are raised at the SOVA meeting, whether she would still be happy to receive a service from this agency or whether she would like support in considering alternative local care agencies.</td>
</tr>
<tr>
<td>Care Agency</td>
<td></td>
</tr>
<tr>
<td>Ido Care</td>
<td></td>
</tr>
<tr>
<td>Valley Hill</td>
<td></td>
</tr>
<tr>
<td>Outskirts Town</td>
<td></td>
</tr>
<tr>
<td>Tel 01234 998877</td>
<td></td>
</tr>
</tbody>
</table>
**EXAMPLE: CPA CARE PLAN—part d**

<table>
<thead>
<tr>
<th>Prescribed Medications: as at: Date: .............................. (list the names of all prescribed medications, dose &amp; frequency)</th>
<th>Diagnosis (ICD10 Code No.) OR Main Presenting Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine 5mg once each day</td>
<td>F555 – early onset dementia</td>
</tr>
<tr>
<td>Trimethoprim 200mg: 100mg in the morning &amp; 100mg in the evening</td>
<td></td>
</tr>
<tr>
<td>Simvastatin once each day</td>
<td></td>
</tr>
</tbody>
</table>

**Does a capacity assessment need to be completed for any parts of the care plan?**  
**No** (please circle)

**Are any services required to support this care plan?**  
(If yes please specify the following details)

<table>
<thead>
<tr>
<th>Service:</th>
<th>Date identified:</th>
<th>Date Service received:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Agency</td>
<td>June 2008</td>
<td>August 2008</td>
</tr>
</tbody>
</table>

**I have received or seen a copy of this care-plan, which has been explained to me.**  
Signature of User: Ethel Shakespeare  
26-1-09

<table>
<thead>
<tr>
<th>Signature of CPA Care Coordinator:</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emma Smith</td>
<td>26-1-09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Team Manager:</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>George Harrison</td>
<td>27-1-09</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Consultant:</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Knowall</td>
<td>26-1-09</td>
</tr>
</tbody>
</table>

**Enter date for formal CPA Review Meeting:**

<table>
<thead>
<tr>
<th>Record date of distribution to the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
</tr>
<tr>
<td>28-1-09</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
References & Bibliography


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