

Cross-national mixed-methods comparative case study of recovery-focused mental health care planning and co-ordination in acute inpatient mental health settings (COCAPP-A)

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Scientific summary

The COCAPP-A mixed-methods study

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Scientific summary

Background

Improving the treatment and care of people with mental illness is a key priority in both England and Wales. Despite shifts towards community-based care, considerable resources are spent on inpatient beds. Annually, around 112,000 people are admitted to psychiatric hospitals; about 40% are detained under the Mental Health Act 1983 (Great Britain. *Mental Health Act 1983*. London: The Stationery Office; 1983). Considerable planning and co-ordination is required to ensure that effective care is delivered consistently.

The context and delivery of mental health care is diverging across England and Wales while retaining points of common interest. In England, the key vehicle for the provision of care is the Care Programme Approach (CPA). In Wales, the CPA has been superseded by The Mental Health (Care Co-ordination and Care and Treatment Planning) (CTP) Regulations (Mental Health Measure), a new statutory framework [Welsh Assembly Government. *Mental Health (Wales) Measure 2010*. Cardiff: Welsh Assembly Government; 2010].

Both processes are expected to reflect philosophies of *recovery* and *personalisation*. Together, these terms mean tailoring support and services to fit individual needs and enable social integration.

The CPA and CTP are central to mental health care, and yet few studies have explicitly explored community care planning and co-ordination and even fewer have explored this in inpatient services. A rare example of the former is our recently completed COCAPP (Collaborative Care Planning Project), with this sister project extending this research into hospitals. National policies and quality statements include requirements that service users jointly develop recovery-focused care plans with professionals, are given copies of their plans with agreed review dates, and are routinely involved in shared decision-making. These requirements hold true for both informal and detained inpatients, with reasonable adjustments when necessary to ensure that people are supported to live lives that are as full and socially participative as possible.

The limited evidence from audits and regulatory inspections contrasts with aspirations that CPA/CTP processes should be collaborative, personalised and recovery oriented. Research evidence is needed to develop care planning interventions that embed dignity, recovery and participation for all who use inpatient mental health care.

Objectives

The aim of this study was to identify factors facilitating or hindering recovery-focused, personalised care planning and co-ordination in acute inpatient mental health settings.

The results build on our community care planning and co-ordination study to provide a whole-systems response to the challenges of providing collaborative, recovery-focused care.

The objectives were to:

1. conduct a literature review on inpatient mental health care planning and co-ordination, and review English and Welsh policies on care planning in inpatient settings
2. conduct a series of case studies to examine how the care of people with severe mental illness using inpatient services is planned and co-ordinated
3. investigate service users', carers' and practitioners' views of these processes and how to improve them in line with a personalised, recovery-oriented focus

4. measure service users', carers' and staff's perceptions of recovery-oriented practices
5. measure service users' perceptions of inpatient care and their views on the quality of therapeutic relationships and empowerment
6. measure staff's views on the quality of therapeutic relationships
7. review written care plan documentation and care review meetings
8. conduct a multiple comparisons analysis within and between sites to examine the relationships and differences in relation to perceptions of inpatient care, recovery, therapeutic relationships and empowerment.

Design

We conducted a cross-national comparative study, employing a concurrent transformative mixed-methods approach with embedded case studies. In-depth micro-level case studies of 'frontline' practice and experience with detailed qualitative data from interviews and reviews of individual care plans and care review processes were nested within larger meso-level survey data sets and policy reviews to provide potential explanations and understanding. At the macro level, the national context was considered through a metanarrative review of national policy and the relevant research literature.

Methods

The study took place in 19 mental health hospital wards within four NHS trusts in England and two local health boards in Wales. Sites were identified to reflect variety in geography, population and setting.

The metanarrative literature and policy review and synthesis were completed during the project, with the search strategy guided by the project advisory and lived experience advisory groups.

The quantitative component of the study involved surveys of service users ($n = 301$), ward staff ($n = 290$) and carers ($n = 28$). The measures used were the Views of Inpatient Care Scale (VOICE), the Recovery Self-Assessment (RSA), the Scale to Assess the Therapeutic Relationship (STAR) [Scale to Assess the Therapeutic Relationship – Patient Version (STAR-P) and Scale to Assess the Therapeutic Relationship – Clinician Version (STAR-C)] and the Empowerment Scale (ES). The VOICE is a patient-reported outcome measure of perceptions of acute mental health care that was completed by service users. The RSA measures the extent to which recovery-oriented practices are evident in services and was completed by service users, carers and staff. The STAR assesses therapeutic relationships and was completed by service users and staff. The ES measures empowerment, which is strongly associated with recovery, and was completed by service users.

Descriptive site summaries provided total and subscale scores alongside reference values for the VOICE, RSA, STAR-P/STAR-C and ES to produce a 'recovery profile' for each site. Across-site comparisons were completed using one-way analysis of variance and subsequent Tukey's post hoc tests. We conducted analyses of covariance to adjust for potential confounders. Correlational analyses were conducted to identify relationships between measures.

The qualitative component involved semistructured interviews with service users ($n = 36$), multidisciplinary ward staff ($n = 31$) and carers ($n = 9$). Service users' care plans ($n = 51$) were reviewed against a template, and observations of care review meetings were conducted ($n = 12$).

The framework method was utilised to explore the relational aspects of care planning and co-ordination, the degree to which service users and carers participated in CPA/CTP processes and decision-making, and the extent to which practitioners were oriented towards recovery and personalised care. Data extraction and summary was completed by several researchers and checked against original summaries. Second-level

summary and charting led to the identification of within-case themes, which were then analysed for cross-case comparisons and contrasts.

Ethics review

The study received NHS Research Ethics approval from the National Research Ethics Service Committee London – Fulham (reference 14/LO/2062) on 29 December 2014.

Quantitative results

No global differences were found across the sites for any of the four questionnaires completed by service users. It was not possible to analyse carer responses because the rate of return was too low. For staff, there was a significant difference between research sites in the mean RSA total score [$F(5,279) = 6.35$; $p < 0.001$; $\eta^2 = 0.32$] and the mean total score for the STAR-C [$F(5,273) = 3.02$; $p = 0.011$; $\eta^2 = 0.23$]. There were also significant differences in all of the mean item subscale scores of the RSA and the positive collaboration subscale of the STAR-C, with two sites scoring significantly higher for the mean RSA total score. This scale measures perceptions that may have a significant effect on patient outcomes and concordance with care and collaboration with service users. Differences between sites on subscales were explored.

Pearson's correlations were completed at the global level to determine any associations between responses on the four questionnaires. For service user respondents there was a strong negative correlation between the RSA and the VOICE ($r = -0.70$; $p < 0.001$); when recovery-orientated focus was high, the quality of care was viewed highly. There was also a positive correlation between the RSA and the STAR-P ($r = 0.61$; $p < 0.001$), indicating an association between recovery-orientated focus and the quality of therapeutic relationships among service users. There was also a strong negative correlation between the STAR-P and the VOICE ($r = -0.64$; $p < 0.001$); when therapeutic relationships were scored highly, the perception of quality of care also scored highly. There were negligible relationships between the RSA and the ES, between the STAR-P and the ES and between the VOICE and the ES.

For staff, there was a small to moderate correlation between the RSA and the STAR-C ($r = -0.28$; $p < 0.001$) with considerable variability across sites ranging from a large correlation in one site ($r = 0.50$; $p = 0.001$) to only moderate or small to moderate correlations in others ($r = 0.28$; $p = 0.034$). Across all sites, staff gave significantly higher scores than service users on the Scale to Assess Therapeutic Relationships.

For service users, there were three measures where comparisons could be made between this study and the COCAPP community study: the RSA, the STAR-P and the ES. For ratings on the recovery-focus of services there were only small differences between total RSA scores, which can be considered equivalent. For the STAR-P measure of therapeutic relationships, service users consistently scored total and subscales lower in COCAPP-A (Collaborative Care Planning Project-Acute) than in COCAPP, suggesting relationships are rated more positively in community services. For the measure of empowerment (ES), service users scored higher overall in the acute study than in the community study. For staff, only one measure, the RSA, was used across the two studies. In all sites staff rated 'diversity of treatment options' higher in COCAPP-A than in COCAPP.

Exploratory inferential analyses were conducted to compare results from COCAPP and this study, which indicated that there was a significant difference in the way empowerment was scored by service users in community mental health services and those in acute mental health services.

Qualitative findings

Across the sites, many staff talked of the importance of collaborative care planning. Many also spoke of the value of keeping plans up to date, actively involving service users, and using plans to pull together multidisciplinary contributions and to help transitions between hospital and community. However, the interviews with staff, service users and carers all revealed gaps between shared aspirations and realities, even in cases when service users drew attention to good-quality care that they had received. Staff's accounts of routinely collaborating with service users in care planning contrasted with service users' accounts and also with care plan reviews that pointed to a lack of involvement or ownership. Staff sometimes spoke about service users' unwillingness or inability to collaborate, or about barriers resulting from the introduction of electronic records. In one inner-city site, the lack of a shared language was cited as a barrier. In one Welsh site, staff said the all-Wales CTP template was not well suited to short-term hospital care, and described adding on 'intervention' or 'management' plans for inpatient use. Many staff identified coherence and continuity in care across hospital and community interfaces as important; examples were given of detailed and collaborative discharge planning, and innovations were described. Rapidly arranged discharges were also mentioned, as were protracted admissions. Across the sites, carers reported generally low levels of formal involvement, but also that high-quality care was being provided.

Staff described formal multidisciplinary ward rounds as key events and a time when progress and plans could be reviewed, with the involvement of service users and carers whenever possible. Service users' views about and experiences of these rounds differed both within and across sites. Some found them helpful, providing opportunities to catch up with psychiatrists and the team, and some service users and carers described how they had been supported to plan and prepare for participation in the meetings. Others mentioned that there was limited time to fully consider needs and issues, that excessive jargon was used and that there was inflexibility in terms of scheduling.

The assessment and management of risk was central to care planning and provision; formal ward rounds were identified as times when risks could be discussed, although this did not necessarily occur in the presence of service users. Particularly challenging discussions were described in relation to medication, risk and decision-making with service users who were detained. Risks mentioned by staff included those to the self and to others; some also noted the dangers of overestimating risks and the importance of attending to strengths and positive risk-taking. A general staff view in one Welsh site was that the CTP template was not suited to the regular updating of risk assessments. Most service users said that their safety had been attended to and sometimes gave specific examples (e.g. objects being removed and observations being used), even though risk assessments and management plans were often not actively discussed with them. Others, however, talked of feeling unsafe in hospital and of asking for more staff.

Definitions and understandings of recovery varied, as did views of the role of hospital care in promoting recovery. 'Personalisation' was not a familiar term, although there was recognition that care and services should be oriented to the individual. While some staff talked of inpatient care as person centred, there was also widespread recognition of the challenges of this. Within and across the sites there were differences in service users' views and experiences of individually tailored care. Some were clear that hospital had been pivotal, and that their personal needs and wishes had been attended to. Others were equally clear that care had not been personalised, or said that care at home was more personalised. Carers gave positive accounts of care provided.

Conclusions

Our results suggest that there is a lot of positive practice taking place within acute inpatient wards, with evidence of a widespread commitment to safe, respectful, compassionate care underpinned by strong values. Although ideas of recovery were evident, there was some uncertainty and discrepancy among some staff about the relevance of recovery ideals to inpatient care or the ability of people in acute distress to

engage in recovery-focused approaches. However, service users saw inpatient admissions as important, and often necessary, stages in stabilising their mental state and perhaps their lives, with medication an important component. They often appreciated the efforts made to keep them safe and to help them take their next tentative steps. They also rated highly staff using recovery-focused language and values. Many service users spoke of care being personalised and gave examples of staff being responsive and considerate when reacting to particular needs or concerns. Similarly, carers often described positive views of care. Perhaps surprisingly, service users experienced inpatient care as more empowering than many do when receiving community care. Although they valued their relationships with ward staff, they did not rate these quite as highly as staff did.

Most staff spoke of efforts to involve service users, and carers and families when possible, in care planning. However, most service users did not appreciate the written care plan as an integral or important part of their experience, and many did not have, or could not find, copies of this. As in our community study, the majority of service users did not feel that they had been genuinely involved in processes.

Service users, and carers, were often aware of efforts that were made to keep them safe, and this was frequently appreciated. However, as was found in the community study, the involvement of service users in discussions about personal risk factors and safety is challenging, especially with those who have been legally detained.

Future work

Future research should investigate approaches that increase contact time with service users and promote personalised, recovery-focused working; introduce shared decision-making in risk assessment and management; and improve service user experiences of care planning and review and the use of recovery-focused tools during inpatient care. Implications for practice are also identified.

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