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

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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 to community-based care considerable resources are spent on inpatient beds. Annually, around 112,000 people are admitted to mental hospitals; about 40% of them detained under the Mental Health Act 1983. Considerable planning and coordination is required to ensure effective care is delivered consistently.

The context and delivery of mental health care is diverging across England and Wales whilst 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 In Wales the CPA has been superseded by The Mental Health (Care Co-ordination and Care and Treatment Planning) (CTP) Regulations (Mental Health Measure), a new statutory framework.

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

The CPA/CTP is central to mental health care yet few studies have explicitly explored community care planning and coordination and even fewer in inpatient services. A rare example of the former is our recently completed COCAPP, 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 with agreed review dates, and are routinely involved in shared decision-making. These hold true for informal and detained inpatients, with reasonable adjustments where necessary to ensure people are supported to live as full and socially participative lives 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 using inpatient mental healthcare.

Objectives

The aim of this study was to identify factors facilitating or hindering recovery-focused, personalised, care planning and coordination in acute inpatient mental health settings. The results build on our community care planning and coordination study to provide a whole systems response to the challenges of providing collaborative, recovery-focused care.

Objectives were to:

1. Conduct a literature review on inpatient mental health care planning and coordination 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 coordinated;
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 user, carer and staff 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 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 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 datasets and policy reviews to provide potential explanations and understanding. At the macro-level the national context was considered through a meta-narrative 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 meta-narrative literature and policy review and synthesis were completed throughout the duration of 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). Measures used were the Views of Inpatient Care Scale (VOICE), the Recovery Self-Assessment (RSA) Scale, the Scale to Assess the Therapeutic Relationship (STAR-P and STAR-C) and The Empowerment Scale (ES). The VOICE is a patient-reported outcome measure of perceptions of acute mental health care, 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, 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/C and ES to produce a 'recovery profile' for each site. Across-site comparisons were completed using one-way ANOVAs and subsequent Tukey post-hoc tests. We conducted ANCOVAs to adjust for potential confounders. Correlational analyses were conducted to identify relationships between measures.

The qualitative component involved semi-structured 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 were conducted at care review meetings (n=12).

Framework method was utilised to explore the relational aspects of care planning and coordination and 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 summarising was completed by several researchers and checked against original summaries. Second-level summarising and charting led to the identification of within-case themes which were then analysed for cross-case comparisons and contrasts.

Ethical Review

The study received NHS Research Ethics approval from the NRES Committee NRES Committee London – Fulham (Ref: 14/LO/2062) on 29th December 2014.

Quantitative results

No global differences were found across sites for any of four questionnaires completed by service users. Analysis of carer responses was not possible given low returns. 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 to care and collaboration with service users. Differences between sites on sub-scales 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 VOICE ($r = -.70$, $p < 0.001$); 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 ($r = .61$, $p < 0.001$), indicating an association between recovery-orientated focus and the quality of therapeutic relationships amongst service users. There was also a strong negative correlation between the STAR-P and VOICE scale ($r = -.64$, $p < 0.001$); when therapeutic relationships were scored highly the perception of quality of care also scored highly. There were negligible relationships between the RSA and ES; STAR-P and ES and the VOICE and ES.

For staff, there was a small to moderate correlation between the RSA and STAR-C (r = -.28, p < 0.001) with considerable variability across sites ranging from a large correlation in in one site (r = 0.50, p = 0.001) and only moderate or small to moderate correlations in others (r = 0.28, p = 0.034). Across all sites staff scored significantly higher than service users on the Scale to Assess Therapeutic Relationships.

For service users there were three measures where comparisons could be made between this and the COCAPP community study: RSA, STAR-P and 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 than 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 the 'diversity of treatment options' higher in COCAPP-A than 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 services and acute mental health services.

Qualitative Findings

Many staff across sites talked of the importance of collaborative care planning. Many also spoke of the value of plans being kept up-to-date with service users actively involved, and of plans being used to pull together multidisciplinary contributions and to help transitions between hospital and community. However, staff, service user and carer interviews all revealed gaps between shared aspirations and realities, even where service users drew attention to receiving good quality care. Staff accounts of routine collaboration with service users in care planning contrasted with service user accounts and care plan reviews which pointed to lack of involvement or ownership. Staff sometimes spoke of service users' unwillingness or inability to collaborate, or of barriers brought about by the introduction of electronic records. Lack of a shared language was cited as a barrier in one inner city site. Staff in one Welsh site said the all-Wales CTP template was not well-suited to short-term hospital care. Staff described adding-on 'intervention' or 'management' plans, for inpatient

use. Coherence and continuity in care across hospital and community interfaces were identified as important by many, and examples of detailed and collaborative discharge planning were given and innovations described. Rapidly arranged discharges were also talked of along with protracted admissions. Across sites carers reported generally low levels of formal involvement but also high quality care being provided.

Staff described formal multidisciplinary ward rounds as key events, and as places where progress and plans could be reviewed involving service users and carers wherever possible. Service user views and experiences of these differed, within and across sites. For some they were helpful, providing opportunities to catch-up with psychiatrists and the team. Some service users and carers described having been supported to plan and prepare for participation. Others spoke of limited time to fully consider needs and issues, of excessive jargon being used and inflexibility over scheduling.

Assessing and managing risk were central to planning and providing care, with formal ward rounds being named as places for risks to be discussed although not necessarily 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 self and others, with some also noting the dangers of over-estimating risks and the importance of attending to strengths and positive risk-taking. A staff view in one Welsh site was that the CTP template was not suited to the regular updating of risk assessments. Most service users talked of their safety having been attended to, sometimes giving specific examples (e.g., through removal of objects and the use of observations), 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 hospitals in promoting this. ‘Personalisation’ was not a familiar term, although there was recognition that care and services should be oriented to the individual. Whilst some staff talked of inpatient care as person-centred there was also widespread recognition of the challenges to this. Within and across sites there were differences in service user views and experiences of individually tailored care. Some were clear that hospital had been pivotal, and that 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 much positive practice taking place within acute inpatient wards with evidence of a widespread commitment to safe, respectful, compassionate care underpinned by strong values. Whilst ideas of recovery were evident there was some uncertainty and discrepancy amongst 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 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 spoke of care being personalised with examples given of staff being responsive and considerate in response to particular needs or concerns. Carers often similarly described positive views of care. Perhaps surprisingly, service users experienced inpatient care as more empowering than many do when receiving community care. Whilst 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 where 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. As with our community study, the majority of service users did not feel they had been genuinely involved in processes.

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