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# Cross-national comparative mixed-methods case study of recovery-focused mental health care planning and co-ordination: Collaborative Care Planning Project (COCAPP)

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## Scientific summary

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# Scientific summary

## Background

The context and delivery of mental health care are diverging between England and Wales, despite retaining points of common interest; therefore, these countries provide a rich geographical comparison for research. Across England, the key vehicle for the provision of recovery-focused, personalised, collaborative mental health care is the care programme approach (CPA). The CPA is a form of case management introduced in England in 1991, then revised in 2008. In Wales, the CPA was introduced in 2003 but has now been superseded by The Mental Health (care and treatment planning) (CTP) Regulations (Mental Health Measure), a new statutory framework.

In both countries, the CPA/CTP requires providers to comprehensively assess health/social care needs and risks; develop a written care plan (which may incorporate risk assessments, crisis and contingency plans, advanced directives, relapse prevention plans, etc.) in collaboration with the service user and carer(s); allocate a care co-ordinator; and regularly review care. Both the CPA and CTP processes are now also expected to reflect a philosophy of recovery and to promote personalised care. Recovery and personalisation in combination means practitioners tailoring support and services to fit the specific needs of the individual and enabling social integration through greater involvement of local communities.

Very little research has been conducted into the processes of care planning and co-ordination in mental health care and the limited evidence available contrasts with the aspiration that CPA/CTP care planning and related processes should be collaborative, personalised and recovery-oriented.

In this study, we aimed to identify and describe the factors that ensure CPA/CTP care planning and co-ordination is personalised, recovery-focused and conducted collaboratively.

## Objective(s)

1. To review the international peer-reviewed literature on personalised recovery-oriented care co-ordination, and compare and contrast the English and Welsh contexts for recovery-based mental health care.
2. To conduct a series of case studies to examine in detail how the needs of people with severe mental illness using community mental health services are assessed, planned and co-ordinated.
3. To investigate service users', informal carers', practitioners' and managers' views of these processes and how to improve them in line with a personalised, recovery-oriented focus.
4. To measure service user and staff perceptions of recovery-oriented practices.
5. To measure service users' views of the quality of therapeutic relationships and empowerment.
6. To identify methods, measures and processes for successfully evaluating a complex intervention aimed at delivering personalised, recovery-focused care planning and co-ordination and improved patient outcomes.

## Design

We conducted a cross-national comparative study of care planning and co-ordination in community mental health care settings, employing a concurrent transformative mixed-methods approach with embedded case studies.

In-depth micro-level case studies of everyday 'frontline' practice and experience with detailed qualitative data from interviews and reviews of individual care plans are nested within larger meso-level survey data sets, senior-level interviews and policy reviews in order to provide potential explanations and understanding. At the macro-level, the national context is considered through a meta-narrative review of national policy and the relevant research literature.

## Setting

The study took place in Community Mental Health Teams within four NHS trusts in England and two local health boards in Wales that are commissioned to deliver community mental health services. These sites were identified to reflect variety in geography and population and to include a mix of rural, urban and inner-city settings.

## Participants

Service users ( $n = 448$ ) and care co-ordinators ( $n = 201$ ) completed questionnaires, and interviews were conducted with senior managers, senior practitioners, service users, carers and care co-ordinators ( $n = 117$ ). Service users' care plans ( $n = 33$ ) were also reviewed against a standardised template.

## Methods

This cross-national comparative mixed-methods study involving six NHS sites in England and Wales included a meta-narrative synthesis of the relevant policies and literature; embedded case studies involving interviews with senior managers, senior practitioners, service users, carers and care co-ordinators; and a review of care plans; and a survey using standardised measures of recovery, empowerment and therapeutic relationships in service users and recovery in care co-ordinators.

The meta-narrative literature and policy review and synthesis were completed throughout the duration of the project with the search strategy guided by the expertise of the Project Advisory Group and Lived Experience Advisory Group.

The qualitative component of the study involved semistructured interviews with senior managers ( $n = 12$ ), senior practitioners ( $n = 27$ ), care co-ordinators ( $n = 28$ ), service users ( $n = 33$ ) and carers ( $n = 17$ ) and a review of written care plans ( $n = 33$ ).

A deductive form of analysis, namely framework method, was used to explore the relational aspects of care planning and co-ordination and the degree to which service users and carers participate in CPA processes and decision-making, and the extent to which practitioners are 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 across-case comparisons and contrasts.

The quantitative component of the study involved a large-scale postal questionnaire survey of service users' and care co-ordinators' perceptions on three measures. The main measures were the Recovery Self-Assessment (RSA) scale, the Scale to Assess the Therapeutic Relationship – Patient version (STAR-P) and the Empowerment Scale (ES). The RSA scale is designed to measure the extent to which recovery-oriented practices are evident in services and completed by service users and care co-ordinators. The STAR-P is designed to assess therapeutic relationships in community psychiatry and was completed by service users. The ES is designed to measure empowerment, which is strongly associated with recovery, and was also completed by service users.

Descriptive summaries were provided for all sites providing total scores and subscale scores alongside reference values for the three measures (the RSA scale, STAR-P and ES) to produce a 'recovery profile' for each site. Across-site comparisons on the measures were completed using one-way analyses of variance and subsequent Tukey post-hoc tests. We conducted analyses of covariance to adjust the analysis for potential confounders. In addition to this, correlations were conducted to identify if there were relationships between the measures.

## Ethical review

Ethical review was sought from the National Research Ethics Service Committee Yorkshire and The Humber – Sheffield (Ref: 13/YH/0056 A). Ethical approval was obtained on 13 February 2013. A subsequent major amendment was sought and approved on 7 May 2013.

## Results

Quantitative and qualitative data were analysed within and across sites using descriptive summaries, inferential statistics, correlations and framework method.

## Quantitative results

Our study found no major differences between sites for empowerment or recovery scores for the service-user responses. We did find some significant differences for scores on therapeutic relationships related to positive collaboration and clinician input. We also found significant differences between sites on some recovery scores for the care co-ordinators related to diversity of treatment options and life goals. This suggests that perceptions relating to how well recovery-focused care planning works in practice are variable across sites. Correlations with the measures for service users revealed that there is a strong positive correlation between the recovery scale and the therapeutic relationship scale. The association between these scales suggest that importance in one scale may signify importance in another scale and, therefore, this may be considered in clinical applications of such measures.

## Qualitative findings

Interviews showed great variation in experiences of care planning, as well as variation in understanding of recovery and personalisation within and across sites. There were some differences between England and Wales in this regard, reflecting the more recent introduction of the Mental Health Measure in Wales. Care plans were seen as largely irrelevant by service users who rarely consult them. Care co-ordinators regarded care plans as a useful record but also an inflexible administrative burden that restricts time with service users. Lack of integration in information technology (IT) across organisations and inflexible electronic care plan formats also inhibited recovery-focused work. Service users valued their relationships with care co-ordinators and saw these as being of central importance in their recovery. Carers report varying levels of involvement in care planning and also value good relationships between care co-ordinators, service users and, ideally, carers themselves. Risk is a significant concern for workers but did not appear to be openly discussed with service users who, for the most part, were often unaware of the content of risk assessments. This appeared to limit the potential for greater involvement by service users and carers in exploring and managing their own safety and for positive risk-taking as an aspect of their recovery.

## Conclusions

Administrative elements of care co-ordination may reduce opportunities for recovery focused and personalised work with people using mental health services. There are few shared understandings of recovery or personalisation and this may limit shared goals. A reluctance to engage in a dialogue about risk management may work against opportunities for positive risk-taking as part of recovery-focused work. Conversations on risk appear to be neglected and assessments kept from service users.

Positive therapeutic relationships appear most important in facilitating personalised, recovery-focused care planning and co-ordination. Excessive administrative tasks and inflexible IT systems should be addressed in order that the level of contact with service users and carers can be maximised. Shared understandings of the concepts and the goals of both recovery and personalisation need to be reached at all levels of mental health organisations. These understandings need to be developed through the involvement of people using these services, carers and frontline practitioners. Training in recovery-focused care planning and co-ordination also may be insufficient to bring about the necessary change as wider contextual factors need to be addressed.

## Future work

Research should be commissioned to investigate innovative approaches aimed at maximising staff contact time with service users and carers; enabling shared decision-making in risk assessments; and promoting training designed to enable personalised, recovery-focused care co-ordination. The findings from this study will also inform our sister project, also commissioned by the NIHR HSDR programme [Simpson A, Coffey M, Faulkner A, Hannigan B, Jones A, Barlow S, *et al.* 'Cross-national comparative study of recovery-focused mental health care planning and coordination in acute inpatient mental health settings (COCAPP-A)' (in progress)], in which we employ a similar design and methodology to investigate recovery-focused care planning in acute inpatient mental health settings.

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