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

Short Title: History of the CPA

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Abstract

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

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

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

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

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

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Keywords: Care Programme Approach (CPA), case management, community care, Community Mental Health Teams (CMHTs), teamwork.

Introduction

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

A brief background to the introduction of the CPA

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

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

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

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

The Care Programme Approach (CPA)

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

were recorded on 'CPA registers', introducing paperwork that became the leitmotif of the new policy (Simpson, 1998).

[INSERT FIGURE 1 HERE]

Things were not getting better

The ability of 'community care' policies to provide humane, safe support for severely distressed people remained in doubt (Hogman, 1992). Unkempt and disturbed men and women were sleeping rough in apparently increasing numbers (Craig et al., 1993; Craig & Timms, 1992; Scott, 1993). Mental health was now a key policy area in the government's '*Health of the Nation'* strategy (Department of Health, 1992) but when the media reported and arguably exploited a series of tragic incidents involving people with mental illness pressure mounted on the government to do more (Coid, 1994). Most influential was the case of Christopher Clunis, a man with mental illness, who killed Jonathon Zito (Hallam, 2002). This rare incident involved the death of a total stranger and fuelled the public's anxieties, leading the government to introduce independent inquiries whenever a mentally ill person committed homicide (NHS Executive, 1994). The ensuing rash of inquiries and reports (with attendant publicity) repeatedly highlighted breakdowns in communication between agencies and individuals (Shepherd, 1996). People were still 'falling through the net'.

Further guidance signalled the government's determination to prioritise the needs of people with '*severe* mental illness' (Department of Health, 1993;

1994). Unfortunately, the failure to publish a definition of severity created disagreement and confusion (Powell & Slade, 1996; Walker, 1998).

Initial evaluations of the CPA

Initial evaluations identified many difficulties affecting implementation of the CPA (See Table 2). Psychiatrists in particular perceived it as an encroachment on their clinical judgement and practice. They believed the basic requirements of good practice were already in place and that the CPA was bureaucratic and over-structured (North et al., 1993). Staff were also concerned that with the introduction of CPA registers they would be involved in a more explicit form of surveillance or social control (May, 1996). Consequently, the CPA was being implemented selectively and was not applied to all mentally ill patients (Schneider, 1993).

[INSERT FIGURE 2 HERE]

Supervision Registers and Supervised Discharge

The '*Ten Point Plan'*, aimed at tightening procedures, introduced supervision registers for patients considered most at risk and in need of increased support (Secretary of State for Health, 1994). Supervision registers were more often seen as another controlling response to the needs of mentally ill people, rather than being designed to improve quality of care (Godin & Scanlon, 1997; Kingdon, 1996; Nolan et al., 1998; Ryan, 1994) and were rarely employed (Bindman et al., 1999; Turner et al., 1999). Together with homicide

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

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

Building Bridges

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

Tracking the tiers of the CPA

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

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

Still Building Bridges

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

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

[INSERT FIGURE 3 HERE]

Increased contacts, admissions and costs

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

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

'Community care has failed': the risky shift

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

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

people with a mental illness committing homicide over the 38 years, and a 3% annual decline in their contribution to official statistics despite the enormous increase in the number of people being cared for in the community. Whilst society had witnessed an increase in murders, there had been an annual fall in the number committed by those with a mental illness. Similar findings have been reported internationally (Walsh & Fahy, 2002). A separate review of 14 homicide inquiries involving mentally ill people did however emphasise inadequacies in the planning of care (Parker & McCulloch, 1999). These findings were given further weight by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness in *'Safer Services'* (Appleby et al., 1999). Considerable failings were described, particularly in the care of people recently discharged from hospital, the very target group the CPA was originally introduced to support. Any clinical value of the CPA was reputedly "in danger of being undermined by its administrative demands" (ibid: p86).

Users' experiences of the CPA

Service users' experiences of the CPA have been consistently disappointing. Relatively small studies repeatedly reported little awareness of the policy, patchy allocation and identification of keyworkers, limited involvement in care planning, poor use of care plans, and mixed experiences of CPA review meetings (Lawson et al., 1999; McDermott, 1998; Phillips, 1998; Simpson, 1999a; Wolfe et al., 1997).

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

Carers' experiences of the CPA

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

What went wrong? Money, managerialism and the CPA

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

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

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

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

Sectorisation and community mental health teams (CMHTs)

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

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

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

Teamwork and the CPA

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

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

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

[INSERT FIGURE 4 HERE]

New Labour, new CPA

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

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

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

[INSERT FIGURE 5 HERE]

Conclusion

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

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

words/ 3,900

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Figure 1: Key features of the CPA (1991)

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

(From Department of Health, 1990)

Figure 2: Factors undermining initial implementation of the CPA

- Confusion with social services' care management system
- Shortage of resources
- Insufficient training
- Disagreement over aspects of the policy
- Time restraints
- Lack of agreed standards
- Varying levels of motivation and awareness amongst staff
- Resistance and resentment

(Summarised from North et al 1993 and Schneider, 1993)

Figure 3: Key amendments and additions to CPA

- Tiers - to target resources and limit administration
- Supervision registers - to identify and target patients at most risk
- Supervised discharge - designated supervisors can 'take and convey' patients to where care plan specifies they reside or receive treatment

Figure 4: Key changes to the CPA introduced in 1999

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

(From Department of Health, 1999b)

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