The Care Programme Approach and the end of indefinitely renewable Leave of Absence in Scotland

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Abstract

Objective

To consider the relationship between the restriction of leave of absence (LOA) to 12 months, the introduction of community care orders (CCOs) and the implementation of the Care Programme Approach (CPA).

Design

Multiple methods were employed: scrutiny of Mental Welfare Commission for Scotland (MWC) records; questionnaire to consultant psychiatrists and mental health officers (MHOs) regarding attitudes; survey of psychiatrists in respect of outcomes for named patients.

Setting

Scotland

Subjects

Two hundred and sixty six patients who were affected by the changes introduced by the Mental Health (Patients in the Community) Act 1995.

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Results

Information was available for 195 (73%) patients in relation to CPA. Of these 113 (58%) were included on CPA and for 63/113 (56%) (63/195 (32%)) CPA was considered to have enhanced patient care.

Where CPA was considered useful it was because it was seen as bringing people together, enhancing the patient's role in treatment and managing difficult situations. Negative comments regarding CPA were that it was unnecessary as the patient's needs were straightforward, it duplicated current practices or it was too bureaucratic.

Conclusions

Despite concerns expressed by professionals about the restriction to LOA and the guidance that patients should be on CPA, for only a minority of patients was CPA described as enhancing care. Questions are raised about the low use of CCOs and CPA by psychiatrists for patients who reached the new limits of LOA.

The CPA is designed to ensure good interagency collaboration thus facilitating care and or supervision in the community for people with severe, long-term and complex mental health problems[1]. It has had a chequered history of development and implementation in Scotland and in many areas was reported as being underdeveloped[2].

Patients in Scotland can be subject to compulsion in the community in three ways: leave of absence (LOA), Community Care Orders (CCO) and Guardianship. The latter is not used in relation to enforcing medication and is not discussed here. The Mental Health Act 1984 allows patients detained on a Section 18 to live in the community on LOA. The understanding was that this allowed similar treatment without consent in the community as Section 18 allowed in hospital. LOA was renewable indefinitely in Scotland until the Mental Health (Patients in the Community) Act 1995 which restricted it to 12 months. This Act also introduced CCOs which required patients to comply with conditions approved by a sheriff. These conditions could include where the person lived, where they spent time and the requirement to give access to staff. Although it was believed that CCOs did not allow patients to be compelled to take medication, the majority of CCOs contained conditions that implied or directly stated that patients should comply with medication[3].

The Scottish Office guidelines[4] indicate that good practice requires that all patients on LOA or a CCO should have care plans that comply with the Care Programme Approach (CPA)[5]. A questionnaire survey indicated that almost all mental health officers (MHO)[6] and three-quarters

1 *Greater Glasgow Health Board (1996) Operational arrangements and recommendations arising from the Glasgow Care Programming pilot project 1st July – 31st December 1995*

2 *Social Work Services Inspectorate and Accounts Commission for Scotland (1998) Implementing the Care Programme Approach. Social Work services Inspectorate Edinburgh*

3 *Atkinson, J M, Garner, H C, Gilmour, W H & Dyer, J A T. (2002 a). The introduction and evaluation of Community Care Orders following the Mental Health (Patients in the Community) Act, 1995. Journal of Mental Health 11, 4, 417–429*

4 *Scottish Office (1996a) Draft Guidance on the Mental Health (Scotland) Act 1984 as amended by the Mental Health (Patients in the Community) Act 1995. FRP14203. Edinburgh: Scottish Office.*

5 *Scottish Office (1996b) Community Care: Care Programme Approach for People with Severe and Enduring Mental Illness, Including Dementia Social Work Services Group Circular SWSG 16/96*

6 *Mental health officers are social workers charged with responsibilities under the Mental Health (Scotland) Act 1984 similar to those of approved social workers in England and Wales under the 1983 Act*

of consultants agreed with this, although there were some reservations about its appropriateness in all cases[7].

As part of a wider study evaluating the impact of the Mental Health (Patients in the Community) Act 1995 in restricting LOA and introducing CCOs, the relationship of these new measures to CPA was investigated. Details of the full study including methodology are given elsewhere[8,9]. Since this study was started community-based compulsory treatment orders (C-B CTOs) have been introduced in the new Mental Health (Care and Treatment)(Scotland) Act 1995[10]. This also introduces the need for care plans to be approved by mental health tribunals for patients subject to compulsory treatment. Possible implications of this are discussed.

METHODOLOGY

Information for the study comes from three sources, records of the Mental Welfare Commission for Scotland (MWC) to identify patients, a follow-up survey to consultant psychiatrists about named patients and an anonymous questionnaire to consultants and MHOs about the 1995 Act.

Population

The MWC receives details of all patients in Scotland detained under the Mental Health (Scotland) Act 1984. Their records were scrutinised to find all patients whose LOA reached the new limits between 1 April 1996 when the Act was implemented and 31 December 1998 and all those who were placed on a CCO between these dates.

Named patient survey

A questionnaire was designed to collect follow-up data on all these patients. This was sent to the patient's Responsible Medical Officer (RMO). The RMO at the time of discharge from LOA was identified from the MWC case records. For many patients the RMO had changed and RMOs were asked to indicate to whom care had been transferred. Thus, 308 questionnaires were sent to 146 RMOs regarding 266 named patients. The questionnaires were sent in May 1999 and a reminder in June 1999.

Questionnaire to consultants and mental health officers

A postal questionnaire was designed to obtain consultants and MHOs views about the changes brought about by the Mental Health (Patients in the Community) Act 1995 and their views on CPA. Questionnaires were sent to all adult general psychiatrists in Scotland and a sample of currently practising MHOs. MHOs were more likely to agree with the Scottish Officer guidance regarding CPA than psychiatrists and more positive regarding the limitation of LOA and the introduction of CCOs. Both groups of professionals however made similar assessments of resources available for patients. Peay discusses in detail the differing attitudes of approved social workers and psychiatrists in relation to decisions around detention in England & Wales.[11]

7 *Atkinson, J M, Gilmour, W H, & Garner H C. (2000). Views of consultant psychiatrists and mental health officers in Scotland on the Mental Health (Patients in the Community) Act 1995. Journal of Mental Health, 9, 385–395*

8 *see note 3*

9 *Atkinson, J M, Garner, H C, Gilmour, W H & Dyer, J A T. (2002 b). The end of indefinitely renewable Leave of Absence in Scotland: The impact of the Mental Health (Patients in the Community) Act, 1995. Journal of Forensic Psychiatry 13, 2, 298–314*

10 *Scottish Parliament (2003) The Mental Health (Care and Treatment) (Scotland) Act 1995Edinburgh: The Stationery Office*

11 *Peay, J. Decisions and Dilemmas. Working With Mental Health Law Hart Publishing, 2003*

Full details of the survey and views about the Act are reported elsewhere[12], however the detailed comments regarding the development of CPA across Scottish Local Authorities are reported here.

Ethics approval

Ethical approval was granted by the Multi-Centre Research Ethics Committee for Scotland and 13 Local Research Ethics Committees.

RESULTS

Patients

Two hundred and sixty-six patients were identified from MWC records. The details of the numbers in each health board and estimated rates per 100,000 population are given in Table 1. Any patients from Orkney or Shetland on LOA are included in Grampian Health Board

Health Board	No of patients	Population of Health Board 1998	Rate per 100,000
Ayrshire and Arran	11	375,400	2.9
Argyll and Clyde	16	426,900	3.7
Borders	4	106,300	3.8
Dumfries & Galloway	5	147,300	3.4
Fife	30	348,900	8.6
Forth Valley	10	275,800	3.6
Greater Glasgow	50	911,200	5.5
Grampian (+ Shetland & Orkney)	23	567,660	4.1
Highland	10	208,300	4.8
Lanarkshire	21	560,800	3.7
Lothian	54	773,700	7.0
Tayside	32	389,800	8.2
Western Isles	0	27,940	0

Table 1. Study population by health board n = 266

Source of population figures: ONS Population Estimates series PE no1 (1999)

Development of CPA across Scotland

The data in Table 2 comes from the questionnaire to MHOs and consultants. There were 246/293 (84%) responses from consultants and 259/315 (82%) responses from MHOs. Of those professionals working with detained patients, 202/244 (83%) of MHOs and 160/208 (77%) of consultants responded to the question about how well was CPA developed in their area. Details by local authority are given in Table 2. Although CPA is largely health led, MHOs are employed by

Local Authority	MHOs n=202		Consultants n=160	
	Negative	Positive	Negative	Positive
Aberdeen City	0	13	2	10
Aberdeenshire	2	0	1	3
Angus	0	4	0	3
Argyll and Bute	2	3	4	1
City of Edinburgh	17	19	5	4
Clackmannanshire	3	1	0	3
Dumfries and Galloway	0	5	0	7
Dundee	3	1	5	1
East Ayrshire	5	0	0	1
East Dunbartonshire	0	3	1	4
East Lothian	4	3	0	1
East Renfrewshire	2	0	2	0
Falkirk	4	0	3	3
Fife	0	7	2	9
Glasgow	6	19	7	25
Highland	6	1	7	1
Inverclyde	1	1	1	2
Midlothian	2	0	2	1
Moray	1	2	2	1
North Ayrshire	3	1	0	0
North Lanarkshire	8	7	2	3
Orkney	1	0	0	0
Perth and Kinross	3	1	3	0
Renfrewshire	4	0	7	0
Scottish Borders	1	6	0	6
Shetland	1	0	0	0
South Ayrshire	6	1	2	1
South Lanarkshire	2	2	4	2
Stirling Council	0	5	0	1
West Dunbartonshire	1	2	0	2
West Lothian	2	5	0	2
Western Isles	0	0	0	1

Table 2. Views on the development of CPA by local authority from MHOs and consultants who treat patients detained under the MHA 1984

local authorities who therefore co-determined the implementation of the policy at the smallest unit at which it was possible to gather opinion on its success.

Small numbers in some areas make comparisons difficult but there is broad agreement between the two professions as to the development of CPA in their area. Only a minority of local authorities, 9/32 (28%), were described as having well developed CPA by both sets of professionals and 6/32 (19%) were described as having poorly developed CPA.

CPA and individual patients

Replies were received to the named patient survey from 130/146 (89%) consultants for at least some patients. Of the 308 questionnaires, 250 (81%) were returned, of which 231 (75%) were analysed (the remainder being blank or the patient was unknown to the RMO). There is some information available for 195/266 (73%) of the patients in relation to the impact of CPA. Details are given in table 3. For 8% of the patients for whom forms were returned, the RMO either missed out the questions on CPA or reported they did not know the impact of CPA on that patient's care.

Health Board	Not included on CPA	Enhanced Care	Not affected care	Impaired care	Number of patients
Ayrshire & Arran	5 (63%)	1 (13%)	2 (25%)	0 (0%)	8 (100%)
Argyll & Clyde	8 (80%)	0 (0%)	2 (20%)	0 (0%)	10 (100%)
Borders	0 (0%)	1 (25%)	3 (75%)	0 (0%)	4 (100%)
Dumfries	0 (0%)	0 (0%)	5 (100%)	0 (0%)	5 (100%)
Fife	2 (7%)	19 (66%)	8 (28%)	0 (0%)	29 (100%)
Forth Valley	2 (29%)	2 (29%)	3 (43%)	0 (0%)	7 (100%)
Greater Glasgow	18 (50%)	16 (44%)	2 (6%)	0 (0%)	36 (100%)
Grampian	10 (63%)	4 (25%)	2 (13%)	0 (0%)	16 (100%)
Highland	5 (56%)	1 (11%)	3 (33%)	0 (0%)	9 (100%)
Lanarkshire	3 (38%)	3 (38%)	1 (13%)	1 (13%)	8 (100%)
Lothian	18 (42%)	12 (28%)	12 (28%)	1 (2%)	43 (100%)
Tayside	11 (55%)	4 (20%)	5 (25%)	0 (0%)	20 (100%)
Total	**82 (42%)**	**63 (32%)**	**48 (25%)**	**2 (1%)**	**195 (100%)**

Table 3 Views on the impact of CPA by Health Board from consultants with patients who reached the legal limit of LOA n = 195

Of the 195 for whom information is known 82 (42%) were not included on CPA. If only the 113 (58%) patients who were included on CPA are considered, for 63 (56%) consultants considered the patient's care was enhanced, for 45 (42%) CPA made no difference and in 2 (2%) cases CPA impaired care. For 82 patients psychiatrists said that to their knowledge they had not been included on CPA. Thus for the group as a whole, only one third had enhanced care from CPA.

Comments were made by psychiatrists for a minority of patients (76, 36%). Of the 63 consultants who said CPA enhanced their patient's care, 25 (40%) made comments. The main themes were in the usefulness of bringing people together, enhancing the patient's role in their treatment and managing difficult situations. eg:

> *"CPA has allowed/enabled clear interaction between members of a complex package of care who would not otherwise meet, eg consultant in X psychiatry, consultant in Y psychiatry, consultant in Z, plus housing and social work etc."*
>
> *"CPA has brought everyone together and has enabled (patient) to remain a priority despite being quiet and undemanding."*
>
> *"Has allowed the patient to become a partner in their care rather than a passive recipient."*
>
> *"CPA here is successful, increasing inpatient bed days but reducing community chaos and 'revolving door' situations."*

Where consultants believed CPA had added nothing to patient care, 19 (40%) made comments. Most reflected the view that CPA was unnecessary as the patient's needs were straightforward or CPA reflected what was already happening, eg:

> *"(Patient) needs are relatively simple and would have been met with or without the CPA."*
>
> *"(Patient) wants are minimal (house is his/her own, income is adequate, self care is basic but adequate) as long as he/she receives his/her medication."*
>
> *"CPA ensures good staff liaison – no difference to management."*

Two consultants, however, raised different issues:

> *"Patient him/her self refused to be included on CPA."*
>
> *"CPA unsuccessful as scuppered by patient's behaviour and failure to comply with conditions of CCO."*

In the two cases where CPA was believed to have impaired care only one comment was made:

> *"CPA also is too unwieldy to cope with patient's changeableness."*

CPA was not necessarily available or well developed in all areas but only one comment made reference to this. This relates to a patient who moved between health boards. The end of study LOA RMO, who was also once again RMO at time of the survey, said "*CPA was not available in this area until [after time of discharge from LOA] but I don't think it would have made any difference.*" The RMO for a period of inpatient treatment in another health board for the same patient said, "*CPA ensured that contact was maintained with patient while in the area but progress after his/her return to X last year is unknown.*"

For the patients who were not included in CPA a further 25 (total 32%) comments were made. There were three themes. Firstly, CPA was described as too bureaucratic, eg:

> *"The staff involved know the problems with the patient and the CPA would just create unnecessary bureaucracy."*

Secondly, that CPA is seen as pointless as it cannot enforce medication:

> *"CPA of no value in ensuring compliance with medication so not used."*
>
> *"Compliant by the time we introduced CPA."*

The third theme indicated that the patient already had co-ordinated care and that CPA did not add anything to this, eg:

> *"CPA not used as patient seeing members of team who meet regularly with patient and has own private accommodation and occupation is through [X] dept with whom [patient] has regular contact. Non NHS agencies not involved with this patient."*
>
> *"Decision was made not to proceed to CPA as patient was settled at end of LOA. Also, all professionals involved meet on a regular basis anyway to discuss his/her problems with him/her and appropriate action taken from there."*

DISCUSSION

The response rate from psychiatrists to the named patient postal survey was sufficiently high for us to assume that the data is representative as there is no real reason to suppose the sample is biased in any particular way.

The figure of 58% of patients being on CPA compares well with the 61% estimated by consultants in the postal questionnaire of their LOA patients on CPA but is slightly less than the MHOs' estimate of 71%[13]. The two populations are not entirely similar in that the named patient survey was for predominately post-LOA patients. Nevertheless, this is a group of patients for whom there is considerable concern about their continued management and for whom, despite the Scottish Office good practice guidelines, somewhat under two-thirds were on CPA. There are probably two main reasons why a patient was not on CPA.

Firstly, CPA development varied across Scotland and may not have been available for some patients. Secondly, although most psychiatrists agreed with the Scottish Office guidelines, 22% of consultants actively disagreed with the recommendation[14]. It is unlikely that the 42% of patients in the named patient survey who were not on CPA were all patients of this group of psychiatrists or in areas where CPA development was poor. There were probably other reasons why patients were not placed on CPA. For some it would seem the guidance was regarded as inappropriate. At the end of LOA, these patients' needs were not seen as complex and, thus, CPA was seen as unnecessary. This may be either because the period of LOA allowed the situation to be stabilised or because LOA was an over cautious response. In other cases patients may have benefited from CPA but consultants chose not to use it. This may have been because it was seen as overly bureaucratic or because it could not compel or ensure compliance with medication. These were the same failings psychiatrists attributed to CCOs[15]. CPA was described as useful, however, for some patients who declined services. It could ensure monitoring of mental state and allow appropriate measures to be taken before a crisis developed thus preventing further complications in patients' affairs.

The variation in the use of LOA across the country is of note, but appears to follow no particular pattern in relation to Health Board. Previous research[16] looked at the variation in the use of LOA between health boards over time. There is no apparent relationship between use of LOA and deprivation. Studies of those patients for whom psychiatrists in England would have liked to use

12 *see footnote 6*

13 *see footnote 6*

14 *see footnote 6*

15 *see footnote 3*

16 *Atkinson, J M, Gilmour W H, Dyer J A T, Hutcheson F G, Patterson L E (1998) Variation in Use of Extended Leave of Absence in Scottish Health Boards Health Bulletin 56 6 871–877.*

a hypothetical community treatment order showed that not all psychiatrists with adult community care patients used LOA[17].

Lack of CPA may not indicate that the principles of collaboration were not being adhered to but rather that this was not done in the formal name of CPA. A number of comments indicated that CPA would add nothing to current management. In some cases this would seem to account for the suggestion that CPA had made no difference to the patient's care. This should not necessarily be interpreted as saying CPA is redundant. A safety net may still be appropriate even if no one falls.

The comments about bureaucracy, echoing as they do comments made about CCOs, require further consideration. What is being complained about? Is it an administrative load and additional paperwork or is 'bureaucracy' a euphemism for all the meetings involved and the time taken by multi-disciplinary care and consultation? Comments indicated both meanings but numbers are too small for conclusions to be reached. In depth interviews would be required to elucidate this issue. The administrative load carried by consultants with multiple patients on section, LOA, CCO and CPA, however, should not be underestimated[18].

There is some evidence of patients having positive views on their experience of CPA[19], but how, if at all, this relates to their status in relation to the Mental Health (Scotland) Act 1984 is not known.

Before the introduction of the 1995 Act the use of lengthy LOA was on the increase[20]. There was consistent opposition to its restriction by psychiatrists on the grounds that it would mean that they would not be able to maintain high risk and vulnerable patients in the community without it[21]. It is therefore important to understand why the CPA that was intended to ensure that these patients did not fall through the gaps between agencies was not extensively used. Community Care Orders were also little used[22]. It is not possible to tell from this research if the low use of formal non coercive collaborative methods is due to lack of resources such as clinical time or to antipathy to the philosophy behind these approaches. Alternatively LOA is seen as justified when the only need perceived by services is that the patient continues to take their medication.

The Mental Health (Care and Treatment) (Scotland) Act 2003 raises the prospect of renewed requirements for formal care plans. It will be the MHOs duty to prepare a care plan in conjunction with the patient's psychiatrist after consulting with a wide group of involved and interested parties. The Act lays out what the care plan will need to specify. These plans will be presented to a mental health tribunal who will have the power to authorise or reject them. For patients who are to be placed on a C-B CTO this can be seen as enforcing CPA on psychiatry. Since this will now be a legal responsibility Health Boards and Local Authorities as well as individual consultants and MHOs will have to take it on board. The MHO will have a stronger role in the new legislation in relation to care planning than under current arrangements for CPA. Whether this, the time scale involved for application for compulsory treatment, and the legal imperative will make any difference to

17 *Sensky T., Hughes T, & Hirsch S. (1991) Compulsory Psychiatric Treatment in the Community II A controlled study of patients whom psychiatrists would recommend for compulsory treatment in the community. British Journal of Psychiatry 158 799–804*

18 *Tyrer P.A., Muderi O., Gulbrandsen D. (2001). Distribution of case-load in community mental health teams. Psychiatric Bulletin. 25, 10–12*

19 *Alexander, H. & Brady, L. (2001) What does receiving the care programme approach mean for service users? Health Bulletin 59 (6)*

20 *Atkinson, J M, Gilmour, W H, Dyer J, Hutcheson F, and Patterson, L (1999) Retrospective evaluation of extended leave of absence in Scotland 1988–94 Journal of Forensic Psychiatry 10 131–147*

21 *see footnote 6*

22 *see footnote 3*

attitudes remains to be seen. It might be expected that areas which have well integrated CPA might be better placed to introduce C-B CTOs.

What does seem clear is that the paperwork required by the Act will increase and that given the views on 'bureaucracy' presented in these surveys this is unlikely to be welcomed. A scoping exercise carried out for the Royal College of Psychiatrists Scottish Division[23] includes this in contributing to the need for a substantial increase in the number of consultants in Scotland. The number of additional MHOs required to fulfil the needs of the Act is likely to be even higher.

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23 *Atkinson J M, Brown K, Dyer J A T, Hall D J & Strachan J, (2002c) Renewing Mental health Law; A Scoping Exercise in Respect of the Impact on Psychiatrists' Time. Royal College of Psychiatrists Edinburgh.*