

CARE PROGRAMME APPROACH – A PERSONAL PERSPECTIVE

***“A vision without a task is a dream,
A dream without a vision is a drudgery,
But a vision with a task can change the world”***

Black Elk, native American elder

Buying into the myth

In 1991, the Care Programme Approach (CPA) was introduced with a view to providing a framework for planning the care of people with mental health concerns. Since then the political and cultural climate of mental health policy and practice has changed, as increasing numbers of people who use and have used services work in partnership with committed groups of families, friends and professionals towards dispelling many of the myths that surround mental and emotional distress.

More recently, however, we have witnessed the most radical mental health legislation to date. Central Government demonstrates its' commitment and vision to implementing Recovery Assisting services through the National Service Framework for mental health. The essence of all such recent legislation rests with the values of social inclusion and person centredness. Thus, what back in 1991 appeared to be an appropriate process of planning for people has been very quickly and very publicly challenged - and CPA has been found wanting.

Despite a huge movement throughout the western world in the advancement of a social model of care, there remains incredibly strong resistance to the letting go of the medical model and changing the system from within. The continued use of CPA clearly perpetuates many of the power imbalances that occur with the practical application of the medical model of care and support.

‘It is impossible to resist the conclusion that a gulf exists between the majority of doctors and their patients. First there is a lack of understanding on the doctor’s part of the exigencies of the patient’s situation. Second, the demographic differences between doctor and patient have implications for the type of explanatory model used by the doctor, and how he or she uses (or imposes) this on the patient.’

Phil Thomas 'The Dialectics of Schizophrenia' (1997)

In my experience, both as a person who once used services and in my current capacity as Recovery Support Worker, the CPA process, regardless of the best intentions of practitioners, fails to embrace the tenets of inclusion and recovery. Pre-determined questions requiring little more than yes and no answers, intrusive, personal probing at inappropriate moments and even more alarming, assessment being carried out in the absence of the individual, cannot be viewed as anything other than light years away from a process that includes and respects the individual. CPA when looked at from this angle can be seen as a self-serving, protective mechanism for those 'in control'. How ever did we arrive at this?

If we are to sign up to the vision of Recovery Assisting Systems, we can only do so from a holistic view of the person, with the person. We can no longer look at people in terms of their symptomology, tick boxes and measured outcomes on a sliding scale, and continue to 'do to' in isolation from that which really matters and makes sense to the person. That's the shift. That's the challenge.

Ten years on a shift is clearly apparent. In my own work I have encountered numerous dissatisfied people involved in the system. I have become aware of an increasing number of professionals who see the benefit of values driven practice but allow themselves to be constrained by the paternalism and bureaucracy inherent in their organisations. To demonstrate my point here are a just a few of the many comments staff have shared with me.

"We would love to work with a person's voices, but our manager won't allow it".

"My colleagues think I'm mad myself for wanting to work with the client's voices".

"We have to record a person's self harm as attempted suicide."

Although there is barely a national or local mental health policy written that does not wax lyrical about involving the people who use mental health services we often witness that to be at the most tokenistic and at the least non-existent. Logic then dictates that if people are not involved and respected for their expertise in the design and delivery of effective services how can they possibly identify their own needs? In research recently undertaken by Anthony and Crawford (2000) who were investigating how mental health nurses viewed the inclusion of the 'experts by experience' as fundamental to effective, meaningful care plans, these main themes emerged

- ❖ That there should be inclusion of service users in the planning process
- ❖ That the expressed needs should form the basis for care planning
- ❖ The notion of gaining the patient's agreement
- ❖ The provision of relevant information
- ❖ Choice should be facilitated
- ❖ People's views and opinions should be valued

However, despite this degree of consensus, there were inhibiting factors as to why this was not always carried out – limited resources, lack of patient motivation, lack of insight, negative staff attitudes, conflicting duties and responsibilities inhibited the ability to effect an impartial C.P.A.

Thus, achieving the shift can be achingly slow. Incredibly, despite three hospitalisations in the last seven years, I only first became aware of care planning through my involvement with mental health teams when employed as a Recovery Worker. Talking to a range of people who use or have used services about the experience of being 'assessed' I have discovered that many are unaware of the C.P.A. process. Those who have been 'included' in their care planning have felt excluded by the very process – the language, the terminology and the 'jargon' of the medical model.

Gerry McDermott (1998 Nursing Times) writes:

"There was evidence to suggest that patients were unfamiliar with their treatment programmes and lacked knowledge regarding their care." Given that the CPA was designed to maximise the active interest of patients in the care planning process, McDermott quotes that 61.9% of people surveyed did not know what the letters CPA denoted, and 33% did not understand why they had been placed on the programme.

Equally bemused are some of the people who work in services. Having asked many of my colleagues about the writing and delivery of care plans, most stated that they took up an inordinate amount of time and bore little relevance to how they were really working with their clients. Even more alarming is the fact that care plans are only referred to intermittently and not by all agencies involved in an individual's care package.

The information collected in C.P.A. documentation may provide the clinician with information regarding issues such as "risk behaviour", "treatment non-compliance", "clinical symptoms", "drug and alcohol abuse" and yet tell us nothing of a person's gifts and capacities, their hopes and their dreams: their uniqueness as a human being. Rarely does it provide us with information regarding the "nuts and bolts" of an individual's life, the practical issues of how to sustain the person's day to day schedules and what is important and meaningful to their lives. Should crisis arise, the practicalities of who feeds and walks the dog, cares for the children, is trusted with the financial arrangements, looks after valuables etc. may be of paramount importance to the individual yet totally overlooked by the professional who is more focused on symptomology. Once again the

person becomes the sum of their illness. It does not even give us a starting point to work with people towards positive, possible futures.

Unless we fully commit to working within a system that is values driven, with documentation that reflects every aspect of a person's life, particularly that which is meaningful to the individual, the true potential of INCLUSION, RECOVERY and PERSON CENTREDNESS will never be realised. They will become the 'buzz-words', words used in the name of 'political correctness' rather than as practical actions towards a truly 'Recovery Assisting' mental health service. Now more than ever before we have the opportunity to work together to truly 'Walk our Talk'.

I believe that it is possible to make that long overdue transition from service centred to person centred approaches and, along with many others feel that this is an exciting time to be working in mental health services, as the vision of Recovery gains in momentum.

By reducing an individual's life to fit easily into tick boxes, we automatically reduce their dignity. Given that the current terminology of care plans is in the main negative and problem focussed do we only serve to reduce a person to the sum of their 'problem labels'? We potentially create the institutionalisation of both the worker and the client, cultivating the very environment that will nurture the maintenance of a person within the 'illness' context. Stockwell's research on the unpopular client suggests that certain "illnesses" and symptoms make them less attractive, engendering negative attitudes. This, then, may impact on their package of care, influencing a service centred rather than a person centred approach.

Person Centred Planning

MOVING FROM

Planning owned by the professionals

Trying to "fix" people and waiting until they are ready

People being surrounded by paid staff and services

TOWARDS

Planning owned by the person and those close to them

Creating opportunities now and providing support as and when people need it

People having friends and strengthening community connections

Packaging people

Individual / unique support

**Designing a service
Solution to last for
Ever**

**Expecting services and
supports to change as person
changes**

**Clinical descriptions of
People**

People seen as human

Professionals “in charge”

**Sharing power with person and
Those close to the person**

Focusing on what is

Focusing on what could be

**Professional control
Timetabling with special
Programmes and routines**

**Empowering individual
Creating ordinary community
opportunities**

**Responding to top down
control**

**Challenging and changing the
structures that limit us**

**Isolating, labelling and
Ignoring people who present
A challenge**

**Expanding networks and
opportunities**

**Large scale, cheap and
immediate solutions**

**Starting small and learning from
each other along the way**

Other countries have already adopted a more enlightened attitude to C.P.A. In New Zealand, for example, the Waitemata Mental Health services adhere to principles of recovery planning, reflected in their implementation of personal recovery plans which firmly put the individual at the centre of the recovery plan. Terminology is simple, and the aim is to summarise the person's main needs and goals. Action plans are explicit, with agreed time scales where possible, and both parties agreeing to take responsibility. Rather than a risk assessment done by the worker, the individual writes his or her

wellness maintenance and relapse prevention plan, with guidance for the worker on the early warning signs of crisis, and the expectation of his or her treatment, with cultural and spiritual needs also addressed..

Recovery is a social process. In order to reduce stigmatisation it is not only the individual who needs to be supported on his or her journey of recovery, but also the wider community. Media hype fosters fear, ignorance and hostility towards those who use mental health services.

“It is time for professionals to get their act together. They should not be agents of the state, rather the enablers of their local communities. It is their task to tackle the issue of stigma in our society. Stigma is the great disease that is destroying any chance of recovery for the many, forcing those who have mental health problems to hide their problems, which only perpetuates the myths that surround mental health. Mental wellness can only be achieved in a mentally well society, and the professional must be at the forefront of creating this wellness.”

Assimilating people into their communities so that they are able to assume citizenship, friendship and leadership roles, re-connecting people to their natural networks and assisting them to build up their circles of support should form an integral part of the individual's care plan.

“Segregated classrooms, sheltered workshops, group homes, institutional units, and mini-vans can be like small boxes in which we have hidden people with disabilities, their gifts and contributions. People are often trapped by human service settings that tolerate and reinforce the separation of people with disabilities from people and places in community life in which they can contribute. Without access to opportunities in community life, people give up hope that life can be different and make the best of impossible situations.”

Dr Beth Mount

If we are to fully embrace the challenge of working with a recovery assisted approach, our C.P.A. documentation surely has to reflect the values, the vision, the fidelity of practice. The commitment to move towards enhanced recovery and wellness plans which celebrate the individual's journey of recovery.

“Recovery means different things to different people – it is not necessarily about the complete disappearance of mental distress and symptoms. For some it means learning to cope with difficulties, gaining control of our lives, achieving our goals, developing our skills and fulfilling our dreams”.

We have the vision, we have the dream, do we dare to commit to the task?

References

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