

Care programme approach

Recent government policy and legislation

David Kingdon

The care programme approach has been introduced to improve the delivery of services to people with severe mental illness and minimise the risk that they lose contact with mental health services. Its essential elements are assessment of health and social need, a written care plan, nomination of a key worker, and regular review. It requires interprofessional collaboration and negotiation of care plans with users and carers but individual patients vary in their needs for multidisciplinary involvement and review.

The origins of the care programme approach (CPA) can be traced back to the Spokes Inquiry into the Care and After-care of Sharon Campbell (DHSS, 1988). This concluded that there had been a breakdown in the delivery of services effectively resulting in the death of Ms Campbell's social worker. It recommended that the Secretary of State issue to health and local authorities a written summary clarifying their statutory duties to provide after-care for former mentally disordered patients, and that the Royal College of Psychiatrists publish a document on good practice for discharge and after-care (Royal College of Psychiatrists, 1991). Research demonstrating the relatively high levels of psychotic illness among the homeless and in the criminal justice system also reinforced the need for improvement in the organisation and delivery of services.

Glossary

Care management – assessment is made by a care manager who coordinates delivery of care and ensures review and monitoring of it. Care managers may have budgetary responsibility for purchasing care. (They are not, however, precluded from providing care.)

Case management – the same as care management. (User groups and others asked for the term 'case' to be changed to 'care' prior to the publication of the *Caring for People* White Paper.)

Care programme approach – assessment is made by a key worker who coordinates delivery of care and ensures review and monitoring of it. They

will not usually hold budgets. Key workers will be involved in providing care.

Principles

The care programme approach involves:

- (a) assessment of health and social care needs
- (b) a key worker to coordinate care
- (c) a written care plan
- (d) regular review
- (e) interprofessional collaboration
- (f) consultation with users and carers.

Implications for individual psychiatric practice

The care programme approach provides a framework for good practice in delivering care to people accepted by psychiatric services. It applies to all patients accepted by mental health services but multidisciplinary assessment and review is only required for those who are severely mentally ill.

Assessment

If people are not to slip through the safety-net of care, it is essential that all people accepted by specialist psychiatric services and all psychiatric patients considered for discharge from hospital are assessed to decide the degree of complexity needed to deliver their care plan. Their requirements for multidisciplinary management and review will depend on clinical need. In degrees of complexity, three groups need to be considered:

- (a) people with severe mental illness whose multiple needs are such that they require care management in addition to the care programme approach
- (b) people with severe mental illness requiring multidisciplinary care and review but who do not require care management
- (c) people accepted by specialist mental health services who require assessment and management by one professional.

The latter group require a care plan agreed with the patient and that one professional takes the responsibilities of key worker. Regular review needs to occur and be documented in, for example, out-patients or on home visits.

Key workers

A psychiatrist assessing a patient in an out-patient clinic or at home may become the key worker but when other team members are involved in the care of a patient this would usually be a non-medical role. For most patients with severe and enduring mental illness, a social worker or a community psychiatric nurse will be the most appropriate. The key worker should be the focal point of contact for the patient, carer and other professionals, especially the general practitioner (GP), and is responsible for keeping in touch with the patient and seeing that the agreed programme of care is delivered.

Reviews

Where more than two workers are involved in care, a review meeting will usually need to be convened at regular, but not necessarily frequent, intervals. These are, however, very costly in professional time and so need to be brief with clear agendas. It may be appropriate to review a small group of patients who are involved with the same group of professionals sequentially at review meetings. Where only one or two workers are involved, a specific review skill needs to take place but this may be achieved by telephone. This should also be documented with consideration given to involvement of and dissemination to other professionals, e.g. the GP, and social services and a review meeting as such may not be necessary.

Compliance

If a patient refuses contact, a multidisciplinary discussion (although not necessarily a meeting) may establish alternative ways of presenting a care plan which is acceptable to the patient. The patient may opt only to accept a part of the programme offered and as far as possible, the programme should be sufficiently flexible to accommodate this. But even if the programme is wholly rejected, the offering of contact on a regular basis in consultation with the patient's GP needs to continue. The carer also needs to be offered assistance on a regular basis and a reliable point of contact.

Inter-professional collaboration

Team-working is a fundamental principle of psychiatric practice as demonstrated by a range of research (Kingdon, 1992). But networks with others, e.g. housing officers, police, and duty

solicitors, who may have more generic roles, are also of importance.

Implications for users of mental health services

Individual assessment of health and social need and the development of mental health services to respond to these needs is good professional practice and the CPA reinforces this. It also places responsibility for coordination of care on a key worker who users and carers, including GPs, can contact and who is responsible for seeing that care is delivered. Care plans should be negotiated with users. The nature of severe mental illness is such that the user may not agree to part of a plan which seems essential to the team providing care. Maintaining contact with the person, and any carer involved, is a continuing responsibility for the key worker. At a later stage, the user may change his or her mind, or in some instances need care under the Mental Health Act. Intervention needs to be prompt to limit deterioration and risks to self or others.

Implications for working arrangements with purchasers and providers

As the care programme approach provides a description of good practice in the delivery of care, it is being used to establish quality standards in contracts between purchasers and providers. However these can only be meaningful if psychiatrists become involved in this process.

Targeting of resources on severely mentally ill people is specified in the circular as community mental health teams have been prone to move away from care of the severely mentally ill (Weaver & Patmore, 1990). Similar guidance has been issued to general practice fund-holders (NHSME, 1992). The circular also stresses the importance of developing adequate mental health information systems to ensure that information is readily available when required, e.g. about at-risk status, name of key worker or timing of reviews.

International perspective

Deinstitutionalisation is now a major force in shaping services internationally. The USA and UK have been at the forefront of this process and in both there have been serious concerns about:

- (a) care and aftercare of those who might previously have been admitted to institutions.
- (b) the drift of mental health teams away from caring for the most severely mentally ill.

The CPA is a policy response to both concerns.

Concluding remarks

The provision of appropriate care for people with severe mental illness in consultation with them, and their informal and formal carers, is a most complex activity. Defining good practice is, however, essential but is an evolving process. The care programme approach provides a description which has general professional support (Social & Community Planning Research, 1993). Its implementation is progressively focusing the limited resources available on those who need them most.

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Who works with adult victims of childhood sexual abuse?

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A survey of mental health professionals in a Bristol NHS trust found that most had experience of therapeutic work with sexually abused patients and over half were currently engaged in such work. Supervision was variable and often considered inadequate. Few responders routinely enquired about historical abuse in the course of psychiatric assessment. The findings indicate a need for agreed strategy involving training, supervision and inter-agency co-operation to deal with this increasingly common problem.

Background

In a recent review, Beitchman *et al* (1992) concluded that women who reported a history of childhood sexual abuse were more likely than non-abused women to present with a range of sexual and affective disorders, and revictimisation experiences.

Estimates of the prevalence of sexual abuse have varied widely from 6% to 62% in different studies (Finkelhor, 1987), and methodological problems have led Markowe (1988) to question the feasibility of such research. There is good evidence (Hobbs & Wynne, 1987) that diagnosis

of sexual abuse in childhood has increased in Britain in recent years. Disclosure of historical abuse in adulthood also appears to be increasing, but this area has received little research attention.

Similarly, there seems to be limited information about the experience of professionals in abuse work. Bisset & Hunter (1992) found that 73% of surveyed Grampian and North Tayside general practitioners had seen at least one victim of childhood sexual abuse in the previous two years, many referrals occurring several years after the abuse. A review of the literature revealed no data on the extent of involvement of adult mental health workers in the area. This study aimed to find out which members of the psychiatric multidisciplinary team were engaged in therapy or other work with abused patients, and the nature of supervision for this work.

The study

A questionnaire was sent to a group of mental health workers attached to six consultant-led