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The use of operationalised criteria for inclusion on a Care Programme Approach register

AIMS AND METHOD
To determine the rates at which clinical teams within one NHS trust placed older people on a Care Programme Approach (CPA) register and to examine the degree to which clinicians' use of the register conformed to trust policy. Two retrospective case notes surveys were carried out 6 months apart within a completed audit cycle.

RESULTS
Consultant teams varied considerably in their application of the CPA policy. Feedback to clinicians after the first survey had a variety of effects on subsequent use of the CPA register.

CLINICAL IMPLICATIONS
Health service policies exist to reduce variation in clinical practice and to ensure minimum standards. Clinical audit may be a useful tool in identifying irrational variation within the framework of clinical governance.

The Care Programme Approach (CPA; Department of Health, 1990) has been subject to criticism based on lack of evidence for its usefulness (Tyrer *et al*, 1995) and the bureaucratic burden associated with its implementation (Kingdon, 1998; Marshall, 1999). There has also been wide variation in the numbers of patients placed on CPA registers, which is not explained by variation in need (Bindman *et al*, 1999). This may be partly explained by differing CPA policies and procedures. In old age psychiatry services there can be variation between trusts bound by the same CPA criteria within the same health authority (Philpot *et al*, 1998; Wallace & Ball, 1998). Variation in the use of the register within the same trust has also been observed (Philpot & Banerjee, 1997), despite the criteria for inclusion on the register being clearly set down in trust policy. To investigate this variation further we examined the adherence to CPA criteria and the factors affecting the likelihood of a patient's inclusion on the CPA register in three distinct geographical areas of the trust.

The study

The old age psychiatry service of the Bethlem & Maudsley Trust served the London Borough of Croydon (4 consultants), the eastern part of Lambeth (1 consultant) and the southern part of Southwark (3 consultants). In the first survey the case notes of all patients placed on the CPA register between January and March 1998 were reviewed. Demographic and clinical data, including diagnosis, were recorded as well as the presence of the criteria listed below. Register patients were compared with a similar number of 'control' patients whose cases were active at the same time but who were not placed on the register. Cases were matched for sex, age and borough of home address.

The results of the first audit survey were discussed at local audit meetings and disseminated throughout the service. The second survey included all patients registered between October 1998 and March 1999. On this occasion, five control patients were randomly selected from each of nine geographical sectors. The data were collected in the same way as in the first survey.

Twenty-one patients were registered during the first survey period (3 months) and 56 during the second (6 months). Results were compared with 22 and 45 control patients, respectively.

CPA register inclusion criteria

The criteria employed in the Bethlem & Maudsley NHS Trust at the time of the study were a minor modification of those presented in McCarthy *et al* (1995). The criteria for inclusion on the register (level two CPA) were any of the following:

(a) A diagnosis of severe and persistent major mental illness and multi-agency involvement.

(b) One of the following: a history of repeated relapse of illness owing to a breakdown in the patient's medical and/or social care in the community; a history of social dysfunction or major housing difficulties; or a history of serious suicidal risk or self-harm, self-neglect, violence or dangerousness to others.

(c) The patient fulfils criteria for Section 117 after-care.

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A caveat is that any patient who 'clinicians judge would benefit from inclusion on the register' could also be included.

Data analysis

Chi-square and Fisher's exact test were used to compare categorical data between CPA patients and controls, and changes in adherence to the operationalised criteria. The Mann–Whitney *U* test was used to compare years of contact with the psychiatric service.

Findings

At the first survey there were no differences between CPA patients and controls in terms of age, sex, proportion from ethnic minorities, those living alone or unmarried and diagnosis. However, CPA patients were more likely to have involvement of social services (P=0.001), a history of previous admissions (P=0.0001), a longer period of contact with the service (P=0.004) and greater psychotropic drug prescription (P=0.026) than controls. At the second survey only social services involvement (P=0.021) and the proportion of patients living alone (P=0.031) differentiated the two groups.

Table 1 shows the proportion of CPA patients and controls fulfilling each class of criteria. With the exception of 'category (a)' criteria during the first study, CPA patients were more likely than controls to fulfil each of the category requirements for registration. If strictly applied, values for 'per cent fulfilling (a) and (b) and/or (c)' should have been 100% and 0% for CPA patients and controls, respectively. Treating the CPA policy criteria as the gold standard, Table 2 shows how sensitivity, specificity and misclassification rate differed between the three boroughs within the trust at the two survey times. The only significant changes occurred in sensitivity (i.e. the proportion of cases fulfilling the CPA criteria that were actually registered). Sensitivity fell in Croydon but rose in South Southwark. In East Lambeth there were trends suggesting an increase in sensitivity and a fall in misclassification rate. At the second survey misclassification rates for individual consultants varied between 9 and 63%. Table 2 also shows the average monthly patient registration rates during each audit. The patient's borough was an important factor in registration rate, practice varying between surveys particularly in Croydon and South Southwark.

Discussion

Our results confirm the variability in the use of the CPA register and the application of the defining criteria in an old age psychiatry service. During the discussion following presentation of the first survey results it became apparent that some consultants believed that no clinical benefits to patients were derived from the use of the CPA register and that in one borough social workers would only assess those patients placed on the register. Reaction to the first audit survey varied. The rate of CPA registration by one consultant team rose dramatically to include nearly all patients referred to the service, while registration in one other team virtually ceased.

Table 1. Proportion of registered patients and controls meeting Care Programme Approach (CPA) criteria

	First survey			Second survey		
	CPA	Control	P[1]	CPA	Control	P[1]
Number of cases	21	22		56	45	
Per cent with major mental illness (a)	100	82	0.059	73	44	0.003
Per cent with at least one risk factor (b)	81	36	0.003	86	51	0.0002
Per cent fulfilling (a) and (b)	81	36	0.003	64	36	0.004
Per cent where section 117 applies (c)	33	0	0.004	20	0	0.007
Per cent fulfilling (a) and (b) and/or (c)	81	0	0.003	73	33	0.006

1. χ^2 or Fisher's exact test.

Table 2. Adherence to Care Programme Approach criteria and registration rate in the three geographical areas served by the trust

	Croydon		East Lambeth		South Southwark	
Survey	First	Second	First	Second	First	Second
Sensitivity (%)	78	29[1]	57	78	50	91[2]
Specificity (%)	67	91	50	88	100	50
Misclassification rate (%)	29	44	46	18	33	27
Patients registered per month per 100 000 elderly in catchment area during survey periods	7	0.2	2	1	1	4

1. P=0.0029 χ^2 significant changes.
2. P=0.030 χ^2 significant changes.

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In our study we did not seek to determine whether the clinical care of individual patients was in any way affected by the CPA policy or whether the variation in practice had a bearing on the quality of care given. Slavish adherence to guidelines does not necessarily guarantee quality of service (Marshall *et al*, 1997; Schneider *et al*, 1999). However, failure to fully apply clinical policies such as the CPA has lead to criticism of psychiatric services in a number of recent serious incident inquiries (Baroness Scotland of Asthal *et al*, 1998).

Health service policies are written to reduce variations and to eliminate unacceptable omissions in clinical practice. Where policies are developed in negotiation with clinicians, as was the case with the policy examined here, it is reasonable to expect closer adherence than was found in this study. It is possible that weaknesses in one aspect of a clinician's practice reflects problems elsewhere. Audits of routine matters such as the CPA may be one method of ensuring acceptable practice within the framework of clinical governance.

References

BINDMAN, J., BECK, A., GLOVER, G., *et al* (1999) Evaluating mental health policy in England. Care Programme Approach and Supervision registers. *British Journal of Psychiatry*, **175**, 327–330.

DEPARTMENT OF HEALTH (1990) *Care Programme Approach. C(90)23/LASSL(90)11*. London: Department of Health.

KINGDON, D. (1998) Reclaiming the care programme approach. *Psychiatric Bulletin*, **22**, 341.

MACARTHY, A., ROY, D., HOLLOWAY, F., *et al* (1995) Supervision registers and the care programme approach: a practical solution. *Psychiatric Bulletin*, **19**, 195–199.

MARSHALL, M. (1999) Modernising mental health services. *British Medical Journal*, **318**, 3–4.

MARSHALL, M., GRAY, A., LOCKWOOD, A., *et al* (1997) Case management for severe mental disorders. In: *The Cochrane Library*. Oxford: Update Software.

PHILPOT, M. & BANERJEE, S. (1997) Mental health services for older people in London. In *London's Mental Health. The Report for the King's Fund London Commission* (eds S. Johnson, R. Ramsey, G. Thornicroft, *et al*). London: King's Fund Publishing.

—, SHEEHAN, B. & REEVES, S. (1998) Use of the Care Programme Approach register by an inner-city old age psychiatry team. *Psychiatric Bulletin*, **22**, 772.

SCHNEIDER, J., CARPENTER, J. & BRANDON, T. (1999) Operation and organisation of services for people with severe mental illness in the UK. A survey of the Care Programme Approach. *British Journal of Psychiatry*, **175**, 422–425.

BARONESS SCOTLAND OF ASTHAL, KELLY, H., DEVAUX, M., *et al* (1998) *The Report of the Luke Warm Luke Mental Health Inquiry, Volumes I and II*. London: Lambeth, Southwark and Lewisham Health Authority.

TYRER, P., MORGAN, J., VAN HORN, E., *et al* (1995) A randomised controlled study of close monitoring of vulnerable psychiatric patients. *Lancet*, **345**, 756–759.

WALLACE, J. & BALL, C. J. (1998) Use of the Care Programme Approach register by an inner-city old age psychiatry team. *Psychiatric Bulletin*, **22**, 489–491.

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Use of a prescribing protocol in routine clinical practice: experience following the introduction of donepezil

AIMS AND METHOD
Following the introduction of donepezil into clinical practice a protocol for prescribing it was developed in Leicestershire. A prospective clinical audit was undertaken to monitor compliance with the protocol, which also provided an opportunity to evaluate the outcome of therapy in routine clinical practice.

RESULTS
Overall there was close adherence to the protocol by the clinicians and clinical factors, as well as organisational and resource-related factors, were important in determining who received treatment. The principal outcome measures (Mini-Mental State Examination, Barthel ADL Index and Clinical Dementia Rating Scale) did not demonstrate any significant treatment effect.

CLINICAL IMPLICATIONS
This study demonstrates the feasibility and acceptability of using a protocol-based approach to manage the introduction of new drug treatments in psychiatry.

Donepezil was the first drug to receive a licence in the UK (in the spring of 1997) for the treatment of Alzheimer's disease. At the time there was only one published clinical trial using the drug (Rogers & Friedhoff, 1996) and this had shown only modest improvement in cognitive performance in patients with Alzheimer's disease. It was estimated that the annual cost of drug treatment (excluding any other costs, e.g. investigations) would be about £1000 per patient. As a result there was widespread uncertainty among both clinicians and health service managers in many parts of the country concerning the cost-effectiveness of providing this treatment (Alzheimer's Disease Society, 1997). Thus, in some parts of the country the policy was simply not to prescribe, while in other areas local guidelines were developed for prescribing donepezil (Harvey, 1999).

In Leicestershire it was decided that donepezil should be available but the treatment should be targeted at patients for whom there is evidence of

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