
Making care programming work

David Kingdon

It is hard to disagree with the principles of the care programme approach (SPCR, 1993; Kingdon, 1994) but it has been much harder to agree how to put them into practice. What should be 'just good practice' becomes more complex the more it is discussed by clinical teams.

This is even more so where the experience and expertise of clinicians have not been made available or used by managers, who have then developed a system required by the Department of Health but not precisely defined by it. In these circumstances, inevitably some provider unit systems have become bureaucratic and over-inclusive. Every unit is different and so procedures for implementation need to be shaped to best fit the needs of the users, carers and others involved locally, and the ways of working of professional staff within services.

The pressures on services are such that the fewer the changes necessary to meet the objectives of the care programme approach (CPA), the more likely are the devised systems to be effective. While there is no one correct way to implement the CPA, this article may provide some useful suggestions on refining local implementation.

Local implementation

It is important to bear in mind that the CPA is primarily designed to ensure that severely mentally ill people do not fall through the 'safety-net of care'. It applies to all people accepted by mental health services or discharged from an in-patient setting.

Only by including all patients in the approach can all patients with severe mental illness be identified. However, this may be a reason why so many districts have been over-prescriptive in the form-filling and review procedures required. Paradoxically, it may have slowed down implementation of the CPA and deterred targeting of severely mentally ill people. As it is to apply to all patients and consequently applied by all staff

receiving direct referrals or involved in discharge of patients, the CPA needs to be integrated as far as possible with present practice, particularly in the absence of computerised systems in most units to support it. However, to introduce the CPA, many districts have commenced by identifying patients with severe mental illness currently in contact with services and applying the CPA to them before extending it to the service as a whole.

Box 1. The care programme approach should ensure that mentally ill people have:

- 1 Their health and social care needs assessed**
- 2 A named key worker**
- 3 An identifiable care plan**
- 4 A review date when their care is to be reviewed**

Collaboration

The CPA also involves interprofessional collaboration which should occur within teams (Kingdon, 1992). But this does not mean that everyone, or even the majority, needs a multidisciplinary review – clearly that would be quite impractical as thousands of patients are seen by individual sector teams annually.

The care plan should always be drawn up in consultation with the user/patient. Unless it is understood and agreed, a care plan is unlikely to be followed. This means discussion, understanding and agreement of the different components of the plan as it is developed. Exceptionally there may be necessary components which are not agreed despite full discussion, for example placement on a supervision register or taking of medication while on leave under a section of the Mental Health Act, but these will occur rarely.

The care plan should also include the views of carer, GP and any other involved professional.

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Sometimes patients do not want their carer involved and difficult issues of confidentiality can arise. While information about the patient can be disclosed against their will only in exceptional circumstances, patients are often prepared to allow limited information to be given and this should be negotiated with them.

Needs assessment

As part of good practice, assessment should be of both health and social needs, whoever carries it out, for example as part of a psychiatric interview or social work assessment. For psychiatrists, the CPA was intended to draw particular attention to the social care needs of patients, the importance of which may have been neglected previously. Where specific needs are noted, it may be appropriate to refer to the relevant professional for further, more detailed or specialised assessment, for example a social worker for social care needs or a doctor or nurse for health care needs.

In most services, this does not involve a radical change in practice – although it may be an improvement in it – and, under the CPA, it does not need duplication of documentation. Inter-professional collaboration means that the results of assessments will be discussed (such as at ward rounds and reviews), written in case notes, mental health nursing records, and so forth, and sent in referral letters/forms or other letters to GPs and to others when they are also involved in the person's care.

Key workers

Basic personal details are collected as part of the initial referral process and so it is difficult to conceive of a reason why they should need to be repeated in CPA documentation. However, they may need to be supplemented and one way of doing this would be to include a sheet attached to the inside of the medical and other clinical notes to include the following:

- (1) name and full address details of current CPA key worker
- (2) other relevant information, regarding inclusion on supervision registers, whether the person is subject to care under Section 117, and care management details.

This could be completed on initial assessment, even if it has only the name of the person making that assessment prior to another key worker being appointed, and then kept up-to-date. Labels with the names, addresses and telephone numbers of

all potential key workers can be produced by most patient administration systems and can be circulated so that everybody has a stock of their own to use. If someone is appointed as a key worker, they should agree to this – which, unfortunately, has not always been the case, as detailed in the Ritchie Report (HMSO, 1994).

CPA key workers can come from any discipline, including psychiatry, psychology, social work, occupational therapy, art therapy and mental health nursing. Their major responsibilities are to be a specific contact point for users/patients, carers, GPs and others, and to ensure that reviews occur where needed. Such reviews may be made regularly, usually every three to six months or even annually where someone's needs are not changing, or urgently, where concern arises.

Key workers cannot be responsible for all the care of any individual but they can ensure that if problems do arise, they are brought to the attention of those others caring for the person (or rarely, where there is concern about an individual professional's performance, the relevant manager.)

Flexibility

One of the key principles of the care programme approach is that of flexibility in response to severely mentally ill people, so that where one aspect of a care programme is unacceptable to a patient, alternatives are offered as far as is practical. For example, a patient may refuse depot medication but accept oral or an alternative type of neuroleptic or even day care, and while this may be medically less appropriate, it may be worth offering as an alternative.

While the patient may then fail to comply with the alternative, the use of a negotiating approach in the longer term is likely to improve compliance and is certainly what patient groups are asking for. (There are several Medical Research Council projects under way to further develop techniques for improving treatment compliance.) 'All or nothing' approaches, in which the response where the patient does not accept the 'package' on offer has been that 'there's nothing we can do', cannot be acceptable any longer.

Keeping in contact

If the patient will not take medication, or accept a rehabilitation programme or offer of supported accommodation, they may nevertheless agree to continuing contact. They may change their mind about treatment or deteriorate to an extent when intervention under the Mental Health Act is appropriate. But at least continuing contact means that this occurs early rather than late, before the

secondary impairments caused by the illness (damage to relationships, loss of job or accommodation) can occur.

It may be that the only continuing contact possible is with the carer, who then can be offered continuing support and access to services if the patient deteriorates. Although, occasionally, the patient may object to such continuing contact with carers, carers also have rights to support which can not be over-riden by patient's demands as long as confidentiality boundaries are maintained.

Ensuring continuity

Interprofessional collaboration is integral to the provision of continuing care. When interruptions to care occur, for example where patients fail to attend appointments or they discharge themselves from hospital, follow-up by a social work or mental health nurse to re-engage them with services may be the most cost-effective strategy. It may be more appropriate for the GP or psychiatrist to make contact by telephone or by visiting. This would be the case where contact by a nurse or social worker has failed, or where specific medical issues or reassessment mean that a medical opinion is necessary. It would be appropriate where the relationship between the patient and GP or psychiatrist has been good, and is especially likely to result in successful re-engagement.

The organisation of continuing care and supervision for severely mentally ill people outside hospital is best done by a combination of community team members, usually a nurse, social worker and doctor – although only one of the group may be required to be in contact at any one time. Continuity can be a problem where out-patient settings are relied upon, unless the consultant ensures continuing personal contact with patients. Patients commonly complain that each time they come to out-patient departments they see a different doctor. This reduces the potential for early intervention.

Prioritisation

Associate specialists, staff grade and clinical assistants as well as consultants can assist in improving continuity of care although their workloads may need re-prioritising.

Expressed need for mental health care is constantly increasing and caseloads cannot be expanded infinitely. Prioritisation of new referrals and continuing cases according to need is fundamentally important. Consultants and nurse, social work, and psychology managers acting together can produce manageable and equitable systems for allocating work which are defensible

to GPs and DHA purchasers, but too often this is still dependent on goodwill and hard bargaining rather than rational criteria.

Prioritisation may mean that examination of referrals together with current case loads leads to increased waiting times or briefer interventions for those with less severe mental health problems. The introduction of the Health of the Nation Outcome Scales (DoH, 1994) may assist in the future by giving some quantification of need and outcome on which to base prioritisation. It may be easier to 'sell' prioritisation to DHA and GP purchasers, other GPs and also psychiatric and community team colleagues if the evidence for the comparative effectiveness of treatments for severe and less severe mental illnesses is cited (Conway *et al*, 1994; DoH, 1994).

Counsellors

In this context, while the rapid growth of counsellors in general practice has mixed blessings, they are likely to be most effective and of greatest assistance to community and primary care teams if integration or at least good communication with them occurs. Counsellors are expected to develop their own support and supervision frameworks, and participation in these by community teams can maximise their effectiveness and allow community teams to concentrate their efforts on those with greatest need. Self-help techniques and voluntary groups also have a major part to play, being as effective in management of minor neurotic disorders as trained nursing staff (Tyrer *et al*, 1988).

Individual care plans

Written care plans should be completed at initial assessments and updated at reviews. This simply means that the care plan, which would normally be completed at the end of an assessment and re-assessment, for example in an out-patient clinic or at a review meeting, should be written in clinical notes. A care plan needs to be clearly identifiable, i.e. on a separate sheet or under a separate heading. It is important that a current care plan does not get lost within clinical records, and that it can be located rapidly by medical colleagues or locums who may be looking after a patient temporarily.

For most patients with severe mental illness, a care plan would contain specific actions involving more than one professional. For example:

- (1) continuing medical review in out-patients
- (2) continue administration of depot medication
- (3) encourage attendance at a day centre

- (4) assist in claiming Daily Living Allowance
- (5) start behavioural family therapy

A review date and location would be set such that reviews occur regularly and as frequently as the team providing care for them decide.

Although it is not specifically a part of the CPA, a copy of this plan may be given to patients/users, carers, GPs and other professionals. For in-patients being discharged and patients who are reviewed by the multidisciplinary team, this can be a way of improving compliance with management regimes and is worth considering in all instances. On the reverse of the plan, spaces for labels giving names and contact points of key workers and others can ensure that the patient, carer and GP know who is involved in care.

Box 2. Patient, carer, GP and others involved should be aware of:

- 1 **The next care plan review date**
- 2 **The name of the key worker**
- 3 **How and where to contact the key worker or deputy**
- 4 **Information about past harm to self or others**
- 5 **What to do if the patient fails to follow their care plan**

Case studies

B, aged 20 and unemployed, was being seen in an out-patient department and by a community psychiatric nurse. She had been distressed with suicidal ideas over the past year and had frequently taken to her bed after minor disagreements with her parents. Work was under way with her parents and herself independently and jointly. Reviews were programmed with the patient and her mother, and also occurred between psychiatrist and CPN at their regular meetings to discuss patients with whom they were both involved. Her care plan involved:

- (1) continue individual counselling at home...SE
 - (2) continue family work with B. and mother...D/SE
 - (3) medication: fluoxetine 20mg (mornings)...DK
 - (4) review in one month in out-patients ...DK/SE
- Key worker: SE
 Day Centre (Tel. No.)

M, aged 39, has a 20-year history of schizophrenia. He lives in a council flat and his parents remain in regular contact with him but find this stressful. He will not attend the local day centre but he accepts visits from a social work assistant (SWA) and attends an out-patient department every six weeks for

medication. A domiciliary care assistant was withdrawn after she became concerned about her safety.

A care manager coordinates his care. He has been considered for inclusion on the local supervision register but after analysis of the evidence of the risk to others (from the care assistant and her supervisor) and to self (as he had made a serious suicidal attempt five years previously), and consultation with the team involved, the consultant psychiatrist decided not to seek his inclusion as he was complying with care and not at risk of 'falling through the net'. This would however be reviewed at his regular six-monthly review meetings which usually last between 30 and 45 minutes. His care plan was:

- (1) medication monitored in out-patients...DK
 - (2) bi-weekly visiting from SWA...GD
 - (3) renegotiate domiciliary services assistance...BH
 - (4) parents to make contact with DK/BH if concerns arise
 - (5) next review meeting – 23 April 1995 at 11.30
- Key worker: BH
 Day Centre (Tel. No.)

Care management, after-care and supervision registers

The CPA and care management (CM) involve very similar processes – assessment, review and coordination of care. The differences are primarily theoretical. The CPA is led by health services, and the CM by social services; the former applies to people referred to specialist psychiatric services, while the latter, which is gradually being introduced, will apply to other client groups, for example old people and people with physical and learning disabilities. Care management is likely to apply to many people with severe mental illness as most have social care needs to be met.

When patients with mental illness are allocated a care manager by social services, it should usually make sense for that manager to be the nominated CPA key worker if they are a mental health worker. Likewise, procedures for the CPA and CM assessments need not duplicate each other and there is much to be said for using the same core procedures to avoid repetition for patients.

The Mental Health Act

Section 117 of the Mental Health Act places legal obligations on health and social services to provide after-care for patients detained under certain sections of the Mental Health Act (e.g. Sections 3 & 37). The care programme approach places precisely the same obligations on health and social services

for all patients accepted by mental health services, but does so in guidance. Thus, using the same core procedures and documentation can avoid repetition.

The procedures for assessing whether someone should go on a supervision register require a multidisciplinary review and, as the guidance describes, this can be usefully combined with a general care programme review (see Box 1). This will be a small group of patients whose risk to themselves and others is greatest.

Conclusions

The care programme approach does mean modifying the way many services deliver care at the moment, allowing the needs of severely mentally ill people to be prioritised, but it is not designed to bureaucratise it. It is essential that systems are comprehensive and comprehensible but not over-inclusive; integrated with procedures for Section 117 after-care, care management & supervision registers; easy to audit; and above all, workable and cost-effective in terms of time expended.

Systems usually have 'teething problems' and so need to be formally reviewed at intervals in the relevant forums, including medical staff meetings. The evidence from evaluations of the CPA (Pierides & Casey, 1994) is now confirming its effectiveness in improving the delivery of care to people suffering from severe mental illness.

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References

- Conway, A.S., Melzer, D. & Hale, A.S. (1994) The outcome of targeting community mental health services: evidence from the West Lambeth schizophrenia cohort. *British Medical Journal*, **308**, 627–630.
- Department of Health (1994) *Health of the Nation. Key Area Handbook: Mental Illness*. 2nd edn (in press). London: HMSO.
- Her Majesty's Stationery Office (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.
- Kingdon, D. G. (1992) Interprofessional collaboration in mental health. *Journal of Interprofessional Care*, **6**, 141–148.
- (1994) The care programme approach. *Psychiatric Bulletin*, **18**, 68–70.
- Pierides, M., Roy, D. & Craig, T. (1994) The Care Programme Approach. Preliminary results one year after implementation in an inner city hospital. *Psychiatric Bulletin*, **18**, 249.
- Social & Community Planning Research (1993) Factors

influencing the implementation of the Care Programme Approach. London: HMSO.

Tyrer, P., Sievwright, N., Kingdon, D., et al. (1988) The Nottingham study of neurotic disorder: comparison of drug and psychological treatments. *Lancet*, *ii*, 235–240.

Appendix

Brief guide to supervision registers

(1) Aim: to ensure that those patients who are most at risk to themselves or others receive adequate care, support and supervision in the community.

(2) The decision about inclusion rests with the consultant psychiatrist responsible for care, in consultation with a multi-disciplinary team.

(3) Evidence on which judgement of risk is made must be recorded in written form and made available to the relevant professionals for the review meeting.

(4) Categories of inclusion:

(a) significant risk of suicide

(b) significant risk of serious violence to others

(c) significant risk of severe self-neglect

This applies to those outside hospital – if they are immediately admitted to hospital, registration may not be necessary unless they are already on the register. But they should not be removed during the period of admission while significant risk persists.

(5) Method of including a patient on the register:

(a) All patients should be assessed for above categories of risk, at assessments, e.g. in out-patients and at review meetings.

(b) If they may qualify, a review meeting should be set up with relevant team members, the person and their carer to consider whether the person should be included on the register.

(c) If they are included, a register form should be completed and conveyed to the Register Manager.

(d) If they are included, the patient must be informed orally and in writing:

i. when and broadly why they have been included

ii. to whom the registration details may be disclosed

iii. mechanisms of review.

Only in very exceptional circumstances can they not be informed and such a decision would need to be taken by the team and psychiatrist. The GP should always be informed.

(e) Review of inclusion should occur at least every six months and the patient taken off the register if risk no longer exists.

(6) If the patient appeals against being on the register, the consultant psychiatrist needs to consider this in consultation with other members involved in the person's care. If the patient remains dissatisfied, the normal routes for complaint and right to a second opinion apply.

(7) If someone on the register is transferred to another provider unit, a copy of their record should be urgently transferred with them.

(8) An executive member of the Trust, preferably with a clinical background, should be identified to oversee the management of the register.

(Note: this guide is not a substitute for reading the full guidance)

Multiple choice questions

1 The care programme approach:

- a only applies to severely mentally ill people
- b is designed to ensure that a 'safety-net of care' exists
- c requires regular multidisciplinary reviews on all severely mentally ill patients
- d involves interprofessional collaboration

2 A CPA keyworker:

- a cannot also be responsible medical officer
- b could also be the patient's care manager
- c should ensure that assessment of a patient's health and social needs occurs
- d should see that a review of a patient's care occurs at least every six months

3 If a patient:

- a has not had their basic community care needs met, they should not be discharged from hospital
- b fails to comply with medication or a rehabilitation programme, there is nothing much else you can do
- c has been detained under section 2 of the Mental Health Act, the relevant social services department, but not the DHA, are legally obliged to provide aftercare
- d is placed on a supervision register, they should be informed both orally and in writing (unless there are exceptional circumstances)

MCQ answers

- | | |
|-----|-----|
| 1 | 3 |
| a F | a T |
| b T | b F |
| c F | c F |
| d T | d T |
| 2 | |
| a F | |
| b T | |
| c T | |
| d F | |