The care programme approach

A descriptive study of its use among discharges from the Southsea acute psychiatric unit

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The CPA encourages good psychiatric practice in the continuing care in the community of people who suffer with serious mental illness. The tiered CPA has recently been proposed with a view to channel resources towards those patients who are most in need. This study assesses whether the CPA is used appropriately and effectively among patients discharged in an inner city sector where there is a high level of serious mental illness. The results suggest that it is feasible provided there is an adequately developed community mental health team.

Health Authorities were required to introduce the Care Programme Approach (CPA) in 1991 (Department of Health, 1990). It was envisaged that it would form the cornerstone of good practice in the care of people with mental illness. In broad terms, anyone who is involved with specialist psychiatric services is entitled to be included in the CPA. In narrower terms, it ensures that those who are especially vulnerable or who pose a risk in other ways due to mental illness will receive appropriate psychiatric and social care in the community. The latter, care management, is provided by Local Authority Social Services Departments who have duties under the NHS and Community Care Act 1990 to assess people's needs for community care services, to formulate a care plan and to ensure its implementation (House of Commons, 1990). Care programming and care management are founded on the same principles and with psychiatric patients are necessarily closely interlinked.

There are four basic elements to any effective care programme:

(a) systematic multidisciplinary assessment of health and social care needs
(b) a care plan agreed between relevant professionals, the patient and main carers, recorded in writing
(c) the allocation of a key worker to coordinate services
(d) regular review of the patient's progress and continuing health and social care needs.

The concept of the tiered CPA has now been introduced (Department of Health, 1994*a*), with elaboration (Department of Health, 1994*b*). It recognises that patients' needs vary widely, attempts to avoid unnecessary bureaucracy thus channelling resources more effectively towards patients with serious mental illness or who pose higher risk. Therefore, patients with low needs will require a minimal CPA, with little inter-agency working, others will require a more complex CPA, and a minority will require a full multidisciplinary CPA depending on factors including their vulnerability and risk to themselves and others. Given the continued move towards community based psychiatric care, requirements of statutory aftercare, the introduction of the supervision register, supervised discharge and pressure on finite resources, it is essential to ensure that the CPA is implemented appropriately and operates to required standards. The present study sets out to test this.

The study

Southsea mental health services

Southsea occupies the southern third of the city of Portsmouth and has an adult population of approximately 40 000 aged between 15 and 65 years. It has many features of an inner city, including a high level of cheap bedsit accommodation. This tends to attract people with serious mental illness, because they drift there or find themselves placed there by outside agencies. The community base, Cavendish House is a converted three story Victorian mansion which is staffed by a team including a consultant psychiatrist, senior registrar, CPNs, trained counsellors, one full time occupational therapist, one part time psychologist, support workers and secretarial staff. It is well established, and close links with general practitioners and social services have evolved. The in-patient unit comprises 30 beds, including a six bed ICU and is shared with the other two Portsmouth City teams. It is situated at St James Hospital, an old Victorian asylum currently under redevelopment.

All patients discharged during the last four months of 1994 were identified and their medical case notes studied further. Where indicated, additional information was sought from other

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sources including professionals involved in their care, in particular, the key worker. In addition to basic personal, sociodemographic and clinical details, the following variables were assessed:

(a) Level of risk to self or others on a 3 point scale: little or no risk, usual risk as identified in psychiatric patients in general, and significant risk to self or others or both. Factors taken into account in the assessment were past and current acts of DSH or harm to others, past and current self-neglect, past compliance with medication, current mental state and social support
(b) allocation of key worker
(c) level of CPA on a three point scale: no CPA, minimal CPA and full multidisciplinary CPA
(d) presence in clinical notes of prescribed CPA form.

Findings

There were 68 recorded discharges during the period of study involving 61 patients (34 women, 27 men), mean age 39 years (range 18–64). Fifty-four (88.5%) were single, separated, divorced or widowed and 46 (75.4%) had previous psychiatric admissions. Among all discharges, 17 (25%) had been admitted under the MHA and a further three (5.9%) of the informal patients were subsequently detained formally. The mean length of stay was 26 days (range 1–378). If the three shortest and three longest admissions were excluded, this figure fell to 18 days.

Schizophrenia, serious affective disorder or other psychosis was diagnosed in 51 (75%) of the cases, and non-major depression, substance misuse or personality disorder, or a combination of these in the rest. Risk assessment indicated that six (8.8%) posed no risk, 57 (83.8%) posed a normal risk and five (7.4%) posed a significant risk.

A key worker was identified in 61 (89.7%) of discharges and 63 (92.6%) received at least a minimal CPA, in that decisions about their discharge and aftercare were made at a ward review attended by senior members of the medical and nursing teams. Of the completed CPAs, 17 (27%) were full multidisciplinary meetings, 21 (33.3%) were reviews of previously held full CPAs and 25 (39.7%) were minimal CPAs. Of the 51 cases diagnosed as suffering from a serious mental illness, 35 (68.6%) received a full or review CPA, 12 (23.5%) a minimal CPA and four (7.8%) no CPA.

The prescribed CPA form was present in 35 (55.5%) of the medical notes of those who had received a CPA and in 34 (89.5%) of the notes of those who had received a full or review CPA.

Comment

Data from the OPCS Morbidity Survey (1995) give a prevalence of functional psychosis in adults in the community of 4/1000/year nationally, 50% of whom, on average, are in touch with the psychiatric services in any year. In Southsea, therefore, an annual prevalence of 160 people with a functional psychosis and approximately 80 identified to the local service would be expected. However, by extrapolation from the figures presented here, there was an annual discharge rate of 153 for this group, suggesting an extremely high prevalence level for Southsea. As multiple repeat admissions were not a pronounced feature of this sample, two other factors may be relevant. First, Southsea is an inner city area with an abundance of cheap bedsit and hostel accommodation. People with serious mental illness are frequently placed there from outside the catchment area and are already identified to the service. Second, there are well established links with local general practitioners, social services and user groups, not least of which is an accessible emergency walk-in service at the community base. Therefore, Southsea would have both a higher than average prevalence of people suffering with a functional psychosis, together with a higher than average identification rate. These factors require further study as they raise important questions regarding future resource planning.

All five patients who were assessed as posing a significant risk received a full CPA. Among the five patients who did not receive a CPA at the time of discharge, two left the ward and did not return, two discharged themselves against medical advice at weekends and one took her discharge within 24 hours of admission. However, three were subsequently followed up by psychiatric services in the community, one was referred to a GP and one was lost to follow-up entirely. In terms of those seven patients who did not have a key worker, two were discharged to a GP, one left without returning and four were transferred to the care of other psychiatric services. Of the 25 patients who received a minimal CPA, 15 were offered psychiatric out-patient support together with CPN involvement or involvement with other counselling services, six were offered psychiatric out-patient support alone, three were transferred to other professional services and one was discharged to a GP.

Only one seriously mentally ill patient was lost to follow-up. On closer examination, the patient was a young single male, of no fixed abode, who was most likely suffering from a drug induced psychosis and who went AWOL during a weekend. This highlights a major weak point. Mechanisms must be in place to ensure that the service is alerted to self-discharges and 'out of hours'

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discharges so that appropriate follow-up is implemented. In this respect, a weekly review of such cases or a 'CPA review' as part of the formal ward round is recommended. The required CPA form should also be completed in all cases at the same time and circulated appropriately.

Although 44.5% of CPA forms were not filled in during the period of the study, observation suggested that this rate was improving as colleagues became more aware of the concept of the CPA while it was in progress. In a recent study from an inner city area (Tyrer *et al*, 1995), those vulnerable patients who received close supervision in the community by a key worker along CPA guidelines were found to be much less likely to be lost to follow-up compared with similar patients who received standard care from psychiatric and social services. Therefore, it seems logical that by mandatory use of a standard CPA form attention among all health workers would become more focused to the aftercare needs of patients with subsequent improvement of their care in the community. Audit of this aspect of psychiatric practice could also then be readily undertaken.

Concern has been expressed among many mental health professionals regarding the feasibility of adopting the CPA. Critics claim that it is overinclusive and puts additional pressure on strained resources. The tiered CPA has been fully implemented in the Southsea sector of the city of Portsmouth. This study suggests that it can be used appropriately and effectively without the need for additional staff or other special resources, provided well developed community services are in place.

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