

Introducing the care programme approach to a multidisciplinary team: the impact on clinical practice

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This paper describes the development of a simple computer-based care programme system. An important issue in its development was the attitude of professional staff. After one year of use staff recognised the system as a useful and practical aid in the management of their cases.

In 1990 the Department of Health issued guidance in Circular HC(90)23 requiring health authorities to implement the care programme approach (CPA) for all patients with mental illness referred to specialist psychiatric services. The exact methods to be used in the clinical care of patients were not specified but the paper stressed the importance of close multidisciplinary working in the approach. The 'key-worker' was defined as a named person appointed to keep in close touch with the patient and to monitor that the agreed health and social care was given.

Although the concept of the key-worker was already commonly used in mental health services, written multidisciplinary care plans and CPA were not. What is the impact of these methods on the practice of mental health professionals? This paper describes the effect of introducing a simple care programme system on the work of one multidisciplinary mental health team.

The setting

Central Merton Mental Health Team (CMMHT) is a multidisciplinary team providing a specialist general psychiatric service to approximately 32,000 people in the London Borough of Merton. Before 1991, key-workers had been allocated to individual patients in the community, but standardised written care plans were not in use and multidisciplinary

discussion was on an informal basis. As Pathfinder, the Wandsworth Mental Health Unit, conducts a yearly audit of all patients known to have been in contact with psychiatric services for two years or more, CMMHT planned to introduce a care programme system after the 1991 census and compare the pattern of care given then with that after the 1992 census.

The care programme system

The team decided to develop an information system that had the following objectives:

- (a) to monitor the workload of the team
- (b) to collect the information required by the Pathfinder long-term case register on all cases in contact with the team
- (c) to organise a care programme system for the team which would incorporate regular multidisciplinary reviews
- (d) to provide demographic and clinical information on the team's caseload
- (e) to ensure that patients received an ICD-9 diagnosis on their discharge from Springfield Hospital.

As no extra resources or expertise were allocated to implement the CPA, the team decided to use software readily available and invest some time in staff training. The consultant psychiatrist went on a two day course to learn the operation of the database component of SMART, an integrated word processor, database and spreadsheet package, and developed a system to fulfil the requirements given above. Members of the team obtained examples of written care plans from other services and designed a form for this service. The form contains the name of the

patient, the key-worker and his/her profession, basic administrative information and the diagnosis. Five objectives including the methods to achieve them and the professional responsible follow. There is space for free text and the date of the next review. We expected the reviews to take place at least every six months. We introduced a diary for planning case reviews in the setting of a weekly case conference. Security for the system was assured by the normal procedures in use in the mental health unit.

Patients and their carers were to be involved in drawing up care plans, and to have copies of them if they wished. We agreed that normally patients would not attend their reviews as we felt this was not an appropriate setting for detailed discussion. If necessary, the key-worker could modify a care plan outside of the review meeting. Copies of the care plan would be made available to a patient's GP, key-worker and anyone else with a major role in the plan. We agreed to collect basic demographic information on all patients in contact with and referred to the team. Short questionnaires were completed by key-workers on current patients, and the assessing professionals for new referrals. The system was to be reviewed after six months as part of the team's clinical audit.

Identifying benefits to the members of the team was a very important part of the process in gaining commitment from staff to implement the system. Initially, many of the team felt that it would involve extra form filling with no gain to patients or staff. In particular, the secretaries thought their work load would be excessive as they had the task of putting data onto the system. We held a number of planning meetings to discuss implementation of the system, and to negotiate what tasks we could stop. Finally, all members of the team signed up to the process. The 'carrot' was the probability that staff would no longer have to complete detailed forms for the long-term case register on an annual basis. Junior doctors would benefit as discharge summaries for in-patients could be reduced in length, partly replaced by the individual care plans. Everyone remained uncertain and apprehensive about the effect of the structure of the written care plan on their own practice.

Outcome

On 1 April 1991, the long-term case register audit showed that the team was in contact

with 89 long-term patients. All had an allocated key-worker, but none a written care plan. On 1 April 1992 100 long-term patients were in contact with the service. All had a key-worker and 90% a written care plan. All members of the team were now using written care plans as the main framework for managing cases. The earlier fears about writing down plans had not been fulfilled, and staff had moved towards using them in a high proportion of new referrals of acute cases as well. In the year up to April 1992, 182 new patients were assessed by the team, 83% were allocated a key-worker and 54% received a written care plan.

As new patients with acute problems needed frequent discussion, meeting time became crowded and required careful management by the team. We undertook eight to ten reviews each week in multidisciplinary meetings with one member of the team taking responsibility for co-ordinating the reviews in a diary. The length of specific reviews was between five minutes and one hour. At the six month appraisal of the system it was apparent that the target of reviewing patients at least twice a year was unrealistic, and for some long-term patients in stable circumstances it was not necessary. We set a minimum standard of yearly reviews and within this have followed a flexible approach with reviews being held as appropriate.

Conclusion

By setting aside a small amount of time to plan and train staff it has been possible to develop our own system to implement CPA in daily clinical work. The use of written individual care plans has become the norm for both long-term and new patients and formed the framework for discussion about individual patient care. Discussions have been more focused and efficient, although we could not quantify this. The key-worker system has been effective in ensuring the production of the plans and their regular review. Keeping a diary of reviews has enabled the team to develop a greater sense of its overall workload and areas of pressure, leading to a change in the standard for a minimum frequency of review and a recognition of the need for flexibility in the system. Positive staff attitudes and experience have been important in enabling the system to work. Identifying potential benefits at the beginning helped us recognise

the intangible gains to clinical practice as we implemented the system.

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CMMHT Database Individual Careplan form available from the author on request.

Can staff predict day hospital responders?

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To maximise the effectiveness of psychiatric day hospitals it is important to establish which patients benefit most. We tested the hypothesis that day hospital therapists can predict responders. The consultant, key-workers, junior psychiatrist and secretary predicted outcome for 26 patients. These were measured blind using the Brief Psychiatric Rating Scale (BPRS), Global Assessment Scale (GAS), Beck's Depression Inventory (BDI) and the Social Functioning Questionnaire (SFQ). There was poor correlation generally between staff predictions and patient progress as measured by the standardised instruments. The only significant correlation was the consultant's prediction with the BPRS. We suggest this is consistent with the consultant's experience and training in phenomenology. We conclude that consultants should be fully involved in day hospital assessments.

Day hospitals play an important role in community care, particularly since they have the advantage of offering structured treatment while patients continue to live at home. The Jules Thorn Day Hospital is a psychiatric day hospital with an inner city catchment area. It offers a mixture of group therapies as well as individual support and medication. The multidisciplinary team consists of nurses, occupational therapists, a psychologist, a psychiatric social worker, a consultant psychiatrist and a junior psychiatrist (senior

house officer with one year's psychiatric experience). There is a key-worker system whereby each patient is allocated a named therapist who may be any member of the team except the consultant. The secretary is based in an open-planned reception area and has contact with all patients on a daily basis.

In spite of psychiatric day hospitals being an important resource little is known about which patients benefit most from day patient care (Creed *et al*, 1988). Vidalis & Baker (1986) found that basic demographic data failed to predict day hospital responders. Although Vidalis *et al* (1990) found that staff's predictions of success correlated positively with an overall assessment of success after six weeks, they failed to show a direct correlation between prediction and outcome on any of their four scales and they did not include a consultant's prediction. We chose four scales for their breadth of outcome measurement and ease of use (the scales added only five to ten minutes to a standard history and mental state examination). The two observer-rated scales were the Brief Psychiatric Rating Scale (BPRS), designed to measure patient change over 16 areas of psychopathology on a seven point scale, and the Global Assessment Scale (GAS), a short